Support Level Review Request Form

Member Information		
Last Name:	First Name:	M.I.:
Medicaid ID#:	SSN:	Date of Birth:
Mailing Address:		
Date of most recent SIS Assessment:		
Risk Factors Impacting Support Level (check all that apply): ☐ Extreme Safety Risk to Self ☐ Public Safety Risk: Convicted ☐ Public Safety Risk: Non-Convicted ☐ Risk Factor Transition ☐ No Risk Factors		

Calculated Support Level:	Current Support Level:	Requested Support Level:	Review Type:
Support Level 7 Budget Sheet Completed by Provider(s) and Included with Request: ☐ Yes ☐ No ☐ N/A			

Residential Services and Supports Information		
Residential Setting: ☐ Host Home ☐ Group Home ☐ 3 Person IRSS ☐ Privately Leased/Owned Home/Apt. ☐ Family Home	HCBS Waiver:	Certification Period Start: End:
Residential Habilitation Agency:	Day Habilitation Agency:	
Other Provider Agency:	Other Provider Agency:	

Name of individual, legal guardian, authorized representative, or family member that reviewed this information (This information will be used for the decision letter, which is addressed to the individual or their guardian)	
Name:	Relationship:
Email:	Date Reviewed and Approved:
Mailing Address:	

Case Management Information	
Case Management Agency:	Contact Name:
CM Completing Form:	Date Submitted:
Email:	Phone:

Answer ALL the following questions to demonstrate how the situation meets the criteria for a Support Level Review. *NOTE: Answers that extend beyond the size of the space provided will not appear in print form.*

1. Indicate IDT members who were a part of the Support Level Review planning process; check all that apply.	
☐ Member	☐ Day Habilitation (administration)
☐ Legal Guardian	☐ Day Habilitation (staff)
☐ Parent(s)	☐ Residential Habilitation (administration)
☐ Other Family Member(s)	☐ Residential Habilitation (staff)
☐ Friend(s)	☐ Job Coach
☐ Other Natural Support	☐ Respite Provider
☐ Advocate	☐ Behaviorist
☐ Mentor	☐ Personal Care/Homemaker Staff
☐ Regional Center Admin or Staff	☐ Case Manager
☐ Other:	☐ Other:
If any applicable participants were not involved in the planning process, please explain why:	
Conflict of interest evaluated: ☐ Yes ☐ No	

2. Provide authorized and utilized waiver services outlined in the Support Plan. Explain any over/under utilization.

Service	Utilized	Authorized	%	Service	Utilized	Authorized	%
Res. Hab.				Homemaker (Enhanced)			
SCC Tier I/II				Homemaker (Basic)			
SCC Tier III				Personal Care			
Spec. Hab. Tier I/II				Mentorship			
Spec. Hab. Tier III				Unit Respite			
Prevocational Services				Per Diem Respite			
Behavioral Assessment				Camp/Group Respite			
Behavioral Consultation				Job Development			
Individual Counseling				Job Coaching			
Group Counseling				Group Supported Emp.			
Behavioral Line Staff				Disposable Supplies			
Hippotherapy				Spec. Med Equipment			
Movement Therapy				Mileage Band			
Massage Therapy				CDASS Health Maintenance			
Personal Emergency Response							

Number of Months in certification period:	Number of Months that have elapsed:

3. Indicate State Plan Benefits currently in place, as well as additional or enhanced supports associated with the increase in care needs.

State Plan Benefits

Service	Temp	Ongoing	Service	Temp	Ongoing	Service	Temp	Ongoing
Private Duty Nursing	☐	☐	Behavioral Health	☐	☐	Specialist I	☐	☐
LTHH	☐	☐	EPSDT	☐	☐	Specialist II	☐	☐
Hospice	☐	☐	Dental	☐	☐	Specialist III	☐	☐
Speech Therapy	☐	☐	Physical Therapy	☐	☐	Occupational Therapy	☐	☐

Additional Supports

Service	Temp	Ongoing	Service	Temp	Ongoing	Service	Temp	Ongoing
Exceptional Travel Time	☐	☐	LOS Supervision	☐	☐	CDASS	☐	☐
Specialized Medical Protocols	☐	☐	1:1 Support	☐	☐	Family Caregiver	☐	☐
Specialized Medical Care	☐	☐	2:1 Support	☐	☐	Medication Management	☐	☐
Specialized Non-Medical Training	☐	☐	Awake Overnight Support	☐	☐	Other:	☐	☐

Duplication of services evaluated: ☐ Yes ☐ No

If no State Plan Benefits or Additional Supports are indicated above, please explain why:

4a. Provide an overview of discrepancies between the SIS Assessment and current ADL/care needs. This summary must **clearly explain** how the circumstances and needs were not properly captured by the SIS Assessment and Support Level determination process.

Changes in ADL/Daily Care Needs

☐ Bathing	☐ Dressing	☐ Transfer	☐ Mobility	☐ Receptive Language
☐ Paralysis/Loss of Limb	☐ Psychiatric Care	☐ Behavioral Intervention	☐ Toileting	☐ Expressive Language
☐ Eating	☐ Memory	☐ Decision-Making	☐ Self-Regulation	☐ Planning/Follow-Through

Summary of discrepancies between care needs and SIS Assessment, and why reassessment is not being pursued; if no discrepancies, please explain why:

4b. Summarize the member's exceptional need and factors impacting need:	
Projected timeline for increased support: __ years __ months	Does this request extend beyond the certification period? ☐ Yes ☐ No

5. Provide a summary of steps taken to meet support needs leading up to this request.			
IDT Planning			
Meeting Date(s):			
Critical Incident Reporting (check all that apply, including reports as witness):			
☐ Mistreatment	☐ Abuse	☐ Neglect	☐ Exploitation
☐ Displacement	☐ Death	☐ Criminal Activity	☐ Excessive Property Damage
☐ Emergency Medical Treatment	☐ Medication Management	☐ N/A	☐ Other:
Referrals & Complaints in Past Year:			
☐ APS	☐ RFP	☐ RAE	☐ HCPF Escalations
☐ CDPHE	☐ Advocate	☐ Provider Integrity	☐ New HRC Submission
☐ Community Support Team	☐ Emergency DD Enrollment Request	☐ Medicaid Fraud Control Unit	☐ SLS Exceptions Process
☐ Tier 3 Day Habilitation	☐ Other:		
Summary/Outcomes/Recommendations:			

6. For Risk Factor Transition/Step-Down ONLY

Describe the plan included in the Rights Modification to restore the Member's rights in a comprehensive and structured transitional manner, sometimes referred to as a "fading plan" or "right's restoration plan."

Describe in detail the steps taken in the plan and any progress that has been made to date:

Describe in detail the extensive supports and supervision levels that are needed to maintain the Member's and/or community's safety:

Does the Right Modification include a controlled environment? ☐ Yes ☐ No
If yes, select all that apply: ☐locked/secured setting ☐window/door alarms ☐delayed egress
☐ video/audio monitoring ☐ Other: (please specify)

Describe in detail how controlled environment right modification(s) are being or have been reduced to lesser restrictive methods or discontinued:

Describe in detail the Support Level necessary to meet the Member's needs during this transition period:

7. If approved, how will the additional funds be utilized?		
Indicate the nature of the action plan to justify the additional funds for a Support Level increase. (check all that apply)		
☐ Aging Out Transition	☐ Progressive/Neurocognitive Diagnosis	☐ Community Transition
☐ Short-Term Injury/Illness	☐ Long-Term Injury/Illness	☐ Risk Factor Transition
☐ Other:		

Send completed form with any additional documentation in an encrypted email to:

sis_sl@state.co.us