Colorado Medicaid
Home Health Telehealth Enrollment Form

Home Health Telehealth is defined as the remote monitoring of health care data through electronic information processing technologies, which includes the collection of clinical data; transmission of data between a client and the home health care agency; the clinical review and assessment of the transferred data; and responsive activities or an amendment to the care plan as needed. Clients who meet the criteria below may receive the service.

Fax service approval forms to: Home Health Policy Specialist at 303-866-2803.

Client Information

Name:		Medicaid ID#:	
Address:	City:	State:	Zip:

Home Health Agency Information

Name:		Provider ID#:	
Address:	City:	State:	Zip:

Service Criteria:

1. Is Medicaid the primary payer? (If the answer is no, do not complete this form) ☐ Yes ☐ No
2. Has the client been assessed for and found in need of telehealth services? ☐ Yes ☐ No
   a. Are these services authorized on the care plan and prescribed by a physician? ☐ Yes ☐ No
3. The client must be treated by the Home Health Agency for one or more of the following (select all that apply):
   a. ☐ Congestive Heart Failure
   b. ☐ Chronic Obstructive Pulmonary Disease
   c. ☐ Asthma
   d. ☐ Diabetes
4. Does the client require ongoing and frequent monitoring to manage their qualifying diagnosis? ☐ Yes ☐ No
5. Does client meet inclusion criteria (frequent ER/inpatient visits to manage symptoms, new onset of life altering diagnosis (listed below) or new exacerbation of a chronic condition (listed below)? ☐ Yes ☐ No
6. Is the client and/or caregiver competent and willing to comply with the telehealth equipment instructions and home health agency direction? ☐ Yes ☐ No
   a. And, willing to achieve, at least, an 85% compliance rate for monitoring activity? ☐ Yes ☐ No
7. Is the client's home environment compatible for the use of the telehealth equipment? ☐ Yes ☐ No
8. Is a signed Home Health Telehealth Patient Agreement in the client's chart? ☐ Yes ☐ No

Please attach the following documentation. This enrollment form will not be considered without the documentation.

1. Describe the home health agency's monitoring and treatment of the qualifying diagnoses.
2. List hospitalizations in previous 12 months, including date of admission, length of stay, and diagnosis.

We, the Assessing Nurse and Agency Director of Nursing, attest that the Agency listed above has assessed this client, and determined them appropriate for and able to benefit from Telehealth services.

Assessing Nurse	Date	Agency Director of Nursing	Date

I, the client and/or caregiver, have reviewed this PAR, agree with the Agency findings, and request Telehealth services.

Client	Date	Caregiver	Date

Internal Use Only: Approved: ☐ Not Approved: ☐

Notes: