DSHS
WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
MANAGED CARE ORGANIZATIONS (MCO)

Behavioral Health Wraparound Support (BHWS) Request

DATE SENT TO MCO

TO: MCO EMAIL

- ☐ Community Health Plan of Washington - bhpc@chpw.org
- ☐ Coordinated Care of Washington - WA_Behavioral_Health_UM@coordinatedcarehealth.com
- ☐ Molina Health Care - MHW_BHPC_Requests@molinahealthcare.com
- ☐ United Health Care - mpc_etr@uhc.com
- ☐ Wellpoint - personalcarerequest@wellpoint.com

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 PROVIDERONE ID	DATE OF BIRTH
	WA	

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:

Additional support the client requires 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:

For In-Home Clients

CARE generated hours per month:

Wraparound Support additional hours:

Total hours per month requested:

Monthly estimated cost of care: $

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

I have reviewed this packet and the MCO:

☐ **Approves** this request – This client's need for wraparound support 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

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 MCOBHOforms@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 Wraparound Support (BHWS).

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.
  - Use the statewide average IP / homecare agency rate of $35.96 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.
    - 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%
      - 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 BHWS 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 BHWS 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 BHWS request will be necessary.
- 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.