

Notification of Out of State (OOS) 90-Day Review

Childs Name:	District:	Medicaid No:	Today's Date:
		SSN:	Date of Birth:
<input type="checkbox"/> 90-Day OOS Review <input type="checkbox"/> Reconsideration <input type="checkbox"/> Reschedule		<input type="checkbox"/> Client to be assessed via Secure Video Teleconference <input type="checkbox"/> Client to be assessed telephonically <input type="checkbox"/> Client to be assessed face-to-face	
Appointment Date:		Appointment Time:	
Single Point of Access (SPOA):		Phone:	Email:
Qualified Evaluator (QE):		Phone:	Email:
Address (Office):		Supporting documentation due to QE by: Send to the following address:	
<p>Residential Treatment Facilities: In accordance with Department of Children and Families (DCF) guidelines please ensure the following arrangements have been made:</p> <p>(a) Separate space is available for the Qualified Evaluator to conduct the secure video teleconference assessment with the child.</p> <p>(b) The child's medical records are available for review and include all up-to-date clinical information.</p> <p>Notification of the above appointment must be provided to the GAL and AAL so they will have an opportunity to contact the evaluator.</p> <p style="text-align: center;">Thank you for your Cooperation</p>			