Reconsideration of Qualified Evaluator (QE) Recommendation

|  |  |
| --- | --- |
| Date:      | **District/ SPOA Information:**      |
| Child Information |
| NAME:      | DOB:      | medicaid number:      |

| Type of Request |
| --- |
| [ ]  rECONSIDERATION OF rECOMmendation | [ ]  **CLARIFICATION OF RECOMMENDATION** |

| Please Fully Complete All Questions Below |
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|  |  |
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| 1. Date of last suitability assessment: |       |
| 2. Name of QE: |       |
| 3. Current recommendation by QE: |       |
| 4. SPOA contact information: |       |
| **5. What is the reason for this request (please explain in detail):**  |       |
| **6. If a reconsideration of the QE recommendation is being requested, please explain, in detail, what attempts were made to stabilize the child/youth at the recommended level of care:** |       |
| **7. Additional comments for consideration:** |       |

| *BELOW SECTION TO BE COMPLETED BY MAGELLAN MEDICAID ADMINISTRATION ONLY* |
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| [ ]  **APPROVED** | [ ]  Denied | [ ]  **COURT ORDERED** | **Initials** |
| Comments |