

Personal Care Authorization (BHO / MCO)

TO:	NAME OF BHO / MCO	EMAIL	DATE SENT TO BHO / MCO
	NAME OF HCS / AAA WORKER	EMAIL	TELEPHONE NUMBER
FROM:	NAME OF HCS / AAA OFFICE		
	CLIENT'S NAME	CLIENT'S PROVIDER ONE ID	DATE OF BIRTH

Section 1: To be Completed by HCS or AAA worker

Authorization packet includes this form and the client's current CARE Assessment Details.

Client's Assessment Plan Period will be from _____ to _____.

Summary of requested services and reason(s) for the request (List specific personal care services being requested and why / how its related to the client's behavioral health condition(s):

For Residential Clients

CARE generated residential daily rate: \$ _____
 Add-On rate (capital, ECS, SBS): \$ _____
 Additional dollars per day being requested \$ _____
 Total daily rate being requested: \$ _____

For In-Home Clients

CARE generated hours per month: _____
 Additional hours being requested: _____
 Total hours being requested: _____
 Monthly estimated cost of care: \$ _____

Please provide reason(s) for the additional daily rate / monthly hours and how it is related to the behavioral health condition (e.g., what additional service / support will be provided with the additional daily rate / monthly hours):

Section 2: To be Completed by BHO / MCO

DATE RECEIVED	NAME OF BHO / MCO STAFF REVIEWING PACKET	EMAIL ADDRESS	TELEPHONE NUMBER
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I have reviewed this packet and the BHO / MCO:

Approves this request – This client's need for Personal Care services is based primarily on psychiatric disabilities and the BHO / MCO will pay for the state fund portion of this service. Funding approval dates: _____ to _____ (should align with the CARE plan period above).

Denies this request entirely – The BHO / MCO will not pay for the state fund portion of this service. The BHO / MCO must provide justification for the denial in the BHO / MCO response section below.

BHO / MCO SIGNATURE	DATE
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BHO / MCO COMMENTS / RESPONSE

For HCS / AAA use only: Once this form is finalized by BHO / MCO with approval or denial:

- Scan and email completed form to AL TSA at MCOBHOforms@dshs.wa.gov.
- Submit hardcopy of completed form to DMS **Hotmail** to be included in client's electronic case record.

Instructions

Please type or print clearly and fill out completely to assist in processing of the request.

Purpose of form

When a client's need for personal care services is based primarily on a diagnosed psychiatric condition and they are receiving services through a BHO / MCO, the case worker must request funding from the BHO / MCO to cover the state funded portion of the client's personal care services. Use this form to communicate with the Behavioral Health system, document the reason for the request and to request funding for personal care from the client's assigned BHO / MCO.

Personal Care Authorization requests to the BHO / MCO must be requested for every plan period (or prior to the end date the BHO / MCO has approved funding) to allow for review and ensure continued funding by the BHO / MCO.

Section 1: To be completed by the HCS or AAA worker

- The reason box should clearly state why the personal care services are necessary and related to the behavioral health condition. This statement will be supported by the assessment.
- For Residential Clients, complete the residential section, including add-on rates.
- For In-Home Clients, complete the in-home section.
- Use the statewide average IP / homecare rate of \$22.22 to calculate the estimated monthly cost to the BHO / MCO.
- If an ETR is requested, document the reason for the ETR request.

Section 2: To be completed by the BHO / MCO

- Enter information of the BHO / MCO contact who is reviewing this request packet.
- Select only one of two boxes to indicate the BHO / MCO's response to the request:
 - Approves – enter the dates of approval. The approval period should align with the CARE plan period, which is one (1) year.
 - The BHO / MCO is only responsible for the state funded portion of the total rate (50% or less depending on the client program).
 - CFC only or CFC+COPEs: BHO / MCO pays 44% of total cost of personal care.
 - RSW or MPC: BHO / MCO pays 50% of total cost of personal care.
 - Denies – write out justification for the denial in the BHO / MCO comments/response section of the form.
 - Need is not based on a psychiatric diagnosis.
 - State services the BHO / MCO will provide to meet the clients unmet needs.
- Sign and date form. Return the request form to the HCS / AAA worker within five (5) business days of the date the request or contact the requestor to extend this requirement.

To be completed by the HCS or AAA worker once the form is returned by the BHO / MCO

- Document receipt of the completed form in a SER note.
- Confirm / update the reason code on the P1 authorization:
 - Approved – select reason code “MCO_BHO Client/ MCO_BHO Funded” for the Personal Care service line and the Personal Care Add-On service line.
 - Denied – change / remove reason code.
- Set a reminder for at least a week before the end of the approval period (or CARE plan period) so that another request can be made to the BHO / MCO to ensure continued funding.
 - If case is transferred to another office / agency, ensure the next Primary Case Manager is aware of the BHO / MCO's approval period and when another request will be necessary.
- At next assessment, if client meets the criteria, request funding from the BHO / MCO.
- Scan / email the completed form (approved or denied) to ALTSA at MCOBHOforms@dshs.wa.gov.
- Submit hardcopy of completed form to DMS **Hotmail** to be included in client's electronic case record.