

King County Behavioral Health Administrative Services Organization (BH-ASO)

**NON-MEDICAID MENTAL HEALTH OR SUBSTANCE USE DISORDER OUTPATIENT BENEFIT
REQUEST
(Form for Agencies without a Quarterly Allocation)**

Return to Care Coordination Team
Fax: 206-205-1634 or via email at resauth@kingcounty.gov

Basic Eligibility

- A. Individuals must be a resident of King County.
- B. The individual's Income cannot be greater than 220 percent of federal poverty level for a single adult or family, as is appropriate to the individual's living situation. Income cannot be greater than 300 percent federal poverty level for children.
- C. The individual may not be covered by any other health insurance, aside from Medicare in some instances where their income is such that they may not be reasonably expected to meet their spend down.

Please Review the First and Second Priority Criteria in the Provider Manual to assure that benefit to be requested meets one or more of the criteria.

Date Requested: _____

Client Name: _____ KCID: _____

Anticipated Level of Care: _____

Provider Code: _____

Referring person: _____

Referring person phone number: _____

Please indicate if this request is for a person in a First Priority population (check one after referring to Provider Manual in this Section)

State hospital or CLIP discharge

Date admitted to Western State Hospital (WSH): _____

Date being discharged from WSH: _____

Date admitted to CLIP: _____

Date being discharged from CLIP: _____

Release from incarceration

Date admitted to prison or juvenile rehabilitation facility: _____

Date being discharged from prison or juvenile rehabilitation facility: _____

Date Medicaid application initiated: _____

Date Medicaid application expected to be complete: _____

- Extraordinary Treatment Plan
- Housing (person is in SSH, ISH, or ShelterPlusCare)
- Other

If not in a First Priority population, please indicate a Second Priority population (check one)

Housing (in LTR or SL stepping down to SSH) Community hospital discharge

Homeless Discharge from PACT

Date of PACT graduation: _____

High level of care Middle level of care

Specify age: _____

- Medicare qualifiers
- Current non-Medicaid benefit with Medicaid application pending
- Admissions/incarcerations/detentions in past 12 months

Date of discharge or release: _____

Exception to the above

Rationale for exception: _____

Medical Necessity justification, including ASAM; CA/LOCUS score justification: _____
