COLORADO
Department of Health Care Policy & Financing

Long-Term Care Certification Form

Long Term Care Certification		
☐ Initial/Admission	☐ CSR	
Client Meets Level of Care	☐Yes ☐No	
Last Name:	First Name:	M.I.:
Medicaid ID#:	Social Security #:	
County of Residence:	Date of Medicaid Application:	
Facility Name:	Provider Number:	
Admit Date:		

Activities of Daily Living Scores	
ADLs Scores	
Bathing:	Dressing:
Toileting:	Mobility:
Transfers:	Eating:
Supervision Behaviors:	Supervision Memory/Cognition:
Has Developmental Disability eligibility been determined? ☐Yes ☐No	
Comments/Supporting Documentation:	

Service Requirements	
Waiver Services Needed within 30 Days ☐Yes ☐No	
Waitlist: ☐Yes ☐No	
Waitlist Selected: ☐ BI ☐ CHCBS ☐ DD ☐ CES ☐ SLS ☐ CLLI	Wait List Start Date:

Do Not Complete Below if Client is Approved for Waitlist

Target Group
☐ Developmental Disability/MR
☐ Mental Health

Target Group
☐ Frail Elderly (65+)
☐ Physically Disabled (18-64)
☐ Physically Disabled (13-17)
☐ Pediatric (<13)
☐ Brain Injury (16-64)

Program Approval
☐ HCBS -BI
☐ HCBS –CMHS
☐ HCBS –DD
☐ HCBS –EBD
☐ HCBS –CIH
☐ HCBS –SLS
☐ HCBS –CHCBS
☐ HCBS –CWA
☐ HCBS –CLLI
☐ HCBS –CES
☐ HCBS -CHRP
☐ CCT –BI
☐ CCT -CMHS
☐ CCT -DD
☐ CCT -EBD/18-64
☐ CCT -EBD/65+
☐ CCT -SLS
☐ Hospital Back-Up
☐ ICF/IID
☐ Nursing Facility
☐ PACE
☐ HCA-Legacy Only
☐ LTHH Only

Contact Information	
Level of Care Start Date:	Level of Care End Date:
Authorized By:	Agency:
Authorization date:	Open End Date for NF, PACE, or ICF/IID: ☐Yes ☐No

Denial Information	
Date Denied:	Date Denial Letter Mailed:
Case Manager:	