Prior Authorization Request
Supportive Living

Provider Information			
Provider Name:		☐ **Initial Request** ☐ **Concurrent**	
Date Submitted:		**Contracted:**	☐ **Yes** ☐ **No**
Provider NPI: **Provider Medicaid ID:**		**Provider Tax ID (TIN):**	
Provider Contact Name:		**Email Address:**	
Provider Phone:		**Fax Number:**	
Provider Address:			

Member Information			
Member Name:		**Date of Birth:**	
CareSource PASSE ID#:		**Medicaid ID:**	
Care Coordinator Name:			
ICD-10 Diagnosis Code(s):		**Diagnosis Description:**	

Type of Request

Routine ☐ **Urgent** ☐ **Retrospective** ☐

Supportive Living / Complex Care				
Authorization Time Period: Up to 6 months	**Prior authorization required; service is per diem**			
Please check the CareSource Prior Authorization Page - Fee Schedules, HCBS 1915 (c) for the most up-to-date H2016 level modifiers.	**Start Date:**		**End Date:**	
	Code:			
	# of units:			

Supportive Living Transportation				
Authorization Time Period: Up to 6 months or end of year	**For mileage requests greater than 5000 – otherwise, leave blank**			
H2016 1:1 transport ☐ **H2016 Multi-transport** ☐	**Start Date:**		**End Date:**	
	Total # of Miles:			

CES Waiver - Other
This section is intended for waiver services other than Supportive Living /H2016

Code	Description	Authorization Period	# of Units

Disclaimer: An authorization is not a guarantee of payment; Member must be eligible at time of services rendered.

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INSTRUCTIONS:

1.) **This form is to be used for Supportive Living/Complex Care Home requests only. Additional waiver requests can be added to this form.**

2.) **All services should be reflected in the Person-Centered Service Plan (PCSP) and developed in collaboration between member, family/guardian, service providers and Care Coordination. Care Coordination assignment can be found in the Provider Portal or by emailing CareCoordination@CareSourcePASSE.com.**

3.) **The following are the current methods for submitting an authorization. Completed form is required.**

   a. **Provider Portal: ProviderPortal.CareSource.com/**
   b. **Fax: 1-844-542-2605**

Prior Authorization Guidance Page	
The purpose of this Prior Authorization Form is to provide a complete summary of members' support needs. Completing this form in its entirety should reduce requests for additional information and expedite authorization decisions.	
Type of member residence:	**Private Residence ☐ Group Home ☐ Apartment ☐ Other ☐** **If Other: _____**
Staffing Ratio DAY (include staff supporting other CareSource PASSE members)	**1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ Other ☐ Pls specify:**
Staffing Ratio NIGHT (include staff supporting other CareSource PASSE members)	**1:1 ☐ 1:2 ☐ 1:3 ☐ 1:4 ☐ Other ☐ Pls specify:**
Relative/Family/Guardian as Care Giver	**☐Yes ☐No; If yes, number of hours providing paid support**
DSP (non-Family/Guardian/Relative) as Care Giver	**☐Yes ☐No; If yes, number of hours providing paid support**
Total # of SL Hours per Day Required	**☐ 12 hours and less ☐ 16 – 23 hours** **☐ 12 -16 hours ☐ 24 hours**
Overnight	**☐ N/A ☐ Monitoring ☐ Awake Staff**
Support Needs **Supportive Living requests must demonstrate how the member meets the per diem level being requested, # of hours of support, specific behavioral physical, and social support needs must be clearly documented. What types of specialized care are provided that necessitate an exceptional or enhanced level of care?**	
CES WAIVER - OTHER	**Please describe purpose of other waiver services included within this request.**

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PRIOR AUTHORIZATION SERVICE GUIDANCE PAGE:

CODE	Description	Authorization Time Period	Limits / Recommended Documentation
S5160 S5161 S5162 S5165 U1	Adaptive Equipment PERS, installation and testing Adaptive Equipment PERS, service fee per month Adaptive Equipment PERS, purchase, rental, repair Adaptive Equipment, per service 1 unit per equipment item	Up to one year or end of plan	Please visit CareSource policies: PCSP, Statement of Necessity on how support services will prevent disruption to members ability to live in the community; plan for how the member/family will be trained, warranty information on parts and/or services, pictures of current and proposed modifications; 3 quotes if modification > than $1000.; Invoice required.
T2020 UA + U1	Community Transition Services 1 unit per itemized reimbursement	Up to one year or end of plan	PCSP, HDC clinical, Itemized documentation as to how the funds requested will be used help with set-up expenses for clients transitioning from institutional setting, invoice submitted in advance of the supplies with prices (not food); provider should not buy items in advance. Invoice required.
T2025 UK T2025 U1 T2025 U3 T2025 U4	<u>Consultative Services</u> Care Planning Behavior Support Testing/Assessment Goal Training 1 unit = 1 hour	Up to one year or end of plan	PCSP, type of consultation, staff certification providing the consultation service, how the consultation provided will assist the member and team in carrying out goals in the PCSP. Limits: Annually cannot exceed $1320
T2034 UA U1	Crisis Intervention 1 unit = 1 hour	Up to one year or end of plan	PCSP, Detailed narrative on need for crisis intervention to include frequency, duration, description of behaviors. Individual provider plan indicating how crisis intervention will be utilized. If behavioral health symptoms, evidence of collaboration with psychiatric support.

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K0108 UB	**Environmental Modifications** **1 unit per itemized reimbursement**	**Up to one year or end of plan**	**Please visit CareSource policies:** **PCSP, Statement of Necessity on how support services will prevent disruption to members ability to live in the community; plan for how the member/family will be trained, warranty information on parts and/or services, pictures of current and proposed modifications; 3 quotes if modification > than $1000.; Invoice required.**
S5151 UF S5151 U6 S5151 UN S5151 U6 UN	**Care Giver Respite 1:1 (<12 hrs./not overnight)** **Care Giver Respite 1:1 (>12 hrs./ overnight** **Care Giver Respite Shared (<12 hrs./not overnight)** **Care Giver Respite Shared (>12 hrs./ overnight)**	**Up to one year or end of plan**	**PCSP, Detailed narrative on need for crisis respite including anticipated length of need.**
T2028	**Specialized Medical Supplies**	**Up to one year or end of plan**	**PCSP, Statement of Necessity on how supplies will support independence, Plan for how the member/family will be trained. Invoice required.**
T2020 UA	**Supplemental Support Services** **Processed as 1 unit – must submit invoice with total costs.**	**Up to one year or end of plan**	**PCSP, how this support will help members ability to live in the community; referral from medical professional (i.e. gym membership, camps, mi) plan for how the member/family will be trained; 3 quotes if supports > $1000. Invoice required.**
H2023 U1 + UA H2023 UK H2023 UA + UB H2023 UQ H2023 U3 + UA H2023 U2 + UA	**<u>Supported Employment</u>** **Discovery & Career Planning** **Extended Services** **Job Coaching 1:1** **Job Coaching Shared Staffing** **Job Path** **Job Development** **1 unit = 15 minutes**	**Up to one year or end of plan**	**PCSP, Individual Career profile, Arkansas Rehabilitation Services letter of closure, Employment Plan with job goals focused on acquiring and maintaining competitive employment, progress notes.**