



Prior Authorization Request Supportive Living

Provider Information			
Provider Name:		<input type="checkbox"/> Initial Request <input type="checkbox"/> Concurrent	
Date Submitted:		Contracted:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Provider NPI:		Provider Tax ID (TIN):	
Provider Medicaid ID:		Email Address:	
Provider Contact Name:		Fax Number:	
Provider Phone:		Provider Address:	
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 <input type="checkbox"/> Urgent <input type="checkbox"/> Retrospective <input type="checkbox"/>			
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 , 1915(c) Custom Fee Schedule for most up-to-date H2016 levels + 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 <input type="checkbox"/>	Start Date:		End Date:
H2016 Multi-transport <input type="checkbox"/>	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. Email: Servicedeterminations@caresourcePASSE.com
 - b. Fax: 1-844-542-2605
- 4.) The CareSource Provider Portal is not available for submission of these services; however, you can use the portal for viewing the status of an authorization.

Prior Authorization Guidance Page	
<p>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.</p>	
<p>Type of member residence:</p>	<p>Private Residence <input type="checkbox"/> Group Home <input type="checkbox"/> Apartment <input type="checkbox"/> Other <input type="checkbox"/></p>
	<p>If Other: _____</p>
<p># of Person(s) in the Home Receiving Supportive Living:</p>	
<p>Staffing Ratio DAY (include staff supporting other CareSource PASSE members)</p>	<p>1:1 <input type="checkbox"/> 1:2 <input type="checkbox"/> 1:3 <input type="checkbox"/> 1:4 <input type="checkbox"/> Other <input type="checkbox"/> Pls specify:</p>
<p>Staffing Ratio NIGHT (include staff supporting other CareSource PASSE members)</p>	<p>1:1 <input type="checkbox"/> 1:2 <input type="checkbox"/> 1:3 <input type="checkbox"/> 1:4 <input type="checkbox"/> Other <input type="checkbox"/> Pls specify:</p>
<p>Relative/Family/Guardian as Care Giver</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No; If yes, number of hours providing paid support</p>
<p>DSP (non-Family/Guardian/Relative) as Care Giver</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No; If yes, number of hours providing paid support</p>
<p>Total # of SL Hours per Day Required</p>	<p><input type="checkbox"/> 12 hours and less <input type="checkbox"/> 16 – 23 hours <input type="checkbox"/> 12 -16 hours <input type="checkbox"/> 24 hours</p>
<p>Overnight</p>	
<p>Support Needs <small>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?</small></p>	
<p>CES WAIVER - OTHER</p>	<p>Please describe purpose of other waiver services included within this request.</p>

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PRIOR AUTHORIZATION SERVICE GUIDANCE PAGE:

CODE	Description	Authorization Time Period	Limits / Recommended Documentation
S5160 S5161 S5162 S5165 U1	Adaptive Equipment Adaptive Equipment, PERS service fee per month Adaptive Equipment PERS, purchase only. Adaptive Equipment, per service 1 unit per equipment item	Up to 6 months or end of calendar year	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 1 year or end of calendar year	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 6 months	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 6 months	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.
K0108 UB	Environmental Modifications 1 unit per itemized reimbursement	Up to 1 year or end of calendar year	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

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			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 6 months	PCSP, Detailed narrative on need for crisis respite including anticipated length of need.
T2028	Specialized Medical Supplies	Up to 6 months	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 6 months	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	Supported Employment Discovery & Career Planning Extended Services Job Coaching 1:1 Job Coaching Shared Staffing Job Path Job Development 1 unit = 15 minutes	Up to 6 months	PCSP, Individual Career profile, Arkansas Rehabilitation Services letter of closure, Employment Plan with job goals focused on acquiring and maintaining competitive employment, progress notes.

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