COLORADO
Department of Health Care Policy & Financing

Supported Living Services (SLS) Exception Review Request Form

Date Submitted to Telligen:

Clear Form

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

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 the overall Service Plan Authorization Limit (SPAL) help meet the member's needs?	☐ Yes ☐ 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 the SPAL or are there additional service units that could be authorized to support the member?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	A. At risk for seeking an emergency Developmental Disability (HCBS - DD) waiver enrollment in the future? ☐ Yes ☐ No B. Does the member have less than 10% of SPAL funding remaining? ☐ Yes ☐ No C. Are the services needed to support the member not available due to current service unit limitations? ☐ Yes ☐ No	**If A, B, and C are met** proceed with the SLS Exception Review Request. **If A and B are met** proceed with the SLS Exception Review Request. **If A and C are met** proceed with the SLS Exception Review Request. **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.

SLS Exception Review Request Information

Requested Start Date *(review cannot be retrodated)*:

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:

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

Explain your selection above and provide more detail about why the member is at risk of an HCBS-DD waiver emergency enrollment in the future:

Explain what has changed for the member that an increase in services/funds are needed:

Explain member's current living situation and current natural supports:

Explain attempted interventions:

SLS Exception Review Request Information	
Explain 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)?	
Provide any other information about this member's needs to assist in determining approval of this request:	
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. Service being requested: b. Current service unit authorization: c. Anticipated service unit depletion date: d. Additional requested service unit authorization:	

SLS Exception Review Request Information
e. Cost per unit of requested service: f. Additional funds needed for this service:
2. Which SLS waiver service(s) are being requested to support this member in the community? a. Service being requested: b. Current service unit authorization: c. Anticipated service unit depletion date: d. Additional requested service unit authorization: e. Cost per unit of requested service: f. Additional funds needed for this service:
3. Which SLS waiver service(s) are being requested to support this member in the community? a. Service being requested: b. Current service unit authorization: c. Anticipated service unit depletion date: d. Additional requested service unit authorization: e. Cost per unit of requested service: f. Additional funds needed for this service:

Attachments
☐ Attach copy of member's service plan *(required)*
☐ Attach any information for LTHH, 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/utilization-management