COLORADO
Department of Health Care Policy & Financing

Case Management Agency:
Contact Name & Email:
Billing Month:

Individual's Name	Medicaid ID or Unique Identifier

CMA Rural Add-On Tra

Date of In Person Contact	Waiver/Program

avel Invoice

Activity Performed	Comments

Waiver/Program	Activity
HCBS - BI	Initial Level of Care Assessment
HCBS - EBD	Continued Stay Review Level of Care Assessment
HCBS - CMHS	In-Person Monitoring
HCBS - SPI	Individualized Service Plan
HCBS - CLLI	
HBU	
LTHH	
NF	
PACE	
CCT	
HCBS-DD	
HCBS-SLS	
HCBS-CES	
HCBS-CHRP	
State SLS	
OBRA-SS	

Instructions

Single Entry Points (SEPs)
SEPs identified by the Department as Ru

<u>Rural Invoice Template:</u>
Individual's Name

Medicaid ID or Unique Identifier

Date of In Person Contact

Program

Activity Performed

Comments

ıral/Frontier must complete the Rural Invoice Template for all Level of Care Assessments and Moni

Instructions:
Enter the individuals full name

Enter the individuals Medicaid ID or unique identifier if the Medicaid ID is not available

Enter the date of the in person contact

Enter the Program:
HCBS - BI
HCBS - EBD
HCBS - CMHS
HCBS - SPI
HCBS - CLLI
HBU
LTHH
NF
PACE
CCT

Enter the activity completed:
Initial Level of Care Assessment
CSR Level of Care Assessment
In-Person Monitoring

Add comments if applicable

itoring contacts completed in person.

Additional Reimbursement Criteria:

Initial Level of Care Assessment and CSR Level of Care Assessment Only
Initial Level of Care Assessment and CSR Level of Care Assessment Only
Initial Level of Care Assessment and CSR Level of Care Assessment Only
Initial Level of Care Assessment and CSR Level of Care Assessment Only
In-Person Monitoring Only

Instructions

Community Centered Boards (CCBs)
CCBs identified by the Department as Rural/

<u>Rural Invoice Template:</u>
Individual's Name

Medicaid ID or Unique Identifier

Date of In Person Contact

Program

Activity Performed

Comments

'Frontier must complete the Rural Invoice Template for all Level of Care Assessments, Individualized S

Instructions:
Enter the individuals full name

Enter the individuals Medicaid ID or unique identifier if the Medicaid ID is not available

Enter the date of the in person contact

Enter the Program:
HCBS-DD
HCBS-SLS
HCBS-CES
HCBS-CHRP
State SLS
OBRA-SS

Enter the activity completed:
Initial Level of Care Assessment
CSR Level of Care Assessment
In-Person Monitoring
Individualized Service Plan

Add comments if applicable

Service Plans and Monitoring contacts completed in person.

Additional Criteria for Reimbursement:

Initial and CSR Level of Care Assessment Only
Initial and CSR Level of Care Assessment Only
Initial and CSR Level of Care Assessment Only
Initial and CSR Level of Care Assessment Only
In-Person Monitoring and Individualized Service Plan Only
In-Person Monitoring and Individualized Service Plan Only