

BIG SKY WAIVER REQUEST FOR INITIAL PRIOR AUTHORIZATION FOR CC3

1.	MEMBER INFORMATION	
	Name _____	Team Provider No. _____
	Medicaid # _____	Service: Group Home _____ Specialized AR _____
	Current Living Situation: _____	Supported Living _____ Vent/Heavy Care _____
	Explain: _____	CMT Signature: _____
2.	RESULTS IF NOT ACCEPTED ON BSW	
	_____ Remain in or enter hospital/rehab center.	Projected cost: _____
	_____ Remain in or enter NF.	Projected cost: _____
	_____ Remain in community or with family. What other support services are being utilized? Are these services adequate?	

	Describe stress on family or caregiver: _____	

	Comments: _____	

3.	BIG SKY WAIVER SERVICES REQUIRED	
	Explain how needs could be met by BSW and what services would be utilized: _____	

	Anticipated Cost: _____	
4.	HEALTH CARE PROFESSIONAL INVOLVEMENT	
	What is the extent of the health care professional involvement in the planning and delivery of services? _____	

5.	REGIONAL PROGRAM OFFICER	
	<input type="checkbox"/> Concur	<input type="checkbox"/> Do not concur
	_____	_____
	Regional Program Officer	Date
6.	COMMUNITY SERVICES BUREAU	
	<input type="checkbox"/> Concur	<input type="checkbox"/> Do not concur
	_____	_____
	Community Services Bureau	Date

Distribution: Case Management Team; RPO; DPHHS