COLORADO
Department of Health Care Policy & Financing

Service Plan Card/Assessment/Support Plans: Service Plan Form

Service Plan Card Information		
Last Name:	First Name:	M.I.:
Medicaid ID#:	Date of Birth:	
Staffing Held Date:	Verified Date:	
Service Start Date:	Service End Date:	
Service Plan Type: Select:	Waiver: Select one	

Assessment/Support Plans: Service Plan

Medicaid Long Term Care Disclosures
Member has been informed that they have the right to choose between institutional services or Home and Community Based Services. ☐ Yes
Member has been informed of the following Home and Community Based Service (HCBS) Waivers they may be eligible for: ☐ Brain Injury (BI) ☐ Community Mental Health Supports (CMHS) ☐ Developmental Disabilities (DD) ☐ Elderly, Blind, and Disabled (EBD) ☐ Complementary and Integrated Health (CIH) ☐ Supported Living Services (SLS) ☐ Children's Home and Community Based Services (CHCBS) ☐ Children with Life Limiting Illness (CLLI) ☐ Children's Extensive Supports (CES) ☐ Children's Habilitation Residential Program (CHRP)
Was the member provided with fact sheets for the waivers checked above? ☐ Yes
Select Home and Community Based Service (HCBS) waiver program in which member has been offered services and/or placement. ☐ Brain Injury (BI) ☐ Community Mental Health Supports (CMHS) ☐ Developmental Disabilities (DD) ☐ Elderly, Blind, and Disabled (EBD) ☐ Complementary and Integrated Health (CIH) ☐ Supported Living Services (SLS) ☐ Children's Home and Community Based Services (CHCBS) ☐ Children with Life Limiting Illness (CLLI) ☐ Children's Extensive Supports (CES) ☐ Children's Habilitation Residential Program (CHRP) ☐ N/A

Medicaid Long Term Care Disclosures

Member has been offered services and/or placement in the following programs:

☐ CDASS
☐ Hospital Back Up/Nursing Facility
☐ Intermediate Care Facility for Individuals with Intellectual Disabilities
☐ Long Term Home Health
☐ Nursing Facility
☐ PACE

Was the member provided with fact sheets for the waivers checked above?

☐ Yes

Member has been informed that:

1. Long Term Care Medicaid is the payer of last resort.
2. If the member is covered by third party insurance, they must disclose the name of that insurance.
3. Third party insurance, natural/community resources, and the Medicaid State Plan must be utilized prior to accessing Long Term Medicaid benefits.

☐ Yes

Member Roles and Responsibilities

Member has been informed of the roles and responsibilities for participation in an HCBS program.

I agree to participate in the coordination of my services and will be responsible to:

- Give accurate information to my case manager regarding my ability to complete activities of daily living.
- Assist in promoting my own independence.
- Cooperate with my providers and case management agency.
- Notify my case manager of changes in my support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).
- Notify my case manager if I have not received Home and Community Based Services for 30 days or 1 calendar month.
- Notify my case manager of any changes in my care needs and/or problems with services.
- Notify my case manager of any changes that may affect Medicaid eligibility.
- Notify my case manager of any critical incidents that occur.

☐ Yes

Case Manager Roles and Responsibilities

Member has been informed of the HCBS case manager's roles and responsibilities.

The Case Manager agrees to:

- Coordinate needed services.
- Communicate with service providers regarding service delivery, and concerns.
- Review and revise services, as necessary.
- Notify members regarding any change in services.
- Notify members when services are denied, suspended, terminated, or reduced.
- Document, report, and resolve member complaints and concerns.
- Report abuse, neglect, mistreatment, and exploitation to the appropriate authority.
- Provide member with the critical incident definition and explain process of notifying case manager of critical incidents that occur.

☐ Yes

Complaint Process

Member has been informed of their right to file a complaint regarding Medicaid HCBS services.

☐ Yes

Member has been provided contact information to file this complaint. While it is encouraged for a member to begin the process with contacting their case manager, they have been informed that they have the right to file a complaint with any of the contacts provided.

☐ Yes

Appeal Rights

Member has been informed that during the course of each long-term care certification and Service Planning period, if there is a reduction, termination or denial of services, they will be provided a Notice of Action form with their appeal rights and instructions for filing an appeal for a Medicaid Fair Hearing with the Office of Administrative Courts.

☐ Yes

Member has been informed that if there has been a reduction, termination, or denial of a service(s), and they did not receive a Notice of Action, they may ask for the notice with their appeal rights.

☐ Yes

Member has been informed of the contact information for the Office of Administrative Courts: 1525 Sherman Street, 4th Floor, Denver, CO 80203. Phone Number (303) 866-2000.

☐ Yes

Service and Provider Choice

Member has been informed of:

- Their choice of available long term care programs and services
- The availability and right to select among qualified providers
- Their right to change providers at any time
- Providers have the right to accept or deny the request for services
- Any potential conflict of interest

☐ Yes

Member has been offered or given a resource list of qualified providers.

☐ Yes

Type of Choice Select:

Other:

Statement of Agreement

Statement of Agreement

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

☐ 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. * Only check this box if the Member/Guardian does not sign the Service Plan. A Notice of Action must be generated. * CCBs - C.R.S. 27-10.5-102 (20)(b) * SEPs - 10 CCR 2505-10, 8.526 and 8.552.6

Statement of Agreement

Check the following that apply. (At least two signatures are required. One signature must be the Case Manager.)

