# Behavioral Health Personal Care Services Form

Submit completed form electronically using our preferred method at **Availity** or by fax to **1-833-974-0059**.

| | |
|---|---|
| Today's date: | |
| Contact at provider's office: | Secure fax: |
| Name of requestor: | Phone: |
| **Please note:** Provide appropriate contact information, including best working phone number for Humana staff to contact you if clarification or additional information is needed to complete the request. | |

| **Member information** | | |
|---|---|---|
| Last name: | First name: | |
| Humana ID: | Medicaid ID: | Date of birth: |
| Parent/guardian name: | | Phone: |
| Member's living arrangements:<br>☐ At home with guardian ☐ Group home ☐ Foster home | | |
| Authorization reference number (if applicable): | | |

| **Requesting provider/facility** | | |
|---|---|---|
| Provider name: | TIN: | NPI: |
| Address: | City, state, ZIP: | |
| Contact name: | Phone: | Fax: |

| **Treating/servicing provider** | | |
|---|---|---|
| Provider name: | TIN: | NPI: |
| Address: | City, state, ZIP: | |
| Contact name: | Phone: | Fax: |

| **Diagnosis code(s) and date(s) of service (DOS)** | | | |
|---|---|---|---|
| ICD-10*: | ICD-10*: | ICD-10*: | ICD-10*: |
| Start date of service: | | End date of service: | |
| Type of request: ☐ Initial request ☐ Concurrent request | | | |

* ICD-10 codes are from the International Classification of Diseases, Tenth Edition.

Humana Healthy Horizons® in Louisiana

| Service code(s) | | |
|---|---|---|
| Code: | Units: | Frequency: |
| Code: | Units: | Frequency: |
| Code: | Units: | Frequency: |
| Code: | Units: | Frequency: |

**Is member a part of the My Choice Louisiana program?**

☐ Yes ☐ No

**Please indicate other in-home services requested or currently receiving:**

| Household composition | | | |
|---|---|---|---|
| **Name** | **Age** | **Relationship** | **Work/attends school** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Patient assessment**

Attends work/school: ☐ Yes ☐ No

Name of employer/school: _____

Days and times of school /work:

Member is verbal: ☐ Yes ☐ No

Member uses adaptive equipment: ☐ Yes ☐ No

If yes, please explain:

## Patient assessment

Medication: ☐ Yes ☐ No

If yes, please indicate what medications and who administers the medications.

## Dietary factors

Is there a medical reason that requires the member's meals to be prepared separately from the family's meals? ☐ Yes ☐ No

If yes, please specify:

Who prepares the member's meals, and what is their relationship to the member?

Does the member use assistive devices for eating (e.g., feeding tube)? ☐ Yes ☐ No

If yes, specify:

Indicate the number of meals and snacks prepared for member daily. _____ Meals _____ Snacks

Is the member able to feed self without assistance? ☐ Yes ☐ No

If no, specify the type of assistance required:

| Home environment |
| --- |
| Describe access to home (stairs, doors, walks, etc.). |
| Describe home living space (number of bedrooms, bathrooms, etc.). |
| Describe home location (rural, urban, on bus line, etc.). |
| Where does the family do their laundry (washer/dryer in home, laundromat, etc.)? |

| Family responsibilities | |
| --- | --- |
| Which family members assume major responsibilities for caring for the member and what tasks do they perform? | |
| **Family member** | **Tasks performed** |
| | |
| | |
| | |

| Personal care tasks | |
| --- | --- |
| For the personal care tasks of bathing, dressing, grooming, toileting, eating, preparing meals and providing incidental household services the member requires assistance with because of their disability, complete the following: | |
| **Goal:** Include the goal for the personal care task. | |
| **Number of days requested per week:** Indicate the number of days during the week assistance is requested with the personal care task. | |

| Personal care tasks | |
|---|---|
| **Time requested to complete activity:** Indicate the time required in minutes to complete the activity (15 minutes, 30 minutes, etc.). | |
| **Total time requested for week:** Indicate the total time requested for the week by multiplying the number of days the service is requested by the time requested to complete the activity (1 hour and 15 minutes, 3 hours and 30 minutes, etc.). | |
| Complete the following when it is medically necessary that someone accompany the member and their caregiver to medical appointments: | |
| **Goal:** Include the goal for the personal care task. | |
| **Frequency of medical appointments:** Indicate the frequency the member typically has medical appointments within the prior authorization period (weekly appointment, monthly appointment, etc.). | |
| **Time per trip:** Indicate the time it typically takes the member to complete the medical appointment (1 hour, 2 hours, etc.). | |

| | |
|---|---|
| **Provider signature:** | **Date:** |