STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR CHILD HCBS PRIOR APPROVAL AND COST CONTAINMENT

Check the appropriate waiver program with modifier

☐ **CWA**-UL, ☐ **CHCBS**-U5, ☐ **PHW--**UD

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
H0004 Behavior Therapies – Lead Therapist, UL					
H0004 Behavior Therapies – Senior Therapist, UL	52				
H2019 Behavior Therapies – Line Staff, UL					
T1016 CHCBS Case Management, U5					
H0038 IHSS Health Maintenance Activities, U5					
S9125 Respite Care, UD					
T1005 Respite Care, UD					
H0004 Client/Family/Caregiver Counseling- Indiv, UD					
H0004 Client/Family/Caregiver Counseling- Group, UD	HQ				
H0004 Client/Family/ Caregiver Counseling- Family, UD	HR				
G0176 Expressive Therapy, UD					
S9126 Palliative/Supportive Care, UD					
T2043 Palliative/Supportive Care, UD					
S5150 Respite Care – Unskilled, UD					
S5151 Respite Care – Unskilled, UD					

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

21. CASE MANAGER SIGNATURE	22. AGENCY	23. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

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

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

26. AUTHORIZING AGENT SIGNATURE	27. DATE

PAR Completion Instructions

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

Complete this form for Prior Authorization Requests for **CWA**, **CHCBS, and PHW**. Submit the PAR to the HCBS program's authorizing agent listed below.

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 (☐ **CWA**-UL, ☐ **CHCBS**-U5, ☐ **PHW**-UD) at the top of the PAR form for which you are requesting services - **Required**

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 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.

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, Continued Stay Reviews (CSRs) and Revised PARs to:

Send CWA, CHCBS, and PHW PARs to:
ACS PARs PO Box 30 Denver, CO 80201-0030