1. Consumer Name: ___________________________  
2. Medicaid #: ______________________________

3. MH-WIN #: _______________________________  
4. WSA # (if known) : _______________________

5. Was a Comprehensive Diagnosis Evaluation (CDE) or Re-evaluation completed within the previous 365 Days that indicates eligibility requirements and medical necessity is met*? Yes ☐ No ☐ *(If no, a new evaluation and MDHHS approval is needed prior to transfer or re-entry, please upload CDE Form upon completion)

6. Previous Provider: ____________________________

7. New ASD Provider: ____________________________

8. Request Date: ________________  
9. New Provider Case Acceptance Date: ________________

10. Date of Last Service at Previous Provider: ___________________________

11. Was the Previous ASD Provider Notified: ☐ Yes  ☐ No  Date & Contact Name: ____________________________

12. Was the New ASD Provider Notified: ☐ Yes  ☐ No  Date & Contact Name: ____________________________

13. Was the IPOS Case Holder Notified: ☐ Yes  ☐ No  Date & Contact Name: ____________________________

14. Were all authorizations from the previous provider early terminated? ☐ Yes ☐ No ☐ UNK  Date: ____________

Comments: *(Must indicate family reason for case transfer request; Must indicate reason for previous discharge, including any barriers and what is being put in place to ensure success in current enrollment request)*

Name of Person Completing Form: ____________________________________________

Provider Agency Completing Request:

Detroit Wayne Mental Health Authority
AUTISM APPLIED BEHAVIOR ANALYSIS BENEFIT
CASE TRANSFER & CASE RE-ENTRY FORM
☐ ASD Provider Transfer  ☐ ASD Benefit Re-entry

Uploaded Form: TO MH-WIN SCANNED DOCUMENTS AND REQUEST AUTHORIZATION FOR CONTINUED SERVICE
PREVIOUS & NEW ASD PROVIDERS PLEASE INCLUDE CASE TRANSFER ON MONTHLY LOG – TRANSFER TAB

Revised: 6.16.17