COLORADO
Department of Health Care Policy & Financing

Health First Colorado Home Health Telehealth Enrollment Form

Home Health Telehealth is defined as the remote monitoring of health care data through electronic information processingtechnologies, which includes the collection of clinical data; transmission of data between a member and the home health careagency; the clinical review and assessment of the transferred data; and responsive activities or an amendment to the careplan as needed. Members who meet the criteria below may receive the service.

Fax service approval forms to: Home Health Policy Specialist at 303-866-2803.

Member Information

Name:	Health First Colorado ID:		
Address:	City:	State:	Zip:

Home Health Agency Information

Name:	Provider ID:		
Address:	City:	State:	Zip:

Service Criteria:

1. Is Health First Colorado the primary payer? (If the answer is no, do not complete this form) ☐ Yes ☐ No
2. Has the member been assessed for and found in need of telehealth services? ☐ Yes ☐ No
3. Are these services authorized on the care plan and prescribed by a physician? ☐ Yes ☐ No
4. The member must be treated by the Home Health Agency for one or more of the following (select all that apply):
   a. ☐ Congestive Heart Failure
   b. ☐ Chronic Obstructive Pulmonary Disease
   c. ☐ Asthma
   d. ☐ Diabetes
5. Does the member require ongoing and frequent monitoring to manage their qualifying diagnosis? ☐ Yes ☐ No
6. Does the member meet inclusion criteria (frequent ER/inpatient visits to manage symptoms, new onset of life altering diagnosis (listed below) or new exacerbation of a chronic condition (listed below)? ☐ Yes ☐ No
7. Is the member and/or caregiver competent and willing to comply with the telehealth equipment instructions and home health agency direction? ☐ Yes ☐ No
   a. And, willing to achieve, at least, an 85% compliance rate for monitoring activity? ☐ Yes ☐ No
8. Is the member's home environment compatible for the use of the telehealth equipment? ☐ Yes ☐ No
9. Is a signed Home Health Telehealth Patient Agreement in the member's chart? ☐ Yes ☐ No

COLORADO
Department of Health Care Policy & Financing

Attach the following documentation. This enrollment form will not be considered without thedocumentation.

1. Describe the home health agency's monitoring and treatment of the qualifying diagnoses.
2. List hospitalizations in previous 12 months, including date of admission, length of stay, and diagnosis.

We, the Assessing Nurse and Agency Director of Nursing, attest that the Agency listed above has assessed this member and determined them appropriate for and able to benefit from Telehealth services.

Assessing Nurse	Date	Agency Director of Nursing	Date

I, the member and/or caregiver, have reviewed this PAR, agree with the Agency findings, and request Telehealth services.

Member	Date	Caregiver	Date

Internal Use Only: Approved: ☐ Not Approved: ☐

Notes:

Revised January 2022