Colorado Community Living Handbook

HANDBOOK FOR THE COLORADO HOME AND COMMUNITY BASED SERVICES (HCBS) ASSESSMENT & SUPPORT PLANNING PROCESS

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COLORADO
Department of Health Care Policy & Financing

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Table of Contents

Why Should I Read this Handbook? 4
How Will This Handbook Help Me? 4
Who Do I Call? 5
Who Do I Talk to When I Call? 5
What Happens During the Intake Screen? 5
If HCBS is Right for Me, What is Next? 5
Section 2: Do I Qualify for HCBS Benefits? 6
How Do I Schedule the LOC Screen? 6
Who Should I Include During this Process? 6
Who Does the LOC Screen? 6
What Happens During the LOC Screen? 6
What Happens if I Don't Qualify for HCBS Benefits? 6
I Qualify for HCBS, What is Next? 6
Section 3: How Do I Receive HCBS Services? 7
What Does My Case Manager Do? 7
What Are My Responsibilities? 7
What Are My Rights? 8
How Involved Will I Be? Does My Involvement Change If I Have an Intellectual Disability or Cognitive Impairment? 9
How is My Legal Representative Involved? 9
Do I Have to Respond to All Questions? 9
How Can I Prepare for the Meeting? 9
What Happens During the Needs Assessment? 9
- Basic Needs Assessment 10
- Comprehensive Needs Assessment 10
- Assessment Sections 11

Overview of Developing a Support Plan 12
Developing the Support Plan 12
What are my Service Options? 20
- Long Term Home Health (LTHH) 20
- Program of All-Inclusive Care for the Elderly (PACE) 20
- HCBS Waivers 21

DRAFT

Waivers that Support Children 21
Children's Services 22
Waivers that Support Adults 22
Adult Services 23
How do I Report a Complaint or Appeal a Decision? 24
Appendix 1: Common System Acronyms List 25
Appendix 2: Assessment and Support Plan Worksheets 27
Worksheet 1: What to Prepare for the Needs Assessment and Support Plan 28
Worksheet 2- Your Personal Goals 29
Worksheet 3: Who Helps You and What Help You Need 32

DRAFT

Why Should I Read this Handbook?

You should read this handbook if your or your family, friends, or other supports:

- Need information about the supports available to help you live in your community
- Would like information about how to access these supports

Health First Colorado (Colorado's Medicaid program) pays for long-term services and supports (LTSS). These services and supports can include the following:

- Supports in an institution, such as an intermediate care facility for individuals with intellectual disabilities (ICF-IID) or a nursing facility
- Supports in your home or the community, which are called Home and Community-Based Services (HCBS)

HCBS supports can include:

- Help inside your home with things like bathing, getting dressed and cleaning your house
- Help outside your home with things like getting and keeping a job

How Will This Handbook Help Me?

This handbook will help you see if one of the HCBS options offered through Health First Colorado is right for you. If they are, you can use this handbook to work on getting the help you need for qualifying and enrolling in services.

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The handbook provides information about the four major pieces for learning about and accessing HCBS:

- Section 1: Is HCBS Right For Me?

  The first step is to talk to intake staff at one of the HCBS agencies to see if you and the intake staff think HCBS is right for you. This section provides information to help you complete this first step.

- Section 2: Do I Qualify for HCBS Benefits?

  If you and the intake staff think HCBS is right for you, the next step is to see if you qualify for HCBS benefits. This section describes how this will be determined.

- Section 3: How Do I Receive HCBS Benefits?

  If you qualify for HCBS benefits, this section explains what to do to get the help you need. You will work with a case manager and your support team to complete a Needs Assessment and develop a Support Plan that includes the services and supports that will help you achieve your goals and help you stay healthy and safe in the community.

Section 1: Is HCBS Right for Me?

The first step is to figure out if Home and Community-Based Services (HCBS) is right for you. This step usually happens over the phone. It is called an **intake screen**.

Who Do I Call?

Case Management Agencies (CMAs) help you through the entire process. There are two kinds of CMAs: Community Centered Boards (CCB) and Single Entry Point Agencies (SEP). **You will call a SEP or CCB to set up an intake screen.** You will call a CCB if you have Intellectual or Developmental Disabilities. If you don't have Intellectual or Developmental Disabilities, then you will call a SEP.

First, using the steps, find a CCB or SEP in your area. You will need to know what county you live in. When you identify your CCB or SEP, call that agency and ask to set up an intake screen.

- Click on the link or copy and paste the link: https://www.colorado.gov/hcpf/long-term-services-and-supports-programs
- Scroll down the page about halfway, until you see "Case Management Agencies" in a list
- Click on the + sign next to "Case Management Agencies"
- Click on the CCB or SEP link, depending on what you need
  - On the CCB screen, click on your county on the map to see the agency in your area. You can also just scroll down until you see your county listed.
  - On the SEP screen, click on your county in the list to see the agency in your area.

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Who Do I Talk to When I Call?

Let the person who answers the phone know that you are calling for an intake screen. You will probably work with several different people during this process. You and anyone else you choose will talk to intake staff about your needs.

What Happens During the Intake Screen?

Intake staff at the agency will provide you with information about HCBS services. Intake staff will talk to you about your support needs and financial information. Together, you will decide if HCBS is right for you, and if you should move on to the next step of completing a Level of Care Screen to see if you qualify for HCBS benefits.

If HCBS is Right for Me, What is Next?

If you and the intake staff you worked with think HCBS is right for you, the intake staff will help you begin the Health First Colorado (Medicaid) application process or refer you to the appropriate agency. Your income and financial assets will be checked to see if you qualify for HCBS. Your county department of human or social services will process your application to check for financial eligibility. **Section 2** in this handbook describes what steps are completed to see if you qualify for HCBS.

Section 2: Do I Qualify for HCBS Benefits?

If you and the intake staff you worked with think that Home and Community-Based Services (HCBS) is right for you, the next step is to see if you qualify for HCBS. This happens in person. A case manager will complete a **Level of Care (LOC) screen** with you to see if you qualify.

How Do I Schedule the LOC Screen?

During the intake screen call, the intake staff schedules the Level of Care screen with a case manager at a time that is best for you. The Level of Care screen will occur at your home.

Who Should I Include During this Process?

Some people have a parent or guardian who makes legal decisions about their care. If you have a parent or guardian like this, they must be a part of the process.

You can also invite anyone you want. You may want to invite family members, important friends, and people who help you with your care. **You do not have to invite friends, family members or service providers if you don't want to.**

Who Does the LOC Screen?

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A case manager from the Case Management Agency that you called will conduct the Level of Care Screen to see if you qualify for HCBS.

What Happens During the LOC Screen?

A case manager will meet with you in person to conduct your Level of Care Screen. The Level of Care Screen is used to see if you meet level of care for Medicaid waiver services, a nursing facility, or PACE.

The case manager will ask you about your support needs in different activities of daily living like dressing and walking. The case manager will also ask you about how your memory, cognition, and behaviors impact your daily life. The results of the LOC screen will decide if your needs qualify you for HCBS, and if you should move on to the next step, which is completing the Needs Assessment and Support Planning.

What Happens if I Don't Qualify for HCBS Benefits?

If the results show you do not qualify for HCBS, you have the right to appeal the decision. The appeal process is described on page 24 of this handbook.

I Qualify for HCBS, What is Next?

If you meet level of care for HCBS services, this means that you qualify for HCBS. The next step is to complete your Needs Assessment and develop your Support Plan with your case manager. Section 3 of this handbook talks about this next step.

Section 3: How Do I Receive HCBS Services?

Once you qualify for HCBS, you will then complete a Needs Assessment and develop your Support Plan. This is usually started during the LOC screen meeting. During this step, you and your case manager will figure out what help you need and the best way for you to get that help.

Before we talk about what happens during the Needs Assessment and when you develop your Support Plan, let's cover the role of your case manager when you are getting started with HCBS services and also over time when you are receiving services. We also will cover your responsibilities and rights.

What Does My Case Manager Do?

A case manager will:

- Work with you, and the people you choose to have involved, to conduct all the assessments you need to develop your Support Plan.
- Communicate with service providers about service delivery and concerns, if you have them.
- Review and change your services if needed.
- Let you know about any change in your services.
- Let you know if any of your services are denied, put on hold, and/or are reduced.
- Document, report, and take care of your complaints and concerns.
- Report abuse, neglect, mistreatment, and exploitation to the appropriate authority, if any of these things occur.

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What Are My Responsibilities?

You will participate in your assessments, the development of your Support Plan, and the coordination of your services. Your responsibilities include:

- Giving accurate information about how much help you need every day with things like getting dressed, taking a bath or shower, or moving around the house.
- Helping work on continued progress related to your independence.
- Cooperating with your providers and case management agency.
- Letting your case manager know about changes in your support system, health, and living situation. This includes letting the case manager know if you have gone to the hospital, emergency room, nursing facility or intermediate care facility. It also includes letting the case manager know if you plan on moving.
- Letting your case manager know if you have not received services through HCBS that you should be according to your Support Plan.

- Letting your case manager know if your needs have changed or if you are having a problem with your services.
- Notifying your case manager about anything that might change your Medicaid eligibility, like a change in your income.
- Notifying your case manager of any critical incidents that you experience or witness.
- Working with your case manager to make sure your responses and goals in your Support Plan reflect your preferences.

What Are My Rights?

- You have the right to file a complaint or to appeal decisions about your Assessment and/or your Support Plan. The process for filing a complaint or an appeal are described on page 24.
- You have the right to include anyone you would like in the planning process.
- You have the right to be provided with support to help you direct the planning process to the maximum extent possible to help make informed choices and decisions.
- You have the right to schedule the planning process at a time and place convenient to you.
- You have the right to choose any LTC programs and services that you are eligible for. However, you may only be enrolled in one HCBS waiver at a time.
- You have the right to choose any willing and qualified Medicaid service provider that provides services in the area where you live. You also have the right to change providers at any time. Providers have the right to accept or deny your request for services.
- You have the right to be provided with services and supports that do not have any potential conflict of interest with your case management or development of your Support Plan.
- You have the right to choose where you live and where you receive services. However, there are certain factors that may limit where you can live. Your case manager will help you explore your options.
- You have the right to receive a copy of your Support Plan so that you understand the information.
- You have the right to know 15 days in advance if services are going to be stopped.

Now we are ready to talk about the Needs Assessment and Support Plan. The handbook will first talk about information that is important for you to know about the Needs Assessment and Support Plan. Then the handbook will cover what happens during the Needs Assessment and Support Plan.

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How Involved Will I Be? Does My Involvement Change If I Have an Intellectual Disability or Cognitive Impairment?

You should be involved, even if you have an Intellectual Disability or Cognitive Impairment. You should be involved in completing your Needs Assessment and developing your Support Plan as much as possible. Your case manager will talk with you, watch your actions and other non-verbal communications, and talk to people who know your preferences to make sure your goals and support needs are what you want.

How is My Legal Representative Involved?

If you have a parent or guardian who is your legal representative, that person has a legal right to decide what is included in your Support Plan. Case managers will still try to make sure your preferences are included. If you and your legal representative disagree on something, case managers will write down the different opinions in your official records.

Do I Have to Respond to All Questions?

You can skip some sections. Some questions in your Needs Assessment and Support Plan must be answered. Other questions are optional, so you don't have to answer them if you don't want to. If you do not want to answer a question for any reason, let your case manager know and she/he will tell you if you can skip that question.

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How Can I Prepare for the Meeting?

Please use the worksheets at the end of this handbook. Bring them when you meet with your case manager. Completing the worksheets is not required but it is recommended. The worksheets will help you think about the supports and services that you need to stay safe and healthy living in your community. If you complete and bring the worksheets, **you will be more prepared to talk with the case manager when you are completing your Needs Assessment and developing your Support Plan**.

What Happens During the Needs Assessment?

The Needs Assessment may take two or three hours to complete. How long it takes will depend on your needs and how much information you want to share. It should be easier to complete if you fill out the worksheets at the end of this handbook in advance and have them at the Needs Assessment. You can take a break or stop at any time during the Needs Assessment. Let your case manager know if you want to take a break or stop for the day. You can finish after a break or on another day. The Needs Assessment will involve the following:

- Your case manager will ask you questions and look at the information you bring to learn more about your strengths, abilities and needs. This information will help with choosing services that best fit your needs.
- Your case manager will tell you what programs and services you qualify for.

- You will share your Personal Story with your case manager, if you want to.
- You will create personal goals.

There are two types of Needs Assessments that you may choose from: Basic or Comprehensive. Your case manager will explain both assessments. You will choose the one you think is best for you.

Basic Needs Assessment

The Basic Needs Assessment is shorter than the Comprehensive Needs Assessment. For the purpose of this pilot, your case manager will not have access to the Basic Assessment because we are testing the Comprehensive Assessment only.

Following the pilot, if you choose to complete the Basic Needs Assessment, you and your case manager will not discuss the details of how your services are or will be delivered. You will only discuss long-term services and supports that you need for your personal goals and health and safety needs.

The Basic Assessment will still provide a comprehensive Support Plan for you, but it will be limited to required information and whatever you choose to share.

The Basic Assessment is often chosen by people who:

- Are currently receiving services and are already very familiar with long-term services and supports offered in Colorado
- Are only looking for specific services and are not interested in any additional supports

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Comprehensive Needs Assessment

The Comprehensive Assessment is a more detailed assessment than the Basic Assessment. Both the Basic and Comprehensive Assessments cover the same areas; but, you and your case manager will discuss things in greater detail during the Comprehensive Assessment. For example, you will discuss:

- Employment
- Volunteering
- Training opportunities
- Your preferences for how services should be performed to support your activities of daily living with things like bathing, dressing, and eating
- Your interest in becoming a self-advocate
- How to help your caregiver
- Anything else that is important to you to share and discuss

Many Comprehensive Assessment items are voluntary. If you don't want to complete a section or item, tell your case manager and he/she will let you know if it is required or if it can be skipped.

The Comprehensive Assessment will help you and your case manager develop a Support Plan that covers your personal goals and health and safety goals. You and your case manager may discuss supports that you didn't know were available.

The Comprehensive Assessment is recommended for people who:

- Are new to the long-term services and supports system
- Have complicated medical, behavioral health, or other needs
- Would benefit from a careful look at everything that is available

Assessment Sections

Both the Basic and Comprehensive Assessments include these sections:

- **Your Personal Story:** You can share your strengths, preferences and areas of need in your Personal Story so your case manager and other service providers can get to know you and better assist you. You can also share your personal goals that you want to achieve. You and your case manager start your Personal Story early in the process so your goals and preferences are understood from the very beginning. If you don't want to share your personal story, you don't have to.
- **Functioning:** This section is about the support you need for daily living. For example, you will discuss the support you need with things like getting dressed, eating, bathing, cleaning your house, cooking and shopping. Your case manager will ask about how you want to get this help. You will also learn about training or equipment that could help you increase your independence. Equipment can include things like wheelchairs, hearing aids, or a computer.
- **Health:** This section asks about your health, and what you need to maintain your health.
- **Memory and Cognition:** This section is about how you remember and understand information, share ideas, and make decisions in your daily life.
- **Psychosocial:** This section is about your behavior, mood, and lifestyle choices.
- **Sensory and Communication:** This section is about your hearing and vision, how you communicate, and how you receive and respond to information.
- **Employment, Volunteering and Training:** This section is about your current or desired interest in employment, volunteer work, or education or training.
- **Housing and Environment:** This section is about where you live, and if changes like building a ramp or widening doorways would be helpful to you.
- **Participant Engagement:** This section discusses training and assistance opportunities for you or your representative to help you advocate for yourself. You can still have the help of other advocates if you want to, even if you decide you want to be an advocate for yourself.

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- **Safety and Self-preservation:** This section is about the help you need to live safely in the community, especially during an emergency.
- **Caregiver:** This section asks you about the help friends, family members and people you pay are already giving you.
- **Hospital Level of Care:** This section identifies additional supports for people who have challenging medical needs.

Overview of Developing a Support Plan

After you complete the Needs Assessment, developing the Support Plan is the final step. You, your case manager, and anyone else you choose will work as a team to develop your Person-Centered Support Plan.

What is the Support Plan?

A Support Plan is a document that describes the HCBS and other long-term services and supports you agree to receive. This Support Plan will list your personal goals, the plan for helping you achieve your goals, and your health and safety needs to help you stay healthy and safe in the community. Your Support Plan is updated at least annually, but you can work with your case manager to update your Support Plan at any time.

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What Can I Expect as I Prepare For My Support Plan?

Who leads the Support Plan creation?	You lead the planning. You pick your own team. You, your team, and the case manager work together to develop your Support Plan.
Where and when does the Support Plan meeting occur?	You choose the time and place you want.
What does the planning group discuss?	You work with your team to decide what is important. This will be a balance of what is important to you for a happy life, and what is important for you to remain healthy and safe. Your desires, and the information from your Needs Assessment are both considered in creating your Support Plan.
What does the Support Plan contain?	Your plan is personalized to better fit your unique interests and preferences. Some ideas and goals may require major changes in how support is provided. Your plan presents you with different programs you are eligible for, so you can choose what program is best for you.
How is the plan evaluated for effectiveness?	After the Support Plan has been in place for a while, you decide if the Support Plan has been effective and successful.

Developing the Support Plan

What Is My Case Manager's Role?

You and your case manager will work together throughout the process. You will take the lead as much as possible, if you want to take the lead.

Your case manager will help:

- Educate you about the process
- Answer your questions
- Write the Support Plan in a way that uses your own words and your perspective whenever possible
- Allow you to see Support Plan documents and computer screens so you can better understand what is being added
- Discuss with you different ways to meet your goals

What Are the Steps to Develop the Support Plan?

The handbook first provides an overview of the seven main steps to develop your Support Plan. Then the handbook will provide more detail about each step.

1. **Orientation to the Support Planning Process:** Your case manager will explain the Support Plan process. Then you and your case manager will review your identifying information and how you like to communicate. Your case manager will also gather information about your Support Plan meeting like the time and place the meeting is held.
2. **Identify My Personal Goals:** Your Support Plan should be personalized to focus on **your** goals and preferences. Personal goals can be whatever is important to you. Your goals may be getting a job or moving. Your goals could be about changes in your everyday life, like spending more time outdoors or starting a new hobby. You might have several goals in your Support Plan. Your case manager cannot refuse to include your personal goals in your Support Plan.
    - You and your case manager will list your personal goals and what activities and what services and supports are available to you to help you fulfill those goals. HCBS offers many services that may help you achieve your goals, but you and your case manager will probably need to find supports beyond HCBS to fulfill your goals.
    - You and your case manager will decide what types of help you need for each activity and how to measure your progress.
    - You and your case manager will figure out when you will complete the activities you need to meet your goals.
3. **Address Health and Safety Issues Not Included in your Personal Goals:** Your case manager will review your Needs Assessment with you and see if there are any health and safety issues that are not included in your personal goals. You may choose not to address a health and safety issue.

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4. **Directing My Services:** Discuss with your case manager if you want to direct some of your services. Directing your services means you or an authorized representative decides how services are delivered, including choosing and managing caregivers. This information will help you decide which waiver to choose.
5. **Choose the Best Waiver and/or State Plan Option:** Decide which combination of HCBS waiver and State Plan services will be the best for your goals, activities, and types of supports you need. Your case manager will tell you the pros and cons of each option. You can pick whatever option you want.
6. **Identifying My Supports:** Your case manager will help determine the frequency of Medicaid HCBS services you will need. You and your case manager should figure out what supports are available, and also identify gaps in supports you need for daily living. There is a Supports Calendar Worksheet, which your case manager can use to help you identify supports. If you don't want your case manager to fill out the Supports Calendar Worksheet, let them know.
7. **Address Problems that May Come Up:** After you and your case manager have a draft plan, together you will:
    - **Temporary Increase in Services**: Decide if you need a temporary increase in services.
    - **Referrals**: Make referrals for services, support, training, or other information.
    - **Back-up Plans:** Develop a back-up plan for supports.
    - **Disaster Relocation Plan:** Develop a disaster relocation plan.
    - **Lowering my Risk:** Develop plans for lowering your risks.
    - **Modification of Rights:** Explain anything in your plan that limits your rights or where you live.
    - **Advance Directives:** Identify advance directives. Advance directives allow you to choose someone to legally help you make decisions and explain what you want your caregivers to do if something happens to you in the future, like a serious accident.
    - **Case Management Monitoring:** Add your preferences for how often you want your case manager to check in with you. Your case manager must check in with you at least four times per year, but it can be more often if you prefer.
    - **Comments, Guidance, and Concerns from Members of the Team:** Add feedback from your Support Planning team.

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Most of the steps above are optional. You don't have to do them if you don't want to. Now, let's go into more detail about each of the seven steps listed above.

Step 1: Orientation to the Support Planning Process

To help you lead the development of your Support Plan, your case manager will explain the process and answer any questions you have. The Support Plan will be written in your voice because this is your plan.

Then you and your case manager will review your identifying information you provided during the Needs Assessment. It is important for your case manager to know how best to communicate with you to allow you to be as involved as you want. Your case manager will gather information about your Support Plan meeting like who was involved in the process. You will be given your case manager's contact information if you have questions after the meeting.

Step 2: Identify My Personal Goals

Your Support Plan will help you put your goals into action by completing the steps listed below.

List Personal Goals: You choose your personal goals. Your case manager should help you make your goals clear and specific. Goals can be big or small. Examples of goals might be:

- Going to college
- Getting a job
- Meeting new people
- Seeing friends more often
- Taking a painting class
- Going to baseball games
- Going to a concert
- Visiting the library every month
- Getting more exercise
- Finding a new hobby
- Moving to a different apartment

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Rank Each Goal and Rate How Meaningful Each Goal Is: You will rank your goals in the order of how important they are to you and rate how meaningful each goal is to you. This information will be used to decide what goals are most important and make sure that all your personal goals are meaningful to you and not just to someone else. Some goals may be harder and take longer to achieve than others.

Determine how to Measure Progress: You and your case manager will decide how to measure progress towards your goals. When you update your Support Plan, you and your case manager will decide if the goal has been met.

Identify Timeframe for Reaching Goals: You and your case manager will decide when each goal should be reached. You may be able to reach some goals faster than others. Some goals may not end like a goal to continue living in your own apartment.

Identify Activities to Help Reach Goals: You and your case manager should figure out activities that can help you achieve your goals. These should be real-life activities that can be measured.

Activities may be met by a paid or unpaid support or may be completed directly by you without support. For example, if your goal is to go to college, activities might be:

  - *Finishing your GED*
  - *Meeting with a guidance counselor to discuss colleges and careers*
  - *Enrolling in classes and attending classes*

- **Supports:** Supports help you do your activities. Supports include paid services, unpaid services and referrals.
- **Services:** Services in the Support Plan must be paid and authorized by the plan.

  Just like goals, activities should be written in your words. Here is an example:

  My goal is to work at the concession stands at the stadium where the Denver Broncos play. I'll need to do these things to meet my goal:

  - *My case manager and I will contact a job coach to help me find a job opening*
  - *I will work with a job coach to understand my job*
  - *I will need to find a way to get to and from the stadium*
  - *I would like someone to come with me my first few times working because I've never had a job before*

- **Start/End Dates:** You and your case manager will decide the start and finish date for each activity.
- **Preferences:** Identify any preference you have for who helps you with the activity or how it should be completed. Examples include:
  - *I prefer that my job coach is a man who likes football.*
  - *I want a female caregiver who is around my age to help me with personal hygiene tasks. I also prefer to bathe in the morning. I have a certain way I like to get dressed.*
- **Skills Building:** Let your case manager know if you want training that helps you become more independent with the activity.
- **Direct the Activity Yourself:** Let your case manager know if you want to be able to direct the activity yourself or with the support of a legally authorized representative.

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Step 3: Address Health and Safety Issues Not Included in your Personal Goals

Your Support Plan will list any health and safety issues from your Needs Assessment that were not included in your personal goals. You don't have to address a health and safety issue in the goals section of your Support Plan. You also don't have to address every health and safety issue. You will have to tell your case manager that you understand the risk of not addressing the health safety issue and you are willing to accept the risk.

For each health and safety issue you want to address, you and your case manager will list activities to help manage or resolve the issue just like what you did for your personal goals.

Step 4: Directing My Services

In most cases, services such as home health, personal care and homemaking services are provided through an agency (not the case management agency). However, you may have the option to direct some services. This is called participant-direction. This means that with the support of your case manager, you will have a leading role in hiring and firing the people who come into your home, figuring out how much they get paid, and what they do when they come. Your case manager will ask you a few questions and to see if you are interested in directing some of your services.

Not all of the HCBS waivers offer a participant-directed option. See pages 22-24 of this handbook for the waivers that allow you to direct some services.

Step 5: Choose the Best Waiver and/or State Plan Option

Your case manager will discuss with you the pros and cons of each waiver and State Plan services, such as LTHH or PACE, you qualify for so you can select the best option. Your Support Plan lists the pros and cons in case you wanted to know why you picked a certain waiver later on. Your case manager will also help you decide if long-term home health services such as skilled nursing and therapies are right for you and should be a part of your Support Plan. See pages 22-24 of this handbook for details of each service option.

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If there is a waiver you want, but your Needs Assessment says you don't qualify, you can ask your case manager to review your Needs Assessment again to make sure nothing was missed. If you are still denied the waiver you want, you can appeal that decision. See page 24 for information on appeals.

Step 6: Identifying My Supports

When you choose a waiver that you qualify for, the next steps are:

- Coordinating Paid and Unpaid Supports
- Authorizing Medicaid HCBS services
- Reviewing your rights, providers, and options
- Selecting your providers

As part of this step, you and your case manager may choose to complete the Support Calendar Worksheet, which shows all the available supports during a week. The calendar helps your team see gaps in services and estimate the type and amount of services you will need.

The calendar also helps you see when you would like to have services delivered throughout the day and week. Up to eight different support scheduling situations can be entered in the calendar. For

example, school weeks, summer break weeks, and a week where you or your caregiver have a planned surgery may require different services and supports at different times.

Your case manager should also give you a choice of qualified providers, and will give you a list or tell you how to get the list of qualified providers. Your case manager should also let you know you can change providers at any time, and that providers have the right to accept or deny your request for services.

If you select a waiver that allows you to direct services, such as Consumer-Directed Attendant Support Services or In-Home Support Services, your case manager will make sure you understand how to use these services. You may need support or training to help learn how to direct services.

Step 6: Address Problems that May Come Up

The last step in finishing your Support Plan is to discuss how to manage problems that may come up, including the issues below.

- **Temporary Increase in Service**

You and your case manager will discuss if you need additional support because of a temporary need. For example, you may have severe episodes of back pain where you can't walk a couple times a year. When this occurs, you need a lot more personal care.

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- **Make Referrals for services, support, training, or other information**

Your case manager will discuss any referrals that are needed and who should contact the referral agency. If you or your representative plans to follow up with the referral, your case manager will give you the referral information.

- **Back-up Plans**

You and your case manager will have a back-up plan for times when your usual caregiver is not available. This section is federally required. It must always be filled out. The section describes what you should do if a caregiver does not show up, and who will be your back-up caregiver.

- **Disaster Relocation Planning**

  This section is optional and allows you to plan where you will go during a disaster, such as a flood or a fire. If you have a disaster relocation plan, your case manager and other service providers will know how to find you if a disaster happens.

- **Lowering My Risks**

  This is a required section for you and your case manager to identify, discuss, and make a plan for risks resulting from various situations. It has the following main areas:

  - How to manage risks from a power outage if you have medical devices or equipment that use electricity
  - Identify remaining risks in your Needs Assessment and Support Plan

  - Discuss plans to lower the risks from the Needs Assessment and Support Plan
  - Discuss any risks from the Needs Assessment and Support Plan that you or your legal representative accept and do not want to have a plan to lower the risk

- **Modification of Rights**

  A modification of your rights is a situation when your rights are temporarily restricted to protect you from hurting yourself, others, or property. Examples of rights modifications include restraints/restriction of movement, limiting access to food, and locked facilities where you are unable to control your own activities or schedule.

  This section is required if you are in a residential setting or when you are in a day program, including supported employment. This section does not apply when you are in your own home.

  These type of settings must follow federal law to make sure any temporary restriction of your rights is addressed during your Person-Centered Planning process and includes an appropriate reason for the restriction or modification.

  Before any rights modification or exception occurs your case manager must list the reasons why the modification is necessary and other approaches or supports that were tried but did not work. They must also get your or your legal representative's informed consent before the modification is used. Modifications should only be used as long as needed and will be monitored by trained staff.

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- **Advance Directives**

  If you don't have someone with legal authority to make decisions, you and your case manager will decide if you want to select someone who will legally help you make decisions. You will also talk with your case manager about what you want your caregivers to do if something happens to you in the future, like a serious accident.

- **Case Management Monitoring**

  This section is required. It describes how, and how often, you want your case manager to check in with you, to see how you are and check on your progress and goals. Your approval is required before your case manager speaks to any individual or entity about you. You can list the name of anyone you would like to be updated when something important occurs.

- **Comments, Guidance, and Concerns from Members of My Team**

  This is the final section. This is your chance to talk about any comments or concerns you have with your Support Plan before you sign the Support Plan. You and any member of your team can add to this section. This can include concerns about service providers, feedback about your living situation, or a need to talk more about your goals. This section can be empty if no one has comments or concerns they want to add before signing.

What are my Service Options?

When you are deciding which services and supports to include in your Support Plan, your case manager will discuss various service options with you.

Health First Colorado offers three options for HCBS: Long Term Home Health (LTHH), Program of All-Inclusive Care for the Elderly (PACE), and HCBS waivers.

Long Term Home Health (LTHH)

LTHH includes the following services:

- Skilled Nursing (provided by a Registered Nurse or Licensed Practical Nurse)
- Certified Nurse Aide (CNA) services (may also be referred to as a Certified Nursing Assistant or Home Health Aide)
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech/Language Pathology (SLP) services (may also be referred to as Speech Therapy)

You may be able to receive LTHH if you:

- Require home health services for the treatment of an illness (physical or mental), injury, or disability
- Are unable to perform the health care tasks yourself, and you have no family member/caregiver who is willing and able to perform the skilled tasks
- Require services that cannot be received in an outpatient treatment office or for which your residence is the best setting to complete the care required for your medical condition
- Are requesting LTHH services that meet medical necessity criteria and are provided in a manner consistent with professional practice

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Program of All-Inclusive Care for the Elderly (PACE)

Program of All-Inclusive Care for the Elderly (PACE) is operated by Health First Colorado (Colorado's Medicaid Program) and Medicare. The PACE program provides comprehensive medical and social services to certain frail individuals 55 years of age and older. The goal of PACE is to help individuals live and stay in their homes and communities through comprehensive care coordination.

PACE includes the following services:

- Adult day care
- Dental services
- Emergency services
- Durable Medical Equipment
- Home care services
- Hospital care
- Laboratory/X-ray services
- Meals
- Medical specialty services
- Nursing home care
- Nutritional counseling
- Occupational therapy
- Optometry
- Physical therapy
- Prescription drugs
- Preventative care
- Primary care (including doctor and nursing services)
- Recreational therapy
- Respite care
- Social services
- Social work counseling
- Transportation

For individuals enrolled in PACE, the program also includes any services determined medically necessary by their team of health care professionals to improve and maintain their overall health.

You may be able to receive PACE if:

- You are 55 years of age or older;
- You meet nursing facility level of care;
- You live in the service area of the PACE organization; and
- You are able to live in a community (with supports as needed) without risking your health or safety.

HCBS Waivers

Colorado has ten HCBS waivers that are designed for different disability and health care needs and offer a range of services. You can only be enrolled in one waiver at a time, but you can receive waiver services, PACE and/or LTHH.

This section provides a brief description of each of the waivers and a table that shows the services covered by each waiver.

Your case manager will tell you which waivers you are eligible for and will work with you when you develop your Support Plan to select the waiver that is the best match to your goals, needs, and preferences. It will be helpful if you can review the waivers before you meet to work on your Support Plan so that you can be an active participant in that discussion.

If you want to review a brief description of each service, go to the Department's website at: https://www.colorado.gov/hcpf/program-list and click on each waiver.

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Waivers that Support Children

Colorado offers four waivers that provide supports for children:

- The Children's Extensive Support Services Waiver Program (CES) helps members ages 17 and younger who have a developmental disability or delay.
- The Children's Home and Community-Based Services Waiver Program (CHCBS) gives members ages 17 and younger who have major medical needs help with daily living activities. This waiver offers participant direction.
- The Children's Habilitation Residential Program (CHRP) offers residential and other services to members ages 20 and younger who are in foster care and have a developmental disability with high needs. The program helps foster children and youth improve self-help, socialization and adaptive skills needed to live in the community.
- The Children with Life-Limiting Illness Waiver Program (CLLI) helps members ages 18 and younger diagnosed with a life-limiting illness. This benefit helps your child get curative treatment and palliative (quality of life) care.

Children's Services

Services	CES	CHCBS	CHRP	CLLI
Adaptive Therapeutic Recreational Equipment and Fees	X			
Assistive Technology	X			
Bereavement Counseling				X
Case Management		X		
Community Connector	X		X	
Expressive Therapy				X
Habilitation			X	
Hippotherapy	X		X	
Home Accessibility Adaptions	X			
Homemaker	X			
In Home Support Services Health Maintenance Activities (IHSS)		X		
Intensive Support Services			X	
Massage Therapy	X		X	X
Movement Therapy	X		X	
Palliative/Supportive Care Services				X
Parent Education	X			
Respite	X		X	X
Specialized Medical Equipment and Supplies	X			
Therapeutic Life Limiting Illness Support: Individual, Family, and Group Counseling				X
Transition Support Services			X	
Vehicle Modifications	X			
Youth Day Service	X			

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Waivers that Support Adults

Colorado offers six waivers that provide supports for adults:

- The Brain Injury Waiver Program (BI Program) helps members ages 16 and older who have a brain injury.
- The Community Mental Health Supports Waiver Program (CMHS Program) helps members ages 18 and older who have a severe and continuing mental health need and need help with one or more activities of daily living.
- The Developmental Disabilities Waiver Program (DD Program) helps members ages 18 and older with an intellectual or developmental disability live in the community.
- The Elderly, Blind and Disabled Waiver Program (EBD Program) helps members ages 65 and older who have a functional impairment. The program also helps members ages 18 through 64 who are physically disabled, blind, or are 18 or over and have a diagnosis of HIV or AIDS.

- The Spinal Cord Injury Waiver Program (SCI Program) helps members ages 18 and older who have a spinal cord injury. You must live in Adams, Arapahoe, Denver, Douglas or Jefferson counties to be on the SCI Program.
- The Supported Living Services Waiver Program (SLS Program) helps members ages 18 and older who have an intellectual or developmental disability live in the community.

All waivers, except the DD waiver, offer a participant-direction option.

Adult Services

Services	BI	CMHS	DD	EBD	SCI	SLS
Adult Day Health	X			X	X	
Adult Day Services		X				
Alternative Care Facility (ACF)		X		X		
Assistive Technology						X
Behavioral Management and Education	X					
Behavioral Services			X			X
Complementary and Integrative Health Services (Acupuncture, Chiropractic and Massage Therapy)					X	
Consumer Directed Attendant Support Services (CDASS)	X	X		X	X	X
Day Habilitation			X			X
Day Treatment	X					
Dental Services			X			X
Hippotherapy						X
Homemaker		X		X	X	X
Home Delivered Meals	X	X	X	X	X	X
Home Modification	X	X		X	X	X
In Home Support Services (IHSS)				X	X	
Independent Living Skills Training	X					
Life Skills Training		X		X	X	X
Massage Therapy						X
Mental Health Counseling	X					
Mentorship						X
Movement Therapy						X
Non-Medical Transportation		X	X	X	X	
Peer Mentorship	X	X	X	X	X	X
Personal Care	X	X		X	X	X
Personal Emergency Response Systems (PERS)	X	X		X	X	X
Prevocational Services			X			X
Recreational Facility Fee/Passes						X
Residential Habilitation			X			
Respite	X	X		X	X	X
Specialized Medical Equipment and Supplies		X	X			X
Substance Abuse Counseling	X					
Supplies, Equipment, and Medication Reminder				X	X	

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Services	BI	CMHS	DD	EBD	SCI	SLS
Supported Employment			X			X
Supported Living Program	X					
Transition Setup	X	X	X	X	X	X
Transitional Living Program	X					
Vehicle Modifications						X
Vision			X			X

You have now completed the Needs Assessment and developed a Support Plan.

How do I Report a Complaint or Appeal a Decision?

Completed by the Department in the future.

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Appendix 1: Common System Acronyms List

- **AAAs-** Area Agency on Aging (referred to as the triple A's)
- **ACC-** Accountable Care Collaborative
- **ACF-** Alternative Care Facility
- **ADA-** Americans with Disabilities Act
- **ADL-** Activities of Daily Living
- **ADRC-** Aging and Disability Resources Center
- **ADS-** Adult Day Services
- **APS-** Adult Protective Services
- **BHO-** Behavioral Health Organization
- **BI-** Brain Injury
- **CAHHA-** Colorado Association of Home Health Agencies
- **CBMS-** Colorado Benefits Management System
- **CCB-** Community Centered Board (for I/DD)
- **CCT-** Colorado Choice Transitions (out of nursing homes)
- **CDASS-** Consumer Direct Attendant Support Services
- **CDE-** Colorado Department of Education
- **CDHS-** Colorado Department of Human Services
- **CDPHE-** Colorado Department of Public Health and Environment
- **CFCM-** Conflict Free Case Management
- **CFR-** Code of Federal Regulations
- **CHCBS-** Home and Community Based Services-Children's Medical Waiver
- **CHP+-** Children's Health Plan Plus
- **CHRP-** Children's Habilitation Residential Program Waiver
- **CILs-** Centers for Independent Living
- **CLLI-** Children with Life Limiting Illness Waiver
- **CMHC-** Community Mental Health Centers
- **CMHS**- Community Mental Health Services Waiver
- **CMA**- Case Management Agency
- **CMS**- Centers for Medicare & Medicaid Services
- **CNA-**Certified Nursing Assistant
- **CTS-** Community Transition Services
- **DD-** Developmental Disability
- **DOC-** Department of Corrections
- **DME-** Durable Medical Equipment
- **DYC-** Department of Youth Corrections
- **DVR-** Division of Vocational Rehabilitation
- **ED-** Emergency Department
- **EOB-** Explanation of Benefits
- **EPSDT-** Early and Periodic Screening, Diagnostic and Treatment (Preventive Health Care Program for Medicaid Clients Up to age 21)
- **EVT-** Employment, Volunteering, and Training Assessment Module
- **EVV-** Electronic Visit Verification
- **FDA-** Food and Drug Administration
- **FERPA-** Family Education Rights and Privacy Act
- **FFS-** Fee for Service
- **FPL-** Federal Poverty Limit
- **FQHC/Rural Clinic-** Federally Qualified Health Clinic (or center)- health service facility for low income persons in a medically underserved area
- **HCAC-** Home Care Association of Colorado
- **HCBS-** Home and Community Based Services
- **HCBS-BI-** Home and Community Based Services-brain injury waiver
- **HCBS-CES-** Home and Community Based Services-Children's Extensive Support Waiver
- **HCBS-DD-** Home and Community Based Services-Persons with Developmental Disabilities Waiver
- **HCBS-EBD**- Home and Community Based Services-Elderly, Blind, and Disabled Waiver
- **HCBS-MI**- Home and Community Based Services-Mentally Ill Waiver
- **HCBS-PLWA-** Home and Community Based Services-People Living with AIDS Waiver

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- **HCBS-SLS-** Home and Community Based Services-Supported Living for persons with developmental disabilities Waiver
- **HCPF-** Colorado Department of Health Care Policy and Financing
- **HHA-** Home Health Aide or Home Health Agency
- **HHS-** Health and Human Services Federal agency
- **HIBI-** Health Insurance Buy-In Program
- **HIPAA-** Health Insurance Portability and Accountability Act
- **HMO-** Health Maintenance Organization
- **IADL-** Instrumental Activity of Daily Living
- **ICF-** Intermediate Care Facility
- **ICF-IID-** Intermediate Care Facility for individuals with Intellectual and Developmental Disabilities
- **I/DD-** Intellectual and/or Developmental Delay
- **IEP-** Individual Education Plan
- **IHSS-** In-Home Support Services
- **ILD-** Imposition of Legal Disability
- **JBC-** Joint Budget Committee
- **LOC-** Level of Care
- **LTHH-** Long-term Home Health
- **LTSS-** Long Term Supports and Services
- **MCH-** Maternal Child Health
- **MCO**- Managed Care Organization
- **MMP**- Medicaid-Medicare Program (often referred to as "dual eligible")
- **NWD-** No Wrong Door
- **OBH-** Office of Behavioral Health
- **PACE-** Programs of All Inclusive Care for the Elderly
- **PAR-** Prior Authorization Review
- **PCP-** Primary Care Physician
- **PCMP-** Primary Care Medical Provider
- **PDN-** Private Duty Nursing
- **PT-** Physical Therapist
- **OT-** Occupational Therapist
- **QA**-Quality Assurance
- **RAE**- Regional Area Entity
- **RHSS-** Residential Habilitation Services and Supports
- **RN-** Registered Nurse
- **SADS-** Specialized Adult Day Services
- **SB-** Senate Bill (introduced to the Senate in the Colorado General Assembly/Legislature)
- **SCI-** Spinal Cord Injury
- **SCP-** Service Coordination Plan
- **SEP-** Single Entry Point
- **SIM-** State Innovation Model
- **SLP-** Speech/Language Pathologist
- **SLP-** Supported Living Program
- **SNF-** Skilled Nursing Facility
- **SSA-** Social Security Administration
- **SSI-** Supplemental Security Income
- **SSN-** Social Security Number
- **SUD-** Substance Use Disorder
- **TANF-** Temporary Assistance to Needy Families
- **TCA-** Transition Coordination Agency
- **Title XIX-** Social Security Act- Medicaid
- **Title XVIII-** Social Security Act- Medicare
- **ULTC-100.2-** Uniform Long Term Care (client needs assessment tool form)
- **WIC-** Women, Infants, and Children’s food assistance program

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Appendix 2: Assessment and Support Plan Worksheets

You will be able to make the most of your planning time with your case manager if you complete these worksheets before your Needs Assessment and Support Plan meeting. These worksheets can also help you make sure you don't forget anything important when you meet with your case manager. These worksheets are not required, but they are recommended.

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Worksheet 1: What to Prepare for the Needs Assessment and Support Plan

Use this worksheet to keep track of the information you will need for your Needs Assessment and Support Plan. Information you have to share is listed in the top table. The second table is optional. You can mark the "Have" column if you have gathered the item. If you still need to get the item, mark the "Need to Get" column to remind you to get the item before your meeting.

Task/Item – Information You Have to Share	Have	Need to Get	Does Not Apply to Me
A list of people you want in your Assessment/Support Plan meeting and their phone numbers and/or email addresses.	❍	❍	❍
Legal documents that show who your legal guardian or representative is (if you have a legal guardian or representative). If you don't, fill in the "Does Not Apply to Me" column.	❍	❍	❍
Your health insurance card, including your Medicaid or Medicare number if you are enrolled	❍	❍	❍
A list of all your doctors, the type of help they give you, and the name and phone number of their clinic.	❍	❍	❍
A list of your medications. This should include how much you take and when you take it. If you prefer, you can show the medication bottles instead.	❍	❍	❍
A list of the medical equipment and devices you use for activities like seeing, hearing, getting dressed, bathing, eating, and maintaining your health.	❍	❍	❍
A list of the medical equipment and devices you need, but don't have yet.	❍	❍	❍
Documentation of your Legal Disability (ILD), if you have a Legal Disability. If you don't, fill in the "Does Not Apply to Me" column.			
If you are moving, your new address.	❍	❍	❍

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Task/Item – Optional Information to Share	Have	Need to Get	Does Not Apply to Me
Medical records, treatment/therapy plans, and other information from your doctor that you want to share with your case manager.	❍	❍	❍
Disease management plans, behavioral health plans, Individual Education Plans (IEPs), or any other plans that you want to share with your case manager.	❍	❍	❍
Names, phone numbers, and email addresses for your caregivers and people paid to help you. Also list the type of support they provide and if the support will be able to continue	❍	❍	❍
Use this area to write down any other information you want to bring:	❍	❍	❍

Worksheet 2- Your Personal Goals

During the Needs Assessment and Support Planning process, your case manager will talk to you about your goals. This worksheet will help you prepare for this important conversation.

Examples of personal goals include "I would like to go fishing", "I want to go to college", "I would like to live in my own home", "I would like to lose weight", or "I would like to see my sister more often."

Your goals do **not** have to be connected to the services you receive. They do **not** have to be connected to your health and safety, but they can be if that is what you want. They do **not** have to be goals you can complete right away.

It is important to remember that your case manager will help you plan for these goals, but he or she may not be able to get you all the help you need to reach the goals. Your case manager will work with you to find different ways to meet your goals.

Questions 1 and 2 will help you think about what your goals are. Questions 3 and 4 will help you think about how you can meet your goals.

1. **What is important to you?**
   Think of things in your life that are important to you. Some examples might be:
   - Seeing your family and friends
   - Gardening, going to the park or other outdoor activities
   - Playing cards or video games
   - Going to church
   - Working
   - Volunteering
   - Taking care of a pet
   - Having your home or routines a certain way every day

   Write down things that are important to you in the box below:

DRAFT

2. **What do you want to achieve?**
   Think of things you would like to accomplish, today and in the future. Some examples might be:
   - Going to college
   - Getting a new or different job
   - Feeling healthier
   - Saving money for something important to you
   - Learning a new language

- Learning how to play a musical instrument
- Reading more books

Write down things you want to accomplish in the box below:

3. **How can you accomplish this?**

For this step, start by picking the thing you want the most. It may help to phrase this as a goal, such as "I want to go to college." Next, think about the steps you will need to take to make that goal happen. This might include:

- Finishing high school or getting a GED
- Talking to people you know who have gone to college and visiting colleges to pick one that is right for you
- Meeting with a guidance counselor to learn about careers and college degrees
- Signing up for classes
- Finding transportation to get to classes

Try to break down each activity to meet your goal into steps. This will help your case manager understand if you need more support and create a plan for your goal. Write down the goal you want to focus on first, based on the lists you made in Questions 1 and 2. Then, write down the steps you think you will need to take to make that goal happen.

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4. **Who can help you reach your goal?**

Think about the people in your life who can help you with each step to reach your goal. For example:

- A friend may help you find information about colleges
- A brother or sister may take you to visit colleges
- Your service provider will arrange transportation for you to get to classes

You may not have people who can help you with each step, and that is ok. Your case manager will help you think about other ways to get the help you need. In the box below, write down ideas about who might be able to help you with each of the steps you listed in Question 3.

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Worksheet 3: Who Helps You and What Help You Need

You and your case manager may choose to complete a Support Calendar, which outlines all your available supports during a week. Answering the questions in this worksheet will help you create your Support Calendar.

The calendar shows your team what kind of help you need and when you need it. Up to eight different situations can be entered in the calendar. For example, what you need can change during these situations: a school week, summer break, and a week you or your caregiver will have a planned surgery.

This worksheet also helps you think about situations when you might need temporary changes to your services. For example:

- *My mother is my primary caregiver. Sometimes she gets sick and has to go to the hospital. In these situations, I will need more help until she comes back.*
- *Sometimes I get severe back pain and I can't walk. When this happens, I need much more personal care.*

1. **Who helps me (primary and back-up support)?**
   Think about the people who help you. This includes people who are not paid to help and people who are paid to help. It could be friends and family or agencies who provide things like home health care, personal care, transportation, or other things. For example:
   - People who help you get ready in the morning
   - Friends and family
   - Advocates who help you
   - Provider agencies
   - People who drive you places

   List each person who helps you. Include their telephone number and/or email address. Also write if this person is your main support or if they provide back-up support.

DRAFT

2. **What type of help do they provide?**
   For each person you listed above, describe the kind of help they give you.

3. **When would I like help?**
   For each type of help you receive, think of when you would like to get this help. For example, you may like going to church in the morning rather than in the evening. Your case manager will make sure your supports and service providers know your preferences.

4. **How does the type of help I need change during the year?**
   Think about situations when you might need temporary changes to your services. Who else can help and how long can they help? For example:
   - My primary caregiver goes on vacation ever year in the first week of June.
   - My mother is my primary caregiver. Sometimes she gets sick and has to go to the hospital. In these situations, I will need more help until she comes back.
   - Sometimes I get severe back pain and I can't walk. When this happens, I need much more personal care.

   List any situations you have thought of that might need temporary changes to your services in the box below.

5. **What would I like that I am not getting now?**
   Think about the help you get now. Is there something else you need that you don't have yet? For example, your daughter may be able to make your meals and assist you with showering twice a week, but you would like to shower and have a hot meal every day.

DRAFT

6. **What would you need if the people you listed in Question 1 couldn’t help you?**
   Think about the services you might need if your support is temporarily unavailable. For example, if your daughter is going to be out of town in March and she helps you clean your house and prepare your meals, you may need homemaker services during the time that she is gone. You may not know the answer to this question and that is ok. Your case manager can help you.

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