



Supported Living Services (SLS) Exception Review Request Form

Date Submitted to Telligen:

Member Information			
First Name:	MI:	Last Name:	
Date of Birth:	Medicaid ID:	Support Level:	

Community Centered Board Information	
Agency Name:	
Case Manager Name:	Case Manager Phone:
Case Manager Email:	

SLS Exception Review Process Eligibility		
Could an increase to services or to the overall SPAL help meet the member's needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If NO, do not proceed with the SLS Exception Review Request but meet with IDT to explore other waivers and/or options.
Is there room in SPAL or are there additional service units that could be authorized to support the member?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, do not proceed with the SLS Exception Review Request but complete a service plan revision.
Is the member eligible for a new SIS assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, do not proceed with the SLS Exception Review Request but proceed with a SIS Reassessment request.
Does the member need an overall increase to both SPAL and Support Level?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, do not proceed with the SLS Exception Review Request but proceed with a Support Level Review request.
Does the member meet the SLS Flexibility eligibility criteria?	<p>A. At risk for seeking an emergency Developmental Disability (HCBS - DD) waiver enrollment in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Does the member have less than 10% of SPAL funding remaining? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Are the services needed to support the member not available due to current service unit limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If A, B, and C are met proceed with the SLS Exception Review Request.</p> <p>If A and B are met proceed with the SLS Exception Review Request.</p> <p>If A and C are met proceed with the SLS Exception Review Request.</p> <p>If B and C, or only B, or only C are met, do NOT proceed with the SLS Exception Review Process but meet with IDT to review alternative supports.</p>

SLS Exception Review Request Information

Requested Start Date:

A. Why is this member at risk for seeking an emergency Developmental Disability (HCBS-DD) waiver enrollment in the future?

- Medically fragile with skilled care needs
- Behavioral and/or Mental Health needs
- Criminal convictions and/or law enforcement involvement
- Risk of homelessness
- Mistreatment, Abuse, Neglect, Exploitation (MANE) reports with potential need to remove from home
- Extreme danger to self/others
- Caregiver capacity or
- 1:1 supervision needed
- Other:

Explain selection(s) above in **Additional Member Information** below.

B. Does this member have 10% or less remaining funds in their SPAL?

Yes No

1. Current SPAL based on SIS Support Level:
2. Current Utilization of SPAL:
3. Requested increase amount to SPAL:

C. Are the services needed to support the member not available due to current service unit limitations?

Yes No

1. Which SLS waiver service(s) are being requested to support this member in the community?
 - a. Current service unit authorization:
 - b. Anticipated service unit depletion date:
 - c. Requested service unit authorization:
2. Which SLS waiver service(s) are being requested to support this member in the community?
 - a. Current service unit authorization:
 - b. Anticipated service unit depletion date:
 - c. Requested service unit authorization:

SLS Exception Review Request Information

3. Which SLS waiver service(s) are being requested to support this member in the community?
- a. Current service unit authorization:
 - b. Anticipated service unit depletion date:
 - c. Requested service unit authorization:

Additional Member Information

Summary of member's needs and situation that meet the requirements above, include:

- Why the member is at risk of an HCBS - DD waiver emergency enrollment in the future;
- Current living situation;
- Attempted interventions;
- Plans for services and/or funding if approved;
- Is this a temporary need (one year or less) or will this be needed long term (greater than one year)?;
- Any other information about this member's needs that will assist in determining approval of request.

- Attached information for LTHH if any, CDASS Health Maintenance Review information, provider care plans, etc.

Submit completed form with any attachments or supporting documentation, through Telligen's Qualitrac Review and Provider Portal. Find training resources for Qualitrac on the Department's website: hcpf.colorado.gov/long-term-services-and-supports-training#Telligen