NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

SED/SMI DETERMINATION

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

Name: _____ ☐ Original Determination

Medicaid ID: _____ ☐ Annual Re-Determination

SSN: _____ SED/SMI Determination Date: _____

Date of Birth: _____ SED/SMI Determination Site: _____

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.)

18 YEARS OF AGE 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 ☐ YES ☐ NO
County Custody ☐ YES ☐ NO

_____ Agency	_____ Date
_____ Name of Assessor	_____ Title
_____ Agency Unit	_____ Phone Number
_____ Agency Address	_____ Fax Number

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, to ensure timely notification. **Fax to the DHCFP Business Lines Unit, (775) 684-3774.**

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

NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

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 Mental Health and Developmental Services (MHDS) and/or the Nevada Division of Child and Family Services (DCFS).

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 Medicaid ID Number

_____ _____ _____
Signature of Responsible Party Relationship to Child Date

_____ _____
Address Phone Number

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 Medicaid ID Number

_____ _____ _____
Signature of Responsible Party Relationship to Recipient Date

_____ _____
Address Phone Number

NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

MANAGED CARE ENROLLMENT

This form serves as an account of the recipient's wishes in regards 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. *If the recipient is currently exempt from managed care for reasons other than an SED or SMI determination, the recipient will remain Fee-for-Service Medicaid as long as that exemption is in effect.*

If this is your first determination, please indicate your choice below (choose only one):

☐ I wish to disenroll from managed care and be covered under Fee-for-Service Medicaid.
☐ I wish to remain in managed care and keep my enrollment with my health plan.
☐ I am currently covered under Fee-for-Service Medicaid and wish to remain that way.

If this is a re-determination and 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 return to managed care and be enrolled in a health plan.

_____ _____
Print Name of Recipient Medicaid ID Number

_____ _____ _____
Signature of Recipient or Responsible Party if under 18***** Relationship to Recipient Date

_____ _____
Address Phone Number

*****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.

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.