STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR HCBS PRIOR APPROVAL AND COST CONTAINMENT FOR HCBS-BI

REVISION? Yes ☐ No ☐

PA Number being revised

1. CLIENT NAME	2. CLIENT ID NUMBER	3. SEX ☐ M ☐ F	4. BIRTH DATE

5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED FROM	THROUGH

STATEMENT OF REQUESTED SERVICES

9. Description	10. Modifier	11. Max # Units	12. Cost Per Unit	13. Total $ Authorized	14. Comments
S5102 Adult Day Services, U6					
T2029 Assistive Technology, per service, U6					
H0025 Behavioral Management, U6					
H2018 Day Treatment, U6					
S5161 Electronic Monitoring, U6					
S5160 Electronic Monitor Install/Purchase, U6					
S5165 Home Modifications, U6					
T2013 Independent Living Skills Training, U6					
H0004 Mental Health Counseling, Family, U6	HR				
H0004 Mental Health Counseling, Group, U6	HQ				
H0004 Mental Health Counseling, Individual, U6					
T2001 Non-Medical Transportation, U6					
A0100 Non-Medical Transportation-Taxi, U6					
A0120 Non-Medical Transportation-Mobility Van, U6					
A0130 Non-Medical Transportation-Wheelchair Van, U6					
A0425 Non-Medical Transportation- Wheelchair Van Mileage, U6					
T1019 Personal Care, U6					
T1019 Relative Personal Care, U6	HR				
H0045 Respite Care NF, U6					
S5150 Respite Care In Home, U6					
T1006 Substance Abuse Counseling, Family, U6					
H0047 Substance Abuse Counseling, Group, U6	HQ				
H0047 Substance Abuse Counseling–Individual, U6	HF				
T2033 Supported Living Program, U6					
T2016 Transitional Living, per day, U6					

15. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 13 ABOVE) $ _____

16. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD) $ _____

17. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (HCBS EXPENDITURES + HOME HEALTH EXPENDITURES) $ _____

18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE) $ _____

19. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period) $ _____

A. Monthly State Cost Containment Amount $ _____

B. Minus Client's Monthly HCA Warrant Amount $ _____

C. Equals Client's Monthly Cost Containment $ _____

D. Divided by 30.42 days = Daily Cost Containment Ceiling $ _____

20. Immediately prior to HCBS enrollment, this client lived in a Nursing Facility ☐ YES ☐ NO

21. CASE MANAGER SIGNATURE	22. AGENCY	23. DATE
24. CASE MANAGER'S SUPERVISOR' SIGNATURE	25. AGENCY	26. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

27. CASE PLAN: _____ ☐ Approved - Date _____ ☐ Denied - Date _____ ☐ Returned for Correction - Date _____

28. REGULATION(S) upon which Denial or Return is based:

29. DEPARTMENT APPROVAL SIGNATURE	30. DATE

Brain Injury (BI) PAR Completion Instructions

FORM MUST BE COMPLETED IN BLACK BALLPOINT OR TYPEWRITER - PLEASE PRINT

Complete this form for Prior Authorization Requests for **BI**. Submit the PAR to the HCBS program's authorizing agent listed at the bottom of the instructions.

Complete the Revision section at the top of the form ***only*** if you are revising a current approved PAR.

For PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were approved on the original PAR.

Complete the following fields

1. **Client Name – Required**: Enter the client's name.
2. **Client ID number – Required**: Enter the client's Medical Assistance Program ID number.
3. **Sex**: Check M or F.
4. **Birth Date – Required**: Enter the client's date of birth.
5. **Requesting Provider # - Required**: Enter the requesting provider's Medical Assistance Program provider number.
6. **Client's County – Required: Enter the client's county of residence.**
7. **Case Number**: Enter the agency's case number for this PAR.
8. **Dates Covered (From and Through) – Required: Enter the PAR start date and PAR end date.**
9. **Description**: List of approved procedure codes.
10. **Modifier**: Enter all applicable modifiers.
11. **Max # Units:** Enter the number of units next to the services for which you are requesting reimbursement.
12. **Cost Per Unit**: Enter the cost per unit of service.
13. **Total # Authorized**: Enter the total amount authorized for the service.
14. **Comments**: Enter any additional useful information. For example, if a service is authorized for different dates than in Box 8, please include the HCPC and date span here.
15. **Total Authorized HCBS Expenditures** : Enter the total of all amounts listed in column 13.
16. **Plus Total Authorized Home Health Expenditures** (Sum of Authorized Home Health Services during the HCBS Care Plan Period): Enter the total Authorized Home Health expenditures.
17. **Equals Client's Maximum Authorized Cost**: Enter the sum of the HCBS Expenditures + Home Health Expenditures.
18. **Number of Days Covered:** Enter the number of days covered from Field 8.
19. **Average Cost Per Day:** Enter the client's maximum authorized cost divided by number of days in the care plan period.
20. **Immediately prior to HCBS enrollment, this client lived in a Nursing Facility**: Check Yes or No.
21. **Case Manager Signature**: Enter the signature of the Case Manager.
22. **Agency**: Enter the name of the agency.
23. **Date**: Enter the date signed.
24. **Case Manager's Supervisor Signature:** Enter the signature of the Case Manager's Supervisor.
25. **Agency:** Enter the name of the Agency
26. **Date:** Enter the date signed.

Do ***not*** enter anything below the shaded area "**DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY"**. This is for the authorizing agency use only.

Send only *New*, CSRs and Revised PARs to:

Send BI PARs to:
ACS PARS PO Box 30 Denver CO 80201-0030