



## Behavioral Health Personal Care (BHPC) Request for MCO Funding

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

**Section 1: To be Completed by HCS or AAA worker**

Request packet includes this form and the client's current CARE Assessment Details and Service Summary.  
 Client's Assessment CARE Plan Period will be from \_\_\_\_\_ to \_\_\_\_\_.  
 Summary of the request related to client's behavioral health condition.  
**Describe the behaviors and the consequences / outcomes of those behaviors:**

  
  
  
  
  
  
  
  
  
  

**ADLs the client requires assistance with as a result of behavioral symptoms or diagnoses:**

Please identify the mental health professional you spoke with (or tried to connect with) from the client's local mental health agency. This discussion is to review the care plan and to coordinate services.  
 Mental Health Professional's name: \_\_\_\_\_  
 Mental Health Agency (e.g. Compass Health): \_\_\_\_\_  
 Telephone number: \_\_\_\_\_

<p><b>For Residential Clients</b></p> CARE generated residential daily rate:   \$ Add-On rate (capital, ECS, SBS):         \$ <b>Wraparound Support additional rate requested of MCO:</b> \$ Total daily rate:                                 \$	<p><b>For In-Home Clients</b></p> CARE generated hours per month: <b>Wraparound Support additional hours:</b> Total hours per month requested: Monthly estimated cost of care:             \$
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Please provide reason(s) for the BHPC funding request and how it is related to the behavioral health condition (e.g., what additional service(s) / support(s) will be provided with the additional daily rate / monthly hours). **Describe what the caregiver does (or will do) as an intervention to the behaviors listed above:**

**Section 2: To be Completed by MCO**

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

- Approves** this request – This client’s need for BHPC services is based primarily on psychiatric disabilities and the MCO will pay for the state funded portion of this service. Funding approval dates:            to            (should align with the CARE plan period above).
  
- Denies** this request entirely – The MCO will not pay for the state funded portion of this service. The MCO must provide justification for the denial in the MCO response section below.

MCO APPROVAL SIGNATURE	DATE
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MCO COMMENTS / RESPONSE

- For HCS / AAA use only:** Once this form is finalized / signed by MCO with approval or denial:
- Scan and email completed form to ALTSA at [MCOBHOfoms@dshs.wa.gov](mailto:MCOBHOfoms@dshs.wa.gov).
  - Submit hardcopy of completed form (without instructions page) 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**

To request approval by the MCO to fund Behavioral Health Personal Care (BHPC) services.

This form must be requested for every plan period, when changes occur as outlined in Chapter 7h Appendix VI, or prior to the end date the MCO has approved funding, to allow for review by the MCO and ensure continued funding.

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

- The request should describe why the BHPC services are necessary and related to the behavioral health condition.
- 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 agency rate of \$22.22 to calculate the estimated monthly cost to the MCO.
- Document the reason for the additional daily rate / hours required and how the requested services will help this client.

### **Section 2: To be completed by the MCO**

- The MCO contact reviewing this request packet will enter their information.
- Select only one of two boxes to indicate the 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.
    - Client in an Enhanced Services Facility (ESF): The MCO is only responsible for the state funded portion of the total rate.
    - Client is in a residential setting receiving wraparound services: The MCO is only responsible for the state funded portion of the additional wraparound support rate (50% or less depending on the client program).
    - Client is in an in-home setting receiving wraparound services: The MCO is only responsible for the state funded portion of the total rate (50% or less depending on the program).
      - CFC only or CFC+COPES: MCO pays 44%
      - RSW or MPC: MCO pays 50%
  - Denies – write out justification for the denial in the MCO comments/response section of the form.
    - Need is not based on a psychiatric diagnosis.
    - Indicate the services the MCO will provide to meet the client's unmet needs.
- Sign and date form. Return the request form to the HCS / AAA worker within five (5) business days of receiving the complete BHPC 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 MCO**

- Document receipt of the completed form in a SER note.
- Set a reminder for at least a week before the end of the approval period (or CARE plan period) so that another BHPC request can be made to the MCO to ensure continued funding.
  - If case is transferred to another office / agency, ensure the next Primary Case Manager is aware of the MCO's approval period and when another BHPC request will be necessary.
- Scan / email the completed form (approved or denied) to ALTSA at [MCOBHOfirms@dshs.wa.gov](mailto:MCOBHOfirms@dshs.wa.gov).
- Submit hardcopy of completed form to DMS **Hotmail** to be included in client's electronic case record.