NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Request for Clinical Review of CSIDD Tier Assignment

To request a clinical review of the Tier Assignment for Crisis Services for Individuals with Developmental/Intellectual Disabilities (CSIDD), please indicate the reason for the request and submit to the correct office accordingly:

BPIR Re-administration outside of scheduled quarterly assessment
(submit form to your Regional Office CSIDD Liaison)

Tier Assignment does not align with clinical services indicated
(submit form to the Central Office CSIDD Mailbox - CSIDDCOF@opwdd.ny.gov)

Section 1: To be completed by the CSIDD Provider			
Individual's Name:		Date of Birth:	
TABS ID:		Medicaid CIN:	
Type of Residence: i.e., certified setting, family home, etc.		Residence Contact: (Name/Phone #)	
Date Request Submitted:		Date Authorized for CSIDD Services:	
Current Tier Assigned by RO:		Requested Tier by Provider:	

Supporting Documentation to be Included with Request:

CSIDD treatment plan
Current BPIR Protocol (and new BPIR Protocol if re-administered outside of quarterly assessment)
Any other relevant documentation

Clinical summary for the request: *This section must include rationale for the requested change including the clinical needs of the individual and why a different treatment level is clinically indicated.*

Anticipated gains/benefits: *This section must include specific clinical rationale for how the services in the different treatment level are expected to benefit the individual.*

CSIDD Provider Contact: Phone Number:

Section 2: To be completed by OPWDD Regional or Central Office	
Central Office	Regional Office
New Tier Assignment: Tier I Tier II Tier III Tier IV	
Comments/Additional Instructions:	
Name of Approver: Central Office	Regional Office Date: