NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

SED/SMI MCO DISENROLLMENT FORM

DETERMINATION NOTICE FOR SEVERELY EMOTIONALLY DISTURBED (SED) CHILDREN OR SERIOUSLY MENTALLY ILL (SMI) ADULTS

DHCFP – SED/SMI MCO Disenrollment Form Instructions:

To stay current with policy and documentation updates, we recommend that you visit www.medicaid.nv.gov on a monthly basis.

You can find the SED/SMI MCO Disenrollment Form and these instructions online at www.medicaid.nv.gov in the Managed Care webpage.

Instructions for completing this form:

Please complete this form **only** if you are enrolled in a Managed Care Organization and are requesting disenrollment due to SED/SMI determination or if this is your annual SED/SMI re-determination.

All pages of this form must be completed and submitted to the DHCFP or its designee within **five** working days after the SED or SMI determination. If the SED/SMI form is missing any information, it will be discarded.

Fax completed form to the DHCFP Managed Care & Quality Assurance Unit Fax: (775) 684-3774. Instructions do not need to be faxed.

If the recipient is enrolled with Health Plan of Nevada (HPN) please contact Human Behavior Institute (HBI) at Phone (800)-441-4483 or (702)-248-8866, Fax (702)-248-0079, as they are the contracted provider to conduct the SED/SMI assessments.

Disclaimer:
Pursuant to the State of Nevada Title XXI State Plan, Nevada Check Up recipients must remain enrolled with the managed care organization that is responsible for on-going patient care.

Nevada Medicaid Newly Eligibles, defined as childless adults ages 19-64, and the expanded parent and caretakers ages 19-64, who are made eligible as part of the Patient Protection and Affordable Care Act (PPACA) expansion population and who are receiving the Alternative Benefit Plan, cannot opt out of managed care, where available, based on a determination of Serious Mental Illness (SMI).

RECIPIENT INFORMATION

1. Recipients Name – Enter the recipient's name as it appears on their Medicaid card.
2. Date of Birth – Enter the recipient's Date of Birth (DOB).
3. SSN – Enter recipient's Social Security Number.
4. Recipient Medicaid ID – Enter 11-digit number shown on the front of the recipient's Medicaid card.
5. Original SED/SMI Determination - If this is the Original SED/SMI Determination check this box and date it.
6. Annual Re-Determination - If this is your annual re-determination check this box and date it.
7. Determination Site:

18 YEARS AND OLDER

1. Check this box if this is the original determination and recipient is determined SMI.
2. Check this box if recipient is no longer SMI.
3. Check this box if this is the annual re-determination and recipient remains SMI.

17 YEARS OF AGE AND UNDER

1. Check this box if this is the original determination and the child is determined SED.
2. Check this box if the child is no longer SED.
3. Check this box if this is the annual re-determination and the child remains SED.
4. Check this box if the Child is in DCFS Custody or County Custody.

PROVIDER/ASSESSOR INFORMATION

1. Agency – Enter the Agency name.
2. Name of Assessor – Enter the name of the assessor.
3. Signature – Assessors signature.
4. Agency Unit – Enter the name of the unit within the Agency.
5. Agency Address – Enter the address of the Agency (including City, State and Zip Code)
6. Date – Enter the date the form was completed.
7. Title - Enter the title of the Assessor.
8. Phone - Enter the assessors phone number.
9. Fax – Enter the assessors fax number.
10. MCO Enrollment – If the provider is enrolled with an MCO please check all that apply.

SED CONSENT: (For Children under the age of 18)

1. Enter the name of the Agency you are authorizing to conduct the assessment and share the results with the DHCFP. By filling out this section of the form you attest that the named agency has fully explained the reason why the child requires an assessment at this time.
2. Print Name of recipient – Print the recipient's name as it appears on their Medicaid card.
3. Print Name of Responsible Party – Print the name of the person legally responsible for the child (i.e. parent or guardian).
4. Signature of Responsible Party – Signature of the responsible party is required.
5. Address – Enter the recipient's address (including City, State and Zip Code).
6. Recipients Medicaid Id - Enter 11- digit number shown on the front of the recipient's Medicaid card.
7. Relationship to child – Enter the responsible party's relationship to the child.
8. Date – Enter the date the form was signed by the responsible party.
9. Phone/Fax – Enter the responsible party's phone number and fax if any. If the recipient does not have a phone number, enter "N/A" in this field.

SMI CONSENT: (for adults 18 years of age and older)

1. Enter the name of the Agency you are authorizing to conduct the assessment and will be share the results with DHCFP. By filling out this section of the form you attest that the named agency has fully explained the reason why they believe you require an assessment at this time.
2. Print Name of Recipient – Print the name of the recipient as it appears on their Medicaid card.
3. Print Name of Responsible Party (if other than recipient) – Print the name of the legally responsible party, if other than the recipient.
4. Signature of Recipient or Responsible Party– Signature of recipient or responsible party is required.
5. Address – Enter the recipient's address (including City, State and Zip Code).
6. Recipient's Medicaid ID - Enter 11- digit number shown on the front of the recipient's Medicaid card.
7. Relationship to recipient - Enter the responsible party's relationship to the recipient, if other than self.
8. Date – Enter the date the form was signed by the recipient or responsible party.
9. Phone/Fax – Enter the recipient or responsible party's phone number and fax, if any. If the recipient does not have a phone number, enter "N/A" in this field.

MCO Disenrollment request due to SED/SMI Determination

1. Check this box if this is your first SED/SMI determination and you are requesting to be disenrolled from your current MCO to be covered under Fee-for-Service.
2. If this is your annual re-determination or you were previously disenrolled from your MCO due to an SED or SMI determination, please check one of the options.
    a. Check if you wish to remain in Fee-for-Service Medicaid.
    b. Check if you wish to disenroll from your MCO and be covered under Fee-for-Service Medicaid.
    c. Check if you wish to return to managed care.
3. Print name of recipient - Enter the recipient's name as it appears on their Medicaid card.
4. Signature of Recipient or Responsible Party – Signature of recipient or responsible party is required.
5. Address – Enter the recipient's home address (including City, State and Zip Code)
6. Date – Enter the date the form was signed by the recipient or responsible party.
7. Recipients Medicaid Id - Enter 11- digit number shown on the front of the recipient's Medicaid card.
8. Relationship to Recipient (if under 18) – Enter the responsible party's relationship to the recipient if under 18.
9. Phone/Fax – Enter the recipient's phone number and fax, if any. If the recipient does not have a phone number, enter "N/A" in this field.

Note: Verify the recipients address and phone number are current, whether or not they match the information on file with Nevada Medicaid. If the recipient has moved, remind him/her to update address and phone number with the Division of Welfare and Supportive Services (DWSS)

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RECIPIENTS INFORMATION (please Print)	
NAME:	☐ Original SED/SMI Determination Date:
DOB:	☐ Annual Re-Determination Date:
SSN:	Determination Site:
MEDICAID ID:	
18 YEARS AND OLDER	**17 YEARS OF AGE AND UNDER**
☐ YES, individual determined SMI	☐ YES, child determined SED
☐ Adult **no longer** SMI	☐ Child no longer SED
☐ Adult remains SMI	☐ Child remains SED
	☐ **DCFS** Custody ☐ **County** Custody
PROVIDER/ASSESSOR INFORMATION	
Agency:	Date:
Name of Assessor:	Title:
Signature:	Phone:
Agency Unit:	Fax:
Agency Address:	MCO Enrollment:(check all that apply) ☐ SilverSummit ☐ HPN ☐ Anthem ☐ None

This individual has been assessed according to the Nevada Division of Health Care Financing and Policy (DHCFP) diagnostic criteria. (For SED/SMI definitions, see Medicaid Services Manual (MSM) Chapter 2500.)

SED/SMI CONSENT	
This form serves as consent to the evaluator working with the family to communicate determinations with the DHCFP/Medicaid and/or its designee (e.g., contracted Managed Care Organizations (MCOs) or fiscal agent), and, only if applicable, to Nevada Division of Public and Behavioral Health (DPBH), the Nevada Division of Child and Family Services (DCFS) and/or Aging and Disability Services (ADSD)	
SED CONSENT: (For Children under the age of 18)	
I hereby authorize _____ (name of agency) to: 1) Conduct an assessment for the sole purpose of determining whether my child has a severe emotional disturbance (SED) and; 2) Share the results of this assessment and determination only with the above-named entities, and me. This Agency has explained fully, and to my satisfaction, the reasons as to why they believe my child requires an assessment at this time. All parties shall keep such assessment information strictly confidential.	
Print Name of recipient:	Recipient's Medicaid ID:
Print Name of Responsible Party:	Relationship to Child:
Signature of Responsible Party	Date:
Address:	Phone: Fax:
SMI CONSENT: (for adults 18 years of age and older)	
I hereby authorize _____(name of agency) to: 1) Conduct an assessment for the sole purpose of determining whether I have a Serious Mental Illness (SMI) and; 2) Share the results of this assessment and determination only with the above-named entities, and me. This Agency has explained fully, and to my satisfaction, the reasons as to why they believe I require an assessment at this time. All parties shall keep such assessment information strictly confidential	
Print Name of Recipient:	Recipient's Medicaid ID:
Print Name of Responsible Party (if other than recipient):	Relationship to recipient:
Signature of Recipient or Responsible Party:	Date:
Address:	Phone: Fax:

MCO Disenrollment request due to SED/SMI Determination

This form serves as an account of the recipient's wishes in regard to their Medicaid managed care enrollment. If disenrollment is requested and approved prior to monthly cut-off, the Nevada Division of Health Care Financing and Policy (DHCFP) will disenroll the Medicaid managed care recipient from his/her health plan on the first day of the month following submission of this form. Following disenrollment, all covered medically necessary services, including but not limited to services specific to the recipient's SED or SMI diagnosis, will be authorized and reimbursed through Fee-for-Service Medicaid. If no disenrollment is requested, the recipient will continue to receive services through their health plan.

1. If this is your first SED/SMI determination, please check below:

☐ I wish to disenroll from managed care and be covered under Fee-for-Service Medicaid.

2. If this is your annual re-determination or you were previously disenrolled from managed care due to your SED or SMI determination, please indicate your choice below (choose only one):

☐ I wish to remain Fee-for-Service Medicaid.
☐ I wish to disenroll from managed care and be covered under Fee-for-Service Medicaid.
☐ I wish to return to managed care and be enrolled in a health plan.

Print Name of Recipient:	Medicaid ID:
Signature of Recipient or Responsible Party:	Relationship to Recipient (if under 18)
Recipients Address:	Phone Number:
Date:	Fax: (if any)

***Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment, and 2) documentation of this authority is available upon request.

Fax completed form to the DHCFP Managed Care & Quality Assurance unit fax: (775) 684-3774. If any information is missing this form will be discarded

For complete policy regarding SED/SMI disenrollment from managed care, refer to MSM Chapter 3600, which is available on the DHCFP website at http://dhcfp.nv.gov/.