District of Columbia Medicaid Rehabilitation Day Services Initial 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. Is this request being submitted more than 30 days prior to the service start date for Rehabilitation Day services?

☐ Yes.

☐ No.

3. Is this request being submitted less than 7 days prior to the service start date for Rehabilitation Day services?

☐ Yes.

☐ No.

4. For Rehabilitation Day services, a completed and signed Daily Living Activities-20 (DLA-20) functional assessment indicating a score of 5.0 or below must be submitted with the request. Please attest if DLA-20 functional assessment has been uploaded.

☐ Yes, I attest that I have uploaded the DLA-20 functional assessment that has been signed and dated within 90 days of this submission.

If yes, what is the DLA-20 score? (format 0.0) _____

☐ No, I do not have a DLA-20 functional assessment. Per DC Medicaid, DLA-20 functional assessment is required documentation. Failure to provide may result in delay in processing and a technical denial.

5. I attest I have uploaded the required current Patient-Centered Treatment Plan completed with individualized needs and goals signed by the Qualified Practitioner (QP) and the client.

☐ Yes

☐ No. Per DC Medicaid, Patient-Centered Treatment Plan is required documentation. Failure to provide may result in delay in processing and a technical denial.

6. I attest I have uploaded the diagnostic assessment by a QP and/or a Psychiatric Evaluation by MD or APRN, completed within one (1) year of the date of submission, indicating a qualifying mental health diagnosis.

☐ Yes

☐ No. Per DC Medicaid, diagnostic assessment is required documentation. Failure to provide may result in delay in processing and a technical denial.

7. Please affirm and acknowledge ALL 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 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: _____