



Personal Care Related to Diagnosed Psychiatric Condition

TO:	NAME OF BHO / MCO	EMAIL	DATE SENT TO BHO / MCO
FROM:	NAME OF HCS / AAA WORKER	EMAIL	TELEPHONE NUMBER
	NAME OF HCS / AAA OFFICE		
RE:	CLIENT'S NAME	CLIENT'S PROVIDER ONE ID NUMBER	DATE OF BIRTH

To be Completed by HCS or AAA worker

The packet includes this form and a copy of the client's current CARE Assessment Details.

Client's assessment Plan Period date from _____ to _____ .

CARE generated residential daily rate or in-home personal care hours / month _____ + _____ additional daily rate or hours / month for a total daily rate or hours/month of _____ .

Reason for additional rate / hours (e.g. what additional service / support will be provided):

To be Completed by BHO / MCO

DATE RECEIVED	NAME OF BHO / MCO STAFF REVIEWING PACKET	EMAIL ADDRESS	TELEPHONE NUMBER
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I have reviewed this packet and find the following:

- This client meets eligibility for Personal Care services based solely on psychiatric disabilities and the BHO/MCO will pay for this service. Funding approval dates from _____ to _____. Approved number of in-home monthly hours or residential daily rate:
- Although this client has unmet needs because of psychiatric disabilities, another BHO/MCO service will be provided to meet the client's unmet personal care needs indicated on the client's CARE Assessment Details. Funding for Personal Care services will not be provided.
- This client's eligibility for Personal Care services is not based on a solely psychiatric disability. The BHO/MCO will not pay for this service.
- Other (specify in comment box)

BHO / MCO SIGNATURE	DATE
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COMMENTS

cc: Client File

ALTSA Accounting Department, MS 45600; PO Box 45600, Olympia WA 98504-5600