CHILDREN WITH SERIOUS EMOTIONAL DISORDER WAIVER (CSEDW)
EXCEPTIONS REQUEST FORM
REQUEST FOR WRAPAROUND FACILITATION INTENSITY LEVEL CHANGE

Member Name		Medicaid ID#	

This is a request to change the member's Wraparound Facilitation Intensity Level for CSEDW. Please fill out this form completely and attach all documentation that you feel supports your request for services.

The Bureau for Medical Services (BMS) will review the request to determine if the requested services are medically necessary to ensure the member's health and safety to avoid a heightened risk of institutionalization. In making its decision, BMS will consider the member's CAFAS/PECFAS and all POCs from the member's current service year.

BMS may, but is not required to, review any additional documents not attached to this request. If there are any other documents that you would like considered, please attach those documents to this request.

Submit completed form securely to Aetna via email at abhwvcsed@aetna.com or by mail to:

Aetna Better Health of WV
Attn: CSEDW
500 Virginia Street East, Suite 400
Charleston, WV 25301

Wraparound Facilitator Name	
Wraparound Facilitation Agency	
Wraparound Facilitator Phone Number	
Wraparound Facilitator Email	
Legal Representative Name (if applicable)	
Anchor Date	

1. General Questions

A. What is the member's current assessed CAFAS/PECFAS score completed by Acentra?

_____

B. What was the date of the assessment?

_____

C. Was a second CAFAS assessment requested? YES ☐ NO ☐

If yes, what was the date of the assessment and score?

Date: _____Score: _____

2. Are you requesting to INCREASE the member's Wraparound Facilitation Intensity level?

YES ☐ NO ☐ (If no, please skip to Question 3)

If yes, please provide a detailed explanation supporting the request. Please attach an additional sheet if more space is needed and any documentation that supports the request.

_____
_____
_____
_____
_____
_____

How long is this change in intensity needed? _____

3. Are you requesting to DECREASE the member's Wraparound Facilitation Intensity level?

YES ☐ NO ☐

If yes, please provide a detailed explanation supporting the request. Please attach an additional sheet if more space is needed and any documentation that supports the request.

_____
_____
_____
_____
_____
_____

How long is this change in intensity needed? _____

4. **Is there anything else you would like BMS to know about the request for alteration of the Wraparound Facilitation intensity level?** Please attach an additional sheet if more space is needed.

_____
_____
_____
_____
_____
_____

Wraparound Facilitator Signature: _____

Printed Name: _____

Date: _____

Member and/or Legal Representative Signature: _____

Printed Name(s): _____

Date: _____

BMS Use Only:

☐ Approved

☐ Denied

☐ More Information Needed

☐ Closed

Effective date of change: _____

Exception approved until: _____

Date of Committee Meeting _____

BMS Representative Signature _____