Health First COLORADO
Colorado's Medicaid Program

Form to update Live-In Home Care Provider Statement

The care provider should fill out this form.

Care provider name: _____

Case ID: _____

I understand that if I receive a Difficulty of Care payment, I must provide care for someone I live with.

Check the box that applies to you:

☐ I provide care for and live with _____
[care recipient]

☐ I no longer provide care for: _____
[care recipient]

☐ I provide care for: _____, but I do not live with them anymore.
[care recipient]

Under penalty of perjury I certify all information I have given is true and correct.

Name of home care provider

_____

Print name

_____

Signature

Date: _____

Please mail or return this in person to your county department of human or social services.