MassHealth PCA Prior Authorization
Overtime Request Form

General Information

Personal Care Management (PCM) Agency Information

PCM agency name			
PCM MassHealth provider ID			
Requesting contact *(Name, Phone, Fax)*			

Consumer Information

Consumer name	Date of birth
MassHealth ID	
Consumer fiscal intermediary ID number (if known)	
Consumer Tel.	
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 type of overtime authorization you are requesting. An individual PCA is limited to working no more than 66 hours per week under any circumstances.

☐ Temporary authorization (Go to **Section A.**)	☐ Continuity of care authorization (Go to **Section B.**)

Consumer Name _____

SECTION A: TEMPORARY AUTHORIZATION

Temporary authorization requests will be approved when one or more of the following circumstances are present.

Please specify the length of the overtime authorization you are requesting.

Dates from _____ to _____

☐ I need more time to hire additional PCAs.

(Please check one)

- ☐ I placed multiple ads/used multiple resources for seeking PCAs, but received no responses for PCAs who could appropriately fulfill my personal care needs, including registering on a PCA directory website, and I am using that website to try to recruit PCAs.
- ☐ I interviewed multiple PCAs, but no PCA would accept the position.
- ☐ The PCA I hired did not remain in my employment because the PCA could not attain the basic knowledge to carry out the PCA assigned tasks safely.
- ☐ The PCA left employment suddenly.

☐ I will be traveling within the U.S. territories, and it is not possible to bring more than one PCA.

☐ One or more of my PCAs needs to take a short-term leave for one of the following reasons.

(Please check one.)

- ☐ In school, or temporarily unavailable due to school
- ☐ Medical or family leave
- ☐ Maternity/paternity leave
- ☐ Sick leave
- ☐ PCA going on vacation

☐ I am receiving hospice care.

☐ I have a temporary need to schedule an individual PCA to work in excess of 50 hours, but no more than 66 hours per week. Temporary medical needs include post-acute hospitalization or post-skilled nursing facility. *(Please describe the circumstances.)*

_____
_____
_____
_____
_____

Consumer Name _____

SECTION B: CONTINUITY-OF CARE-AUTHORIZATION

Continuity-of-care authorization requests will be approved for your prior authorization (PA) period when one or more of the following circumstances are present.

☐ I need more time to hire additional PCAs

(Please check one)

- ☐ I placed multiple ads/used multiple resources for seeking PCAs but received no responses for PCAs who could appropriately fulfill my personal care needs, including registering on a PCA directory website, and I am using that website to try to recruit PCAs.
- ☐ I interviewed multiple PCAs, but no PCA would accept the position.
- ☐ The PCA I hired did not remain in my employment because the PCA could not attain the basic knowledge to carry out the PCA assigned tasks safely.
- ☐ The PCA left employment suddenly.

☐ I have an ongoing medical need that requires intensive ADL care. Because of this, I need to schedule my PCA to work additional approved hours, and I have made a documented effort to try to hire an additional PCA.

1. The following procedures and equipment are considered when determining the need for intensive ADL care (Time for Task Tool).
   a. Tracheostomy care
   b. Ventilator use
   c. Ostomy care
   d. Catheter care
   e. Transfer and mobility needs with a mechanical lift
   f. Urological equipment and drainage systems
2. The consumer provides evidence that they have other medical needs that require a specialized level of care. These needs include the following.
   a. Behavioral health impairments that result in difficulty engaging with new people, which impacts daily function. (Examples include social anxiety disorder, post-traumatic stress disorder, autism spectrum, schizo-affective disorder, etc.)
   b. Deficits in communication, including a formal diagnosis of aphasia, or communicating only via American Sign Language (ASL)

☐ I am receiving hospice care.

Consumer Name _____

ATTESTATION (ORIGINAL SIGNATURES REQUIRED)

CONSUMER/SURROGATE

I certify that I have reviewed and confirm that the information contained in this document is true and accurate. I understand that falsification, omission, or concealment of any material fact contained in this document 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 in this document. This documentation will be kept by my PCM agency in my record. 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.

Consumer signature **Date**

Surrogate signature (if applicable) **Date**

PERSONAL CARE ATTENDANT

I certify that I have reviewed and confirm that the information contained in this document 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 in this document. This documentation will be kept by the PCM agency in the consumer's record. 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 ☐ PACE

If SCO, One Care, or PACE is checked, fill in the requested information below.

Approved number of hours per week (day/evening, plus night)		Approval start date		End date	

Consumer prior authorization number

Print Clear

Consumer Name _____

MassHealth Personal Care Attendant Program
INSTRUCTIONS FOR FILLING OUT AND SUBMITTING THE OVERTIME REQUEST FORM

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

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

PERSONAL CARE ATTENDANT INFORMATION

Provide your PCA's name, address, phone number, and PCA unique identifier number, located on your PCA's activity sheet. If you don't know your PCA's unique identifier number, contact your fiscal intermediary.

REQUEST OVERTIME TYPE

Indicate which request type you're seeking. If you're approved to schedule a PCA to work more than 10 hours of overtime per week, the number of approved hours will not exceed the amount of your approved PA hours.

PCAs are limited to working no more than 66 hours per week across consumers.

SECTION A: TEMPORARY AUTHORIZATION

You must obtain a temporary authorization for your PCA to work more than 10 hours of overtime per week to avoid a disruption in care while you look to hire additional PCAs, if applicable.

SECTION B: CONTINUITY-OF-CARE AUTHORIZATION

Continuity-of-care authorization requests will be approved for your PA period when one or more of the listed circumstances is present.

ATTESTATION

CONSUMER/SURROGATE

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

PERSONAL CARE ATTENDANT

Your PCA must sign and date the form and certify that all information in 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), One Care, or PACE.

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

ALL DOCUMENTS MUST BE KEPT IN THE CONSUMER'S CASE RECORD.