STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

Check the appropriate waiver program with modifier:

☐ **EBD**-U1, ☐ **CMHS**-UA, ☐ **PLWA**-U2

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
S5105 Adult Day Care (U1, UA, U2)					
T2031 Alternative Care Facility (U1, UA)					
T2038 Community Transition Services (U1)					
T2038 Community Transition Services Items (U1)	52				
T2025 Consumer Directed Attendant Support Services (U1, UA)					
T2025 Consumer Directed Attendant Support Services Administration (U1, UA)	52				
T2040 Consumer Directed Attendant Support Services Per Member/Per Month (U1/UA)			$310		
S5160 Electronic Monitor Install/Purchase (U1, UA, U2)					
S5161 Electronic Monitoring (U1, UA, U2)					
S5165 Home Modifications (U1, UA)					
S5130 Homemaker (U1, UA, U2)					
H0038 IHSS Health Maintenance Activities (U1)					
S5130 IHSS Homemaker (U1)	KX				
T1019 IHSS Personal Care (U1)	KX				
T1019 IHSS Relative Personal Care (U1)	HR, KX				
S5185 Medication Reminder (U1, UA)					
T2029 Medication Reminder Install/Purchase (U1, UA)					
T2001 Non-medical Transportation (U1, UA, U2)					
A0100 Non-medical Transportation-Taxi (U1, UA, U2)					
A0120 Non-medical Transportation-Mobility Van (U1, UA, U2)					
A0130 Non-medical Transportation-Wheelchair Van (U1, UA, U2)					
A0425 Non-medical Transportation-Wheelchair Van Mileage (U1, UA, U2)					
T1019 Personal Care (U1, UA, U2)					
T1019 Relative Personal Care (U1, UA, U2)	HR				
H0045 Respite Care NF (U1, UA)					
S5150 Respite Care, In Home (U1)					
S5151 Respite Care ACF (U1, UA)					

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) – Excludes In-Home Support Services amounts $

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. Divided by 30.42 days = Daily Cost Containment Ceiling $

20. CDASS (amounts must match the client's allocation worksheet) | Effective Date: | Monthly Allocation Amt. $

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

22. CASE MANAGER SIGNATURE	23. AGENCY	24. DATE
25. CASE MANAGER'S SUPERVISOR SIGNATURE	26. AGENCY	27. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

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

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

30. DEPARTMENT APPROVAL SIGNATURE | 31. DATE

PAR Completion Instructions

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

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

Check the type of program (☐ **EBD**-U1, ☐ **CMHS**-UA, ☐ **PLWA**-U2) at the top of the PAR form.

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**: Male or Female.
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.
    In addition to IHSS Health Maintenance Activities H0038, please add the modifier KX for PCP and Homemaker services.
    Example: T1019 U1 HR KX or S5130 U1 KX
11. **Max # Units**: Enter the number of units next to the services for which reimbursement is being requested.
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. **CDASS**: Enter the client's monthly allocation and admin fee from the client's allocation worksheet here.
21. **Immediately prior to HCBS enrollment, this client lived in a Nursing Facility**: Check Yes or No.
22. **Case Manager Signature**: Enter the signature of the Case Manager.
23. **Agency**: Enter the name of the agency.
24. **Date**: Enter the date signed.
25. **Case Manager's Supervisor Signature**: Enter the signature of the Case Manager's Supervisor.
26. **Agency**: Enter the name of the agency.
27. **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 New, Continued Stay Review, (CSR) and Revised PARs to:

Send EBD, MI, and PLWA PAR to:
Xerox State Healthcare PARs PO Box 30 Denver, CO 80201-0030