ASSISTED LIVING FACILITY BEHAVIORAL HEALTH
SPECIALTY RATE PRIOR AUTHORIZATION REQUEST

SECTION A. REQUESTOR INFORMATION

Submit completed form and required documentation through TIBCO: https://tiwebprd.statemedicaid.us	**SUBMISSION DATE**	
	TRIBAL ALTCS PROGRAM	
	CASE MANAGER NAME	
	PHONE/FAX NUMBER	

SECTION B. MEMBER INFORMATION

MEMBER NAME:
DOB:
AHCCCS ID:
PROVIDER ID:

SECTION C. PRIOR AUTHORIZATION REQUEST

☐ **INITIAL REQUEST** **ADMISSION DATE:**

☐ **ONGOING REQUEST**

Documents Attached

- ☐ Case Manger Cover Letter
- ☐ Member is stable on psychotropic medication and not receiving BH services.
- ☐ Clinical Documentation (including Service/Treatment Plan) within the past 30 days.
  - ☐ Behavioral Health (documentation with the contents and results of the initial/quarterly discussion with BHP).
  - ☐ Memory Care
  - ☐ TBI
  - ☐ Wandering/Dementia
  - ☐ Blended Rate
- ☐ Supporting Documentation (BH Physician Documentation, Psych Progress Notes, ALF Notes, Case Manager Case Notes)
- ☐ FFS Authorization Form with new date spans.
  Note: Do not utilize a previous Face Sheet with previous date spans as it will be marked as a duplicate and closed.
- ☐ Most recent PCSP (all pages)
- ☐ CA160 Screen Prints, in line with date of PCSP.
- ☐ Most recent Uniform Assessment Tool (UAT)
- ☐ ALF Agreement
- ☐ Managed Risk Agreement, when applicable

☐ **CES equal to or greater than 81%**

SECTION C. ATTACH ALL REQUIRED DOCUMENTATION.

NOTE: If all necessary documents are not included in the request the request/packet cannot be processed.

Signatures acknowledge that both Tribal ALTCS Case Manager and Supervisor have reviewed and submitted the necessary documentation to proceed with ALF BH Rate and/or CES Overcost.	**SIGNATURES**	
	CASE MANAGER	
	SUPERVISOR	