



Certificate of Medical Necessity for Prevocational Services

Use this form as your cover page. Fax to Utilization Management Waiver Prior Authorization 844-399-0479.

(Please print or type clearly – accuracy is important)

Section A					
1. Member Name (Last)		(First)	(Initial)	2. Case Manager Name	
3. Medicaid SID #		4. Date of Birth		5. Service Plan Dates Covered by Request	
				From	
				To	
		Month	Day	Year	Month
					Day
					Year
6. Name of Item Requested:					
7. Type of Review Being Requested:			<i>Remember to attach all documentation.</i>		
<input type="checkbox"/> Initial		<input type="checkbox"/> Continued Stay Review (CSR)		8. Documentation attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Revised form		<input type="checkbox"/> Re-review		(see Section D)	
9. Number of pages including this one:					

Section B Answer ALL Questions 1 through 9 for Prevocational Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Is this member currently receiving prevocational services? If yes, outline history on program in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Has this member ever received sheltered workshop, enclave, or supported employment? If yes, outline history in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Has this member volunteered or had competitive employment? If yes, outline history in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. What are the long-term employment goals? Outline in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Have goals been updated or changed in the last 12 months? If yes, outline in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Does the prevocational service plan indicate that the services teach job-ready skills? List the services performed in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Has this member been denied from the Vocational Rehabilitation Division? If yes, enclose denial documentation.
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. If enrolled in school, are programs available through the school that provide the same types of skill development? If yes, outline in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Has progress been made to justify prevocational services? If yes, outline in Section C.

Section C Narrative Description
Justification for request. Provide specific information and use additional sheet if necessary.

IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.	Requesting Case Manager	
	Signature of TCM/CM/SW	Date

Section D Include ALL of the Following Documentation

- Comprehensive functional assessment
- Case management or social worker service plan
- Denial documentation from Division of Vocational Rehabilitation
- Supported employment readiness assessment (prevocational assessment of needs)
- Time study reports for three years for initial reviews or past 12 months for a CSR. If less than requested duration, include all time in prevocational services
- Prevocational goals, objectives, and results for three years for initial reviews or past 12 months for a CSR. If less than requested duration, include all prevocational services
- Prevocational provider's service plan
- Individualized Education Program, if enrolled in school and applicable