**VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**
**MI/IDD/Related Conditions SUPPLEMENT: LEVEL II**

**Name: _____ Recommendation for Services _____**

**B. This section is to be completed by the contractor for the Level II evaluation process.**

**1. EVALUATIONS REQUIRED UPON RECEIPT OF REFERRAL (Check evaluations submitted upon receipt of referral)**

_____ Neurological Evaluation
_____ Psychological Assessment
_____ Psychiatric Assessment
_____ Psychosocial/Functional Assessment
_____ History and Physical Examination
_____ Other (please specify)_____

**2.** RECOMMENDATION

_____ Specialized services are not indicated.

_____ Specialized services are indicated.

Comments:_____

_____

_____

_____

**3** .Date referral package received: _____ Date package sent to DBHDS: _____

QMHP Signature (MI diagnosis) **Date** Telephone Number

Psychologist Signature (IDD diagnosis) **Date** Telephone Number

Case Manager Signature/Title **Date** Telephone Number

Agency / Facility Name Agency / Facility Name ID # ( if applicable)

Mailing Address

**C.** THIS SECTION IS TO BE COMPLETED ONLY BY THE DEPARTMENT OF BEHAVORIAL HEALTH AND DEVELOPMENTAL SERVICES**.**

Date referral package received:_____ Concur with recommendations of specialized services**?** **____ yes ____ no**

Comments:

_____

_____

_____

| **Copies of referral package sent to:** | **Representatives Name** | **Date Package Sent** |
|---|---|---|
| ___ PAS representative | | |
| ___ Community Services Board | | |
| ____ Admitting/retaining nursing facility | | |
| ___ Discharging hospital **(if** applicable) | | |
| ____ Individual being evaluated | | |
| ____ Individual's family | | |
| ___ Individual's legal representative **(if** any) | | |
| ___ Attending physician | | |

Appeals information included.

**Signature of State** MH/MRA Title Date Telephone Number