District of Columbia Medicaid Crisis Bed Services Review Assessment

Created November 2025

Please complete all sections of this form. This is only applicable for the first 48 hours of admission.

PATIENT NAME: (First) _____ (Last) _____

MEDICAID ID or ICP #: _____ DATE OF BIRTH (mm/dd/yyyy) _____

TREATING PROVIDER NAME: (First) _____ (Last) _____

TREATING PROVIDER NPI #: _____

FACILITYNAME: _____ FACILITY NPI #: _____

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** with completion of this request.) Please verify eligibility on the DC Medicaid web portal @ Department of Health Care Finance - Home Page prior to submitting an authorization request or contact Department of Behavioral Health for uninsured individual's IPC ID number.

2. **Is this a retrospective request?**

   ☐ Yes (**If yes, please ensure you attach the discharge summary; provider required to answer 2.a**. Continue and a comprehensive review will be conducted.)

   2.a. Discharge Date:

   ☐ No

3. **Has the consumer been discharged from a Crisis Bed facility within the last 14 days?**

   ☐ Yes (If yes, please continue and a comprehensive review will be conducted.)

   ☐ No

4. **Has the Daily Living Assessment-20 (DLA-20) been completed with a score of 4 or less?**

   ☐ Yes

   ☐ No (If no, please continue and a comprehensive review will be conducted.)

5. **Does the consumer have a chronic and persistent mental illness, or psychiatric condition/behavioral health (BH) symptoms with or without co-occurring substance use disorder (SUD)?**

   ☐ Yes

   ☐ No (If no, please continue and a comprehensive review will be conducted.) Stand-alone SUD as the primary diagnosis does not qualify for crisis bed services. SUD can co-occur alongside a primary BH illness.

6. **Does the consumer require care and service that would be provided in an acute inpatient unit?**

   ☐ Yes (If yes, please continue and a comprehensive review will be conducted.) You have selected an answer indicating the member needs a higher level of care.

   ☐ No

7. **At the time of this admission request, did the consumer have a support system that can provide the required care and supervision?**

☐ Yes (If yes, please continue and a comprehensive review will be conducted.)

☐ No (**If no, provider required to answer 7.a**)

7.a. If no, select at least one of the following that applies: Please choose: / High risk environment / Unable to ensure safety / Unavailable

8. **Symptoms/conditions are increasing and potential for acute psychiatric hospitalization within the next 24 hours.**

☐ Yes (**If yes, provider required to answer 8.a**)

☐ No (If no, please continue and a comprehensive review will be conducted.)

8.a. Select at least one of the following symptoms that apply to the recipient within the last 48 hours:

A. ☐ Risk of personal injury and safety

B. ☐ Suspected medication non- adherence

C. ☐ Hypo/Hypermanic symptoms with history of rapid deterioration to mania

D. ☐ Non-suicidal self-injury requiring professional medical attention

E. ☐ Suicidal ideation and high risk of attempt (**if selected, must complete the attestation below**)

- ☐ Yes, I attest that the patient has engaged in safety planning and maintains safe behaviors with the resources available at the current crisis facility.
- ☐ No, the patient has not engaged in safety planning and does not maintain safe behaviors with the resources available at the current crisis facility. (This request will be pended for comprehensive clinical review.)

F. ☐ Other – enter the additional symptoms in the text box below. (For other, this request will be pended for comprehensive clinical review.)

9. Please affirm and acknowledge below:

____ I AFFIRM that the submitted clinical documentation confirms the requested stay/service(s) and is medically necessary and consistent with the recipient's current level of impairment.

____ 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 the 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: _____