The ‘BHRS Downward Authorization Adjustment Request Form’ documents agreement on behalf of the family, treatment team (e.g., provider agency, school, etc.), and/or member, if/when applicable, that an individual’s scheduled service does not need to be provided and/or that the identified member may not need to receive the total amount of an authorized service during a specific length of time.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Member Name** |  | | | |
| **Date of Birth** |  | | | |
| **MAID#** |  | | | |
| **Service Name/Type** |  | | | |
| **Adjustment Date Range** | **Start Date:** |  | **End Date:** |  |
| **Hours (# of hours currently authorized)** |  | | | |
| **Units (# of units to remove)** |  | | | |
| **Reason/Explanation** |  | | | |
| **Provider Agency Name** |  | | | |
| **Provider Agency Contact (Name)** |  | | | |
| **Provider Agency Contact (Phone)** |  | | | |

*\*My signature below indicates agreement for a downward adjustment of the service identified above.*

|  |  |
| --- | --- |
| **Parent/Guardian Name (Print):** |  |
| **\*Parent/Guardian Name (Sign):** |  |
| **Member Name (Print, if applicable):** |  |
| **\*Member Name (Sign, if applicable):** |  |

**PLEASE NOTE:**

* This form **cannot be submitted** because a provider agency is unable to staff a specific service.
* If multiple services require adjustment, a separate form must be completed/submitted for each service type.
* This form is not to be used as a substitute for discharge. If a member is being discharged from services, a full discharge summary and aftercare plan must be submitted.

**FORM SUBMISSION INSTRUCTIONS:**

* This form must be submitted through the CBH **secure website** and appropriately labeled as:  
  **Provider ID#\_MbrMA#\_Adjustment**.
* Each form must be submitted individually. A provider agency may not submit multiple forms in a batch *unless* all forms in the batch pertain to one individual member.