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| MISSOURI DEPARTMENT OF SOCIAL SERVICES CHILDREN’S DIVISION  Prior Authorization Waiver | | | | | | |
| Section I: To be completed by the subsidy worker and submitted with all required documentation for approval. | | | | | | |
| **Subsidy Worker** |  | **County** | |  | | |
| **Supervisor** |  | **Call/Case Number** | |  | | |
| **Child’s Name** |  | **DCN** |  | | **DOB** |  |
| **Family Name** |  | | | | **DVN** |  |
| **Family Address** |  | | | | | |
| **Residential Facility** |  | **Facility Address** |  | | | |
| **Level of Care** |  |
| **Type of Request**  **(select all that apply)** | Initial Prior Authorization Waiver Continuing Stay Review for Prior Authorization Waiver  Child Specific Contract Continuing Stay Review, CD-233 must be attached | | | | | |
| Prior Authorization Waiver Eligibility (select all that apply):  The adoptive parent(s)/guardian(s) filed an appeal of the denial for prior authorization.  The child is a resident of a state whose Medicaid program does not include payment for residential treatment.  Required Residential Treatment Eligibility Criteria (select all that apply):  Treatment of the child in a residential setting is the least restrictive setting to meet the child’s needs.  The residential setting program is necessary and appropriate to meet the child’s needs.  If applicable, the child and family have exhausted all reasonably available, less restrictive treatment modalities.  The child has been accepted for treatment by a residential facility that is licensed by the state to provide the treatment and the facility is either:  An enrolled MO HealthNet provider; or  Is an enrolled provider of the Medicaid program in which the state is located; or  The facility is willing to enter into a child specific contract with the State of Missouri for payment for the services.  The child has a current, written plan of care.  The facility is the closest available facility to the child’s home that provides the array of services that the Children’s Division determines are necessary for the child at a contract price for those services agreeable to the Division.  The child’s treating or examining psychiatrist, psychologist, physician, advanced practice psychiatric nurse, marital and family therapist, nurse practitioner, licensed professional counselor, or licensed clinical social worker certifies to a reasonable degree of medical certainty in writing that treatment in a residential facility at the indicated level of care is necessary.  The Division has determined the child is a danger to self or others.  Attached Required Documentation:  Completed Residential Treatment Referral, CS-9  DLA-20, or assessment tool completed by a licensed and qualified health care professional  Any relevant documentation of Psychiatric/Behavioral Health diagnosis  The most recent psychiatric evaluation completed by a psychiatrist, psychologist, or advanced practice nurse, if available.  A statement that the child has been accepted for treatment by a residential facility detailing the rationale for residential treatment at the requested level of care, and a discharge plan when available.  Documentation of previous treatment history and outcome of treatment when applicable and available.  For Child Specific Contracts, attach documentation of families attempts to secure placement at a licensed and contracted facility. | | | | | | |
| **Duration of Waiver:** (not to exceed six (6) months unless extended following a continuing stay review) | | | | | | |
| In cases where a waiver was necessary as the result of a prior authorization denial and request for administrative review, the waiver shall extend until the appeal has been decided on administrative review. The Division may extend the waiver period if there is a request for judicial review of the administrative decision.  In cases where a waiver was necessary because the child is a resident of a state whose Medicaid program does not include payment for the necessary residential treatment, the waiver shall be subject to continuing stay reviews, or until the Division determines that treatment in a residential facility is no longer necessary. | | | | | | |
| **Section II: To be completed by a supervisor, or above, after reviewing the required documentation.** | | | | | | |
| Date Reviewed:       Approved  Denied | | | | | | |
| Reason for denial: | | | | | | |
| Supervisor Signature: | | | | | | |
| Section II: To be completed by Authorized Designee after reviewing the required documentation. | | | | | | |
| Date Reviewed:       Approved  Denied | | | | | | |
| Reason for denial: | | | | | | |
| Authorized Designee Signature: | | | | | | |