☐ Legal Guardian Signature on file
☐ Member's Signature of file
☐ Additional Legal Guardian Signature on file
☐ Case Manager Signature on file

Date Service Plan was signed.

Service Plan Participants

The following individuals (Name, Title) participated in the development of this plan (You must address service planning participants, both name and title required. Case Manager must be listed as a plan participant.)

Name	Title

Unpaid Supports

Is there Unpaid Support/Provider?

If member enrolled in an HCBS Waiver program an Unpaid Support must be added or NO UNPAID SUPPORTS must be selected.

☐ Yes
☐ No Unpaid Supports

Unpaid Support Service	Unpaid Support Provider	Frequency

Third Party Resources

Are there Third-Party Resources?
If member enrolled in an HCBS Waiver program a Third-Party Resource must be added or NO THIRD-PARTY RESOURCES must be selected.

☐ Yes
☐ No Third-Party Resources

Select Third Party Resource

☐ Adult Protective Services
☐ Benefits/Assisted Payments
☐ Child Protective Services
☐ Dental
☐ Food Stamps
☐ LEAP
☐ Legal Services
☐ Meals
☐ Money Management
☐ Optical Services
☐ Rehabilitation Services
☐ Senior Companion
☐ Subsidized Housing
☐ Transportation

Other, specify:

Provider:	**Frequency:**

Select Third Party Resource

☐ Adult Protective Services
☐ Benefits/Assisted Payments
☐ Child Protective Services
☐ Dental
☐ Food Stamps
☐ LEAP
☐ Legal Services
☐ Meals
☐ Money Management
☐ Optical Services
☐ Rehabilitation Services
☐ Senior Companion
☐ Subsidized Housing
☐ Transportation

Other, specify:

Provider:	**Frequency:**

State Plan Benefits

Are there State Benefits?

If member enrolled in an HCBS Waiver program a State Plan Benefit must be added or NO STATE PLAN BENEFIT must be selected.

☐ Yes

☐ No State Plan Benefit

Select State Benefit

☐ Acute Medical

☐ Dental Benefit

☐ Early and Periodic Screening

☐ Hospice

☐ Medical Equipment

☐ Medical Supplies

☐ Medical Transportation

☐ Mental Health

☐ Money Management

☐ Primary Care Physician

☐ Private Duty Nursing

☐ Professional Therapies

☐ Targeted Case Management

Provider:	**Frequency:**

Select State Benefit

☐ Acute Medical

☐ Dental Benefit

☐ Early and Periodic Screening

☐ Hospice

☐ Medical Equipment

☐ Medical Supplies

☐ Medical Transportation

☐ Mental Health

☐ Money Management

☐ Primary Care Physician

☐ Private Duty Nursing

☐ Professional Therapies

☐ Targeted Case Management

Provider:	**Frequency:**

Home Health Benefits

Are there Home Health Benefits?

If member enrolled in an HCBS Waiver program a Home Health service must be added or NO HOME HEALTH must be selected.

☐ Yes
☐ No Home Health

Service Number	**Services**

Information Provided by
☐ Applicant/Member
☐ Caregiver
☐ Facility Staff
☐ Medical Record

Funding Source
☐ Medicare
☐ Medicaid
☐ Private Insurance

Home Health service provider available
☐ Yes
☒ No

Service Goal:

Provider	**Total Units**
Service Start Date	**Service End Date**

Service Number	**Services**

Information Provided by
☐ Applicant/Member
☐ Caregiver
☐ Facility Staff
☐ Medical Record

Funding Source

☐ Medicare
☐ Medicaid
☐ Private Insurance

Home Health service provider available
☐ Yes
☐ No

Service Goal:

Provider	**Total Units**
Service Start Date	**Service End Date**

Home Community Based Services	
Service:	
Start Date:	**End Date:**
Frequency: Select	**Provider:**
# of Units:	**Care Plan Goal #:**
Backup Designation: Select:	**Backup Relation to Member:**
Backup Provider/Name:	**Backup Effective Date:**
Level of Supervision (If applicable):	
Awake: Select:	**Amount of unsupervised time:**
Overnight: Select:	**Amount of unsupervised time:**
Community: Select:	**Amount of unsupervised time:**
Day Hab/Vocational: Select:	**Amount of unsupervised time:**
Comments (Indicate why level of supervision needed):	
Service:	
Start Date:	**End Date:**
Frequency: Select	**Provider:**
# of Units:	**Care Plan Goal #:**
Backup Designation: Select:	**Backup Relation to Member:**
Backup Provider/Name:	**Backup Effective Date:**
Level of Supervision (If applicable):	
Awake: Select:	**Amount of unsupervised time:**
Overnight: Select:	**Amount of unsupervised time:**
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Day Hab/Vocational: Select:	**Amount of unsupervised time:**
Comments (Indicate why level of supervision needed):	

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Service:	
Start Date:	**End Date:**
Frequency: Select	**Provider:**
# of Units:	**Care Plan Goal # to be attached:**
Backup Designation: Select:	**Backup Relation to Member:**
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