



Targeted Case Management- Transition Coordination Agency (TCM-TCA) Application

Specialty Number: 770

To serve Health First Colorado members wishing to transition out of Nursing Facilities or Intermediate Care Facilities

Thank you for your interest in becoming a Targeted Case Management -Transition Coordination Agency (TCM-TCA). This application must be completed and submitted to the Department in order to be enrolled as a TCM-TCA.

Complete all applicable items in the application. **Incomplete applications will not be processed and will be returned to the submitting Agency for modification and resubmission.**

Please submit any questions you have about this process or application to:

Email: Nora.Brahe@state.co.us

- Do not submit completed applications via email, they will not be reviewed or approved via this email address.
- Contact the provider call center for questions at 1-844-235-2387 for general provider enrollment questions.

In addition to completing this application, each agency must successfully complete all aspects of the Health First Colorado provider enrollment process through the provider enrollment portal of the Department of Health Care Policy and Financing (the Department). Please attach this entire form, and all portions of it, to the electronic application.

Ensure that ALL INFORMATION on the application is consistent with the information provided on your TCM-TCA application. Provider enrollment information, training, FAQs and the application are all available on the Department's website: <https://www.colorado.gov/hcpf/provider-enrollment>

Once initiated in the provider portal, all electronic applications must be reviewed and approved by DXC, the Department's Fiscal Agent. Review and processing times will vary depending on the completeness of the information submitted to DXC. Once this process is complete, the application will be referred to the Department for state review of the content of this application.

Allow a minimum of 30 calendar days for state review of the application, this is in addition to the time necessary for the Department's fiscal agent to complete its review and enrollment processes. Agencies will be notified by email or telephone if additional information is required. Once the DXC and Department review and approval are complete, DXC will issue each agency their Health First Colorado Provider Identification Number. Agencies can neither provide nor be reimbursed for services without an active Health First Colorado Provider Identification Number as well as a National Provider Identifier (NPI).

Application Submission Requirements

- Applicants must submit a one-page summary demonstrating proof that Transition Coordination Agency provider qualifications outlