COLORADO
Department of Health Care Policy & Financing

Service Plan Signature Page

Member Information *(complete all sections that apply)*			
First Name:	Last Name:	DOB:	Medicaid ID:
Staffing Date:	Certification Start Date:	Certification End Date:	
Service Plan Type: ☐ Initial ☐ CSR ☐ Revision			

Statement of Agreement

☐ Member/Guardian indicates that they are in agreement with the information in the Service Plan and agrees to receive services accordingly.

OR

☐ Member/Guardian acknowledges that they are choosing not to sign the Service Plan agreement. A Notice of Action will be provided as a result of not signing the Service Plan.

Signatures

Member Signature	Date	Legal Guardian Signature ☐ Court Appointed Guardian	Date
Case Manager Signature	Date	Legal Guardian Signature ☐ Court Appointed Guardian	Date

Plan Participants

The following individuals participated in the development of this plan. This plan must be signed by all individuals and providers responsible for its implementation.

Name	Title or Relationship	Signature	Date

Member and Provider must receive a copy of this completed signature page and a copy retained in case management agency files.

First Name:	Last Name:	DOB:	Medicaid ID:

Additional Plan Participants

This is a continued list of individuals who participated in the development of this plan. This plan must be signed by all individuals and providers responsible for its implementation.

Name	Title or Relationship	Signature	Date

Member and Provider must receive a copy of this completed signature page and a copy retained in case management agency files.

First Name:	Last Name:	DOB:	Medicaid ID:

Service	Provider	Total Units	Certification Start and End Dates	Service Frequency, Scope, and Duration	HCBS Service Goal

Member and Provider must receive a copy of this completed signature page and a copy retained in case management agency files.

First Name:	Last Name:	DOB:	Medicaid ID:

Service	Provider	Total Units	Certification Start and End Dates	Service Frequency, Scope, and Duration	HCBS Service Goal

Member and Provider must receive a copy of this completed signature page and a copy retained in case management agency files.

First Name:	Last Name:	DOB:	Medicaid ID:

Service	Provider	Total Units	Certification Start and End Dates	Service Frequency, Scope, and Duration	HCBS Service Goal

Member and Provider must receive a copy of this completed signature page and a copy retained in case management agency files.

First Name:	Last Name:	DOB:	Medicaid ID:

Service	Provider	Total Units	Certification Start and End Dates	Service Frequency, Scope, and Duration	HCBS Service Goal

Member and Provider must receive a copy of this completed signature page and a copy retained in case management agency files.