

**Adult Behavioral Health (BH) Home and Community Based Services (HCBS):
Prior and/or Continuing Authorization Request Form**

☐ Prior Authorization Request (mandatory)

☐ Concurrent Review Authorization Request (optional)

Instructions: The HCBS provider must complete this form for every **prior authorization** for Adult BH HCBS. When requesting **concurrent authorizations**, the HCBS provider can either: 1) complete this form and submit to the managed care plan for review (which may include a subsequent telephonic review if requested by the plan); or 2) request a telephonic review only with the plan to discuss progress made and any modified goals/objectives.

Member information

Member Name _____ Member DOB _____

Member Phone _____ Member Email (optional) _____

Member Address _____

Member Medicaid ID _____ Plan ID _____

Health Home _____ Health Home Care Manager _____

Adult BH HCBS Provider information

HCBS Provider Name _____

Provider Address _____

Tax ID # _____

Contact person name _____ Title _____

Phone _____ Email _____

Adult BH HCBS requested

Please select the Adult BH HCBS for which authorization is requested (no more than 3 per request):

- | | |
|---|--|
| <input type="checkbox"/> Education Support Services | <input type="checkbox"/> Psychosocial Rehabilitation (PSR) |
| <input type="checkbox"/> Peer Supports | <input type="checkbox"/> Habilitation |
| <input type="checkbox"/> Pre-vocational Services | <input type="checkbox"/> Community Psychiatric Support & Treatment (CPST) |
| <input type="checkbox"/> Transitional Employment | <input type="checkbox"/> Family Support and Training (FST) |
| <input type="checkbox"/> Ongoing Supported Employment | <input type="checkbox"/> Short-term Crisis Respite (concurrent reviews only) |
| <input type="checkbox"/> Intensive Supported Employment (ISE) | <input type="checkbox"/> Intensive Crisis Respite (concurrent reviews only) |

Please note the anticipated start date*, frequency, intensity, duration, and modality of each requested Adult BH HCBS.

Please consider what the member needs to reasonably achieve the objectives listed in the following section:

Adult BH HCBS #1	Start date* (1 st service visit)	Frequency (# services per wk)	Intensity (hrs per service)	Duration (e.g. 3 mos)
List:				

 Modality (check all that apply)..... ☐ Individual ☐ Group ☐ On-site ☐ Off-site

Adult BH HCBS #2	Start date* (1 st service visit)	Frequency (# services per wk)	Intensity (hrs per service)	Duration (e.g. 3 mos)
List:				

 Modality (check all that apply)..... ☐ Individual ☐ Group ☐ On-site ☐ Off-site

Adult BH HCBS #3	Start date* (1 st service visit)	Frequency (# services per wk)	Intensity (hrs per service)	Duration (e.g. 3 mos)

* first authorized service visit excluding three initial assessment visits

List: _____

Modality (check all that apply).....

☐ Individual☐ Group☐ On-site☐ Off-site**Goals and Objectives**

Clearly state the client's goal(s) and list specific objectives for the period of requested services. Goals must accurately reflect the member's approved Adult BH HCBS Plan of Care. Objectives should be results-oriented, measurable steps towards the overall goal that can be achieved within the requested period of services.

Goal #1 _____

Objective #1 _____

Status..... ☐ New☐ Accomplished☐ Existing (Partially met)☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2 _____

Status..... ☐ New☐ Accomplished☐ Existing (Partially met)☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #3 _____

Status..... ☐ New☐ Accomplished☐ Existing (Partially met)☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Goal #2 _____

Objective #1 _____

Status..... ☐ New☐ Accomplished☐ Existing (Partially met)☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2 _____

Status..... ☐ New☐ Accomplished☐ Existing (Partially met)☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #3 _____

Status..... ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Goal #3

Objective #1

Status..... ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #2

Status..... ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Objective #3

Status..... ☐ New ☐ Accomplished ☐ Existing (Partially met) ☐ Existing (Not met)

Justify continued/modified service for Existing (Partially met) or Existing (Not met) objectives:

Describe any other barriers or obstacles to the member's goals/objectives, and strategies to address them:

___ I attest that the member has elected to receive all Adult BH HCBS requested above

___ I have communicated with the member's Health Home care manager (not required)*

___ I have communicated with the member's managed care care manager (not required)*

Signature of Provider

Name (please print):

Title

Date

** Submission of authorization form does not preclude telephonic review, which may be required by MCO/BHO. NYS encourages providers to reach out to the MCO/BHO regarding authorization protocol to ensure timely delivery of services for members.*

Submission instructions: *[Plans must modify this template to include submission instructions via fax and/or web portal.]*

Molina Healthcare of NY

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Fax #: 1-866-879-4742