

**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 <sup>st</sup> 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 <sup>st</sup> 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 <sup>st</sup> service visit)	Frequency (# services per wk)	Intensity (hrs per service)	Duration (e.g. 3 mos)
List:				

\* first authorized service visit excluding three initial assessment visits

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

V: August 30, 2017

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** Submit to Beacon Health Options, on behalf of Visiting Nurse Service CHOICE Select Health at (855) 293-3850 or email to [VNSNYHCBS@beaconhealthoptions.com](mailto:VNSNYHCBS@beaconhealthoptions.com)