MassHealth PCA Prior Authorization
Overtime Form

MassHealth

Section 1: General Information

Personal Care Management (PCM) Agency Information:

PCM Agency Name:			
PCM MassHealth Provider Number:			
Requesting Contact *(Name, Phone, Fax)*			
PA Review Type *If expedited, explain the necessity* ☐ Standard ☐ Expedited			

Consumer Information:

Consumer Name:	Date of Birth:
MassHealth ID Number:	
Consumer Fiscal Intermediary ID Number (if known):	
Consumer Telephone Number:	
Consumer Address:	
Surrogate Name (if applicable):	Surrogate Phone (if applicable):

Personal Care Attendant Provider Information:

PCA Name:	PCA Unique Identifier Number:
PCA Address:	
PCA Phone Number:	

Request Authorization Type:

Please select the reason below that best explains why the PCA must work in excess of 50 hours per week (select only one). An individual PCA is limited to working no greater than 66 hours per week, unless the consumer has obtained a Temporary Authorization.

☐ Temporary Authorization (Go to **Section A**)	☐ Continuity of Care Authorization (Go to **Section B**)

SECTION A: TEMPORARY AUTHORIZATION

Temporary Authorization requests will be approved when one or more of the following circumstances are present:

☐ I need more time to hire additional PCAs (please check one).

- ☐ Placed multiple ads/used multiple resources for seeking PCAs, but received no responses for PCAs that could appropriately fulfill my personal care needs, including registering on a PCA directory website and is using that website to try to recruit PCAs
- ☐ Interviewed multiple PCAs but no PCA would accept the position
- ☐ The PCA I hired did not remain in my employment because PCA could not attain basic knowledge to safely carry out the PCA assigned tasks
- ☐ The PCA left employment suddenly
- ☐ My PCA works more than 66 hours per week and I need time to hire additional PCAs

☐ I will be traveling and it is not possible to bring more than one PCA

☐ One or more of my PCA's needs to take a short-term leave in their schedule for one of the following reasons (please check one):

- ☐ In school; temporarily absent due to school
- ☐ Family leave
- ☐ Maternity leave
- ☐ Sick leave

☐ I have a temporary need for an individual PCA to work in excess of 50 hours per week that is not listed above. Please describe the circumstance:

_____
_____
_____
_____
_____

SECTION B: CONTINUITY OF CARE AUTHORIZATION

Continuity of Care Authorization requests will be approved for your Prior Authorization period when one or more of the below circumstances are present:

☐ I have complex medical needs that require the specialized skills of a specific PCA. Please describe the circumstance:

_____
_____
_____
_____
_____

☐ I have another circumstance that makes it difficult for me to hire additional PCAs. Please describe this circumstance:

_____
_____
_____
_____
_____

Please explain the progress you are making towards hiring additional PCAs and meeting the scheduling requirement, if applicable (must include registration on the Rewarding Work website):

_____
_____
_____
_____
_____

☐ I am receiving hospice care

☐ My PCA has worked with me for 5 or more years

☐ My PCA lives with me, and is the only PCA working for me and I am approved for 50 to up to 66 hours of PCA services per week.

In order to qualify for this exception, the consumer must present documentation proving that the consumer and PCA live together. The required documents must include physical address and not a P.O. Box.

Consumers must include a minimum of two of the following documents. The documents that you include must have the PCA's name and address. (select and attach both to this document)

- ☐ Water bill - no older than three months
- ☐ Electric bill - no older than three months
- ☐ Cable TV bill - no older than three months
- ☐ Phone bill - no older than three months
- ☐ Current homeowner's or renter's insurance certificate
- ☐ Current automobile insurance certificate
- ☐ Vehicle registration title
- ☐ Voter registration card
- ☐ Property tax bill or receipt
- ☐ Residential rental contract (apartment lease or other rental of real property or original and signed verification letter from landlord)
- ☐ Driver's license or state-issued identification
- ☐ Change of address confirmation from U.S. Postal Service
- ☐ Other form or documentation that contains information identifying the PCA's name and residence

Check if both forms of identification are "Other"

ATTESTATION ORIGINAL SIGNATURES REQUIRED

CONSUMER/SURROGATE

I certify that I have reviewed and confirm that the information contained herein is true and accurate. I understand that falsification, omission, or concealment of any material fact contained herein may result in the determination that I require a surrogate to manage my PCA services. I understand that I may also be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. This documentation will be retained by my PCM Agency in my record and in the event of an audit, the MassHealth agency may at its discretion request any and all medical records of MassHealth Consumers corresponding to, or documenting the services claimed, in accordance with 130 CMR 422.000 and 130 CMR 450.204 and 450.205.

I WILL NOTIFY MY FISCAL INTERMEDIARY IMMEDIATELY IF I HIRE ADDITIONAL PERSONAL CARE ATTENDANTS OR IF MY LIVING CIRCUMSTANCES CHANGE.

Consumer Signature **Date**

Surrogate Signature (if applicable) **Date**

PERSONAL CARE ATTENDANT

I certify that I have reviewed and confirm that the information contained herein is true and accurate. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. This documentation will be retained by the PCM Agency in the consumer's record and in the event of an audit, the MassHealth agency may at its discretion request any and all medical records of MassHealth consumers corresponding to, or documenting the services claimed, in accordance with 130 CMR 422.000 and 130 CMR 450.204 and 450.205.

PCA Provider Signature **Date**

PERSONAL CARE MANAGEMENT AGENCY (TO BE COMPLETED BY THE PCM AGENCY ONLY)

I certify, to the best of my knowledge, that the information on this form is true, accurate, and complete.

PCM Agency Name:	

PCM Agency Signature **Date**

PCM Agency, select one of the following: Consumer is in: ☐ FFS ☐ SCO ☐ One Care					
If SCO or One Care is checked, fill in:					
Approved number of hours per week (day/eve plus night):		Approval Start Date:		End Date:	
Consumer Prior Authorization Number:					

INSTRUCTIONS FOR FILLING OUT AND SUBMITTING THIS FORM

You, the consumer or surrogate, if applicable, must fill out this form and make copies of any required documentation. To request assistance in filling out this form, contact your PCM Agency. Submit this form and required documentation to your PCM Agency.

CONSUMER INFORMATION

Fill in your information to include your name, address, phone number, MassHealth ID number, consumer fiscal intermediary ID number (if known), date of birth. If you have a surrogate, include your surrogate's name and phone number.

PERSONAL CARE ATTENDANT INFORMATION

Fill in your PCA's information to include name, address, phone number, and PCA Unique Identifier Number, located on your PCA's Activity Sheet. If you do not know your PCA's Unique Identifier Number, contact your fiscal intermediary.

REQUEST OVERTIME TYPE

Indicate which request type you are seeking. If you are approved to schedule a PCA to work in excess of 10 hours of overtime per week, the number of approved hours will not exceed the amount of your approved prior authorization hours.

PCAs are limited to working no greater than 66 hours per week, unless the Consumer has obtained a Temporary Authorization. Consumers cannot obtain a Continuity of Care Authorization if their PCA works greater than 66 hours per week.

SECTION A: TEMPORARY AUTHORIZATION

You must obtain a Temporary Authorization for your PCA to work more in excess of 10 hours of overtime per week to avoid a disruption in care temporarily while you seek to hire additional PCAs, if applicable.

SECTION B: CONTINUITY OF CARE AUTHORIZATION

Continuity of Care Authorization requests will be approved for your Prior Authorization period when one or more of the listed circumstances is present. Consumers cannot obtain a Continuity of Care Authorization if their PCA works greater than 66 hours per week. If a PCA works greater than 66 hours per week, the Consumer must apply for a Temporary Authorization.

ATTESTATION

CONSUMER/SURROGATE

You and your surrogate, if any, must sign and date the form and must certify that all information contained within the form is true, accurate, and complete.

PERSONAL CARE ATTENDANT

Your PCA must sign and date the form and must certify that all information contained with the form is true, accurate, and complete.

PERSONAL CARE MANAGEMENT AGENCY

The PCM Agency representative must fill in the PCM Agency name, sign and date the form, and certify that the information is true, accurate, and complete to the best of the PCM Agency's knowledge. The PCM Agency must select if the consumer is enrolled in Fee for Service (FFS), Senior Care Options (SCO), or One Care.

If the consumer is enrolled in SCO or One Care, fill in the approved number of hours per week (day/eve plus night) and SCO or One Care approval start and end date

ALL DOCUMENTS MUST BE MAINTAINED IN THE CONSUMER'S CASE RECORD