V: May 28, 2019

Adult Behavioral Health (BH) Home and Community Based Services (HCBS): Prior and/or Continuing Authorization Request Form

☐ Prior Authorization Request (mandatory) ☐ Concurrent Review Authorization Request (optional)

***Instructions**: The HCBS provider must complete this form for every **prior authorization** for Adult BH HCBS. When requesting **concurrent authorizations**, the HCBS provider can either: 1) complete this form and submit to the managed care plan for review (which may include a subsequent telephonic review if requested by the plan); or 2) request a telephonic review only with the plan to discuss progress made and any modified goals/objectives.*

Member information

Member Name_____ Member DOB_____

Member Phone _____ Member Email (optional)_____

Member Address_____

Member Medicaid ID_____ Plan ID_____

Health Home_____ Health Home Care Manager_____

Adult BH HCBS Provider information

HCBS Provider Name_____Tax ID #_____

Provider Address_____

Contact person name_____ Title_____

Phone_____ Email_____

Date of initial intake/evaluation appointment*: _____

Adult BH HCBS requested

Please select the Adult BH HCBS for which authorization is requested (no more than 3 per request):

- ☐ Education Support Services
- ☐ Peer Supports
- ☐ Pre-vocational Services
- ☐ Transitional Employment
- ☐ Ongoing Supported Employment
- ☐ Intensive Supported Employment (ISE)
- ☐ Psychosocial Rehabilitation (PSR)
- ☐ Habilitation
- ☐ Community Psychiatric Support & Treatment (CPST)
- ☐ Family Support and Training (FST)
- ☐ Short-term Crisis Respite (concurrent reviews only)
- ☐ Intensive Crisis Respite (concurrent reviews only)

Please note the anticipated start date, frequency, intensity, duration, and modality of each requested Adult BH HCBS. Please consider what the member needs to reasonably achieve the objectives listed in the following section:

Adult BH HCBS #1	Start date (1st service visit)	Frequency (# services per wk)	Intensity (hrs per service)	Duration (e.g. 3 mos)
List:				

Modality (check all that apply)……. ☐ Individual ☐ Group ☐ On-site ☐ Off-site

Adult BH HCBS #2	Start date (1st service visit)	Frequency (# services per wk)	Intensity (hrs per service)	Duration (e.g. 3 mos)
List:				

Modality (check all that apply)……. ☐ Individual ☐ Group ☐ On-site ☐ Off-site

Adult BH HCBS #3	Start date (1st service visit)	Frequency (# services per wk)	Intensity (hrs per service)	Duration (e.g. 3 mos)
List:				

Modality (check all that apply)……. ☐ Individual ☐ Group ☐ On-site ☐ Off-site

* No prior authorization is required for up to three (3) initial intake/evaluation sessions within 14 days of the first service visit. For details for the Adult BH HCBS workflow refer to: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/workflow_guidance.htm

Goals and Objectives

Clearly state the client's goal(s) and list specific objectives for the period of requested services. Goals must accurately reflect the member's approved Adult BH HCBS Plan of Care. Objectives should be results-oriented, measurable steps towards the overall goal that can be achieved within the requested period of services.

Goal #1_____

Objective #1_____

Status…… ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2_____

Status…… ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #3_____

Status…… ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Goal #2_____

Objective #1_____

Status…… ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2_____

Status…… ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #3_____

Status…… ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Goal #3_____

Objective #1_____

Status…… ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2_____

Status…… ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #3_____

Status…… ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Describe any other barriers or obstacles to the member's goals/objectives, and strategies to address them:

__ I attest that the member has elected to receive all Adult BH HCBS requested above

__I have communicated with the member's Health Home care manager (not required)*

__I have communicated with the member's managed care care manager (not required)*

_____ _____

Signature of Provider Date

_____ _____

Name (please print): Title

** Submission of authorization form does not preclude telephonic review, which may be required by MCO/BHO. NYS encourages providers to reach out to the MCO/BHO regarding authorization protocol to ensure timely delivery of services for members.*

***Submission instructions**: [Plans must modify this template to include submission instructions via fax and/or web portal.]*