



# District of Columbia Medicaid Community Support Services Review Assessment

*Created June 2026*

**Please complete all sections of this form.**

CONSUMER NAME: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

MEDICAID ID or IPC ID number (if uninsured): \_\_\_\_\_

DATE OF BIRTH (mm/dd/yyyy) \_\_\_\_\_

TREATING PROVIDER NAME: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

TREATING PROVIDER NPI #: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_ FACILITY NPI #: \_\_\_\_\_

REQUEST START DATE (should **not** overlap with current approval dates): \_\_\_\_\_

FACILITY CONTACT NAME: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

FACILITY CONTACT NUMBER: (format: 000-000-0000) \_\_\_\_\_

FACILITY CONTACT FAX NUMBER (optional): \_\_\_\_\_

**1. Has the Consumer's Medicaid eligibility, or Incedo Provider-Connect (IPC) ID number (if uninsured), been confirmed?**

☐ Yes

☐ No (**If no, STOP - DO NOT PROCEED** and verify eligibility on the DC Medicaid web portal at <https://www.dc-medicaid.com/dcwebportal/home> prior to submitting an authorization request, or contact Department of Behavioral Health for uninsured individual's IPC ID number.)

**2. I attest that at least one (1) of the following qualifying primary diagnoses has been confirmed by the Diagnostic Assessment per DCMR subsection 3421.14. (NOTE: For list of qualifying diagnosis codes, go to Comagine Health website <https://comagine.org/program/dc-medicaid-um/providers>).**

☐ Yes. Select the qualifying diagnosis:

☐ a. Schizophrenia or Other Psychotic Disorders

☐ b. Delusional Disorders

☐ c. Affective Disorders

☐ d. Trauma-Related Disorders

☐ e. Obsessive Compulsive Disorder

☐ f. Personality Disorder

☐ g. Anxiety-Related Disorders

☐ No, the consumer does not have a qualifying diagnosis. (**If no, STOP.** Comagine Health is unable to process this request without a qualifying diagnosis.)

**3. For Community Support services, a completed functional assessment tool must be submitted with the request. Please attest if a functional assessment has been attached.**

☐ Yes, I attest I have attached a functional assessment tool that is completed within 90 days of the date of request. Select the tool submitted:

☐ **Preschool and Early Childhood Functional Assessment Scale (PECFAS)** for Consumers ages three (3) through five (5) within the range of **50 to 110**. Select the PECFAS score for this consumer:

☐ 50      ☐ 60      ☐ 70      ☐ 80      ☐ 90      ☐ 100      ☐ 110

**Please validate units requested do not exceed the maximum allowable units for this score.**

(PECFAS: Score 50-70, Number of Allowable Units = 100; Score 80-110, Number of Allowable Units = 200 per DCMR subsections 3421.6 and 3434.4)

☐ **Child and Adolescent Functional Assessment Scale (CAFAS)** for Consumers ages six (6) through twenty (20) within the range of **50 to 110**. Select the PECFAS score for this consumer:

☐ 50      ☐ 60      ☐ 70      ☐ 80      ☐ 90      ☐ 100      ☐ 110

**Please validate units requested do not exceed the maximum allowable units for this score.**

(CAFAS: Score 50-70, Number of Allowable Units = 100; Score 80-110, Number of Allowable Units = 200 per DCMR subsections 3421.6 and 3434.4)

☐ **Daily Living Assessment-20 (DLA-20)** for Consumers aged eighteen (18) and older with a DLA-20 score within the range of 3.1 to 5.0. Select the DLA-20 score for this consumer:

☐ 3.1    ☐ 3.2    ☐ 3.3    ☐ 3.4    ☐ 3.5    ☐ 3.6    ☐ 3.7    ☐ 3.8    ☐ 3.9    ☐ 4.0

☐ 4.1    ☐ 4.2    ☐ 4.3    ☐ 4.4    ☐ 4.5    ☐ 4.6    ☐ 4.7    ☐ 4.8    ☐ 4.9    ☐ 5.0

**Please validate units requested do not exceed the maximum allowable units for this score.**

(DLA-20: Score 3.1-4.0, Number of Allowable Units = 200; Score 4.1-5.0, Number of Allowable Units = 100 per DCMR subsections 3421.6 and 3434.4

☐ No, I do not have a functional assessment tool (**If no, STOP.** Comagine Health is unable to process this request without a functional assessment tool.)

**4. I attest I have attached a MHRS Core Service Agency Consumer Choice and/or a Consent to Treatment Form signed by the client?**

☐ Yes

☐ No (**If no, STOP.** Comagine Health is unable to process this request without a Consumer Choice or Consent to Treatment form.)

**5. I attest I have attached the current Individualized Recovery Plan (IRP) or Individualized Plan of Care (IPC) that is person-centered with specific goals, objectives, interventions, and a discharge/transition plan completed within 180 days of the request, signed by the Qualified Practitioner (QP) and the client.**

☐ Yes

☐ No (**If no, STOP.** Comagine Health is unable to process this request without an IRP or IPC.)

**6. Please affirm and acknowledge these statements:**

☐ I AFFIRM that the submitted clinical documentation confirms the requested service(s) and is medically necessary and consistent with the recipient's current treatment plan.

☐ I ACKNOWLEDGE the services are subject to post payment review of medical necessity and completeness of documentation according to Medicaid program rules and that the Department of Health Care Finance or Department of Behavioral Health may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid program rules.

☐ I ACKNOWLEDGE that approval of this authorization request does not guarantee payment.

☐ I ACKNOWLEDGE that if any clinical documentation contained in or attached to this authorization request is found to include false, fraudulent, or misleading information, the Department of Behavioral Health will be notified and may take regulatory action, including revocation of provider certification.

**TREATING PROVIDER SIGNATURE:** \_\_\_\_\_