



AETNA BETTER HEALTH® OF KENTUCKY

Comprehensive Community Support Services (CCSS) Request Form

Can be submitted through the Availity portal or faxed to AETNA BETTER HEALTH OF KENTUCKY

Fax Numbers: 1-855-301-1564; For SKY 1-833-689-1424

Member Information			
Member Name (First, Last):	Member Medicaid ID #:	Member Date of Birth:	
Provider Information			
CCSS Provider Name and Credenitals:	CCSS Provider phone:	CCSS Provider fax:	
If CCSS provider is a CSA, provide the CSA TRIS ID:		If CSA does not have TRIS ID, state reason and CSA hire date if applicable:	
Provider Group NPI:		Provider Group TIN:	
Service Request Details			
Service Code: H2015	Units Requested:	Request Start Date:	Request End Date:
Request Type: Initial <input type="checkbox"/> Continued <input type="checkbox"/>		If continued request, howlong has the member been receiving CCSS services?	
Primary Diagnosis (Code and Description)		Co-morbid Medical Diagnoses ICD-10 Code:	
Are the symptoms to be addressed by CCSS the result of substance-related disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are the symptoms to be addressed by CCSS related to an intellectual disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the member residing in a group home, residential treatment, nursing home, assisted living or other staffed residence? <input type="checkbox"/> Yes <input type="checkbox"/> No			

For members in PCC Residential Placement only:

Is the member residing in a PCC Residential placement?: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, has a multi-disciplinary team determined that CCSS is appropriate, necessary, non-duplicative? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of multi-disciplinary team meeting:	
Multi-disciplinary team attendees & attendee role:	

Is the member at risk of disrupting the current PCC Residential placement or requiring a higher level of care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do the member's symptoms interfere with successful transition to the next appropriate placement/level of care? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Refer to Aetna Comprehensive Community Support Services Reimbursement Policy for documentation guidelines.

Required attachments:

- Current treatment plan & discharge/transition plan
- Most recent diagnostic assessment by behavioral health practitioner

Treatment Plan Requirements – PLEASE NOTE

Each recipient of CCSS should have an individualized goal-directed treatment plan that contains specific and measurable goals to be accomplished by the provision of CCSS. **This treatment plan must be submitted with the CCSS prior authorization request.** This plan should clearly articulate the primary problem(s) for which the recipient is receiving CCSS services and detail the psychiatric or behavioral rehabilitation interventions to be rendered by the provider. These interventions should target at least one of the following; improving emotional regulation skills, improving crisis coping skills, improving interpersonal skills, improving daily living skills. The treatment plan should detail the modality, frequency, and duration of the planned CCSS interventions, as well as a discharge or transition plan

Functional Impairment Rating Scale (Select the degree of impairment in the following functional areas.)				
Functional Category	N/A	Mild	Moderate	Severe
Self-Care (inability to protect self, perform ADLs, self-injurious, reckless decision-making, failure to address health/safety needs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describe symptoms/impairment:				
Interpersonal Relationships (aggressive/violent interactions, lacks behavioral control, poor decision making/judgement, isolated/withdrawn, unable to form/maintain satisfactory relationships)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describe symptoms/impairment:				
Family Life (inability to live in a family type environment, emotional/disruptive behaviors, violence and/or disregard for safety/welfare of those in the home, inability to conform to expectations)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describe symptoms/impairment:				
School/Work (failing grades, truancy, expulsion, suspension, property damage, violence toward others. poor relationships with co-workers, hostile behavior on the job)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describe symptoms/impairment:				
Self Direction (inability to control behavior/make age-appropriate decisions, violations of law/community norms, disruptive/inappropriate in community)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe symptoms/impairment:

Clinical Justification

Presenting Problem Description: (Provide a brief clinical history. If in a PCC residential setting, also describe the current symptoms, behaviors, and functional impairments that are placing the member at risk of placement disruption or that interfere with the ability to transition to the next appropriate level care.)

Interventions Attempted: (Describe the current services/interventions that have been insufficient to meet care needs. Describe factors contributing to the inability of the current placement to manage current symptoms and behaviors.)

Describe the targeted skill deficits that CCSS services will address and explain why one-to-one skills training services in the natural community setting is necessary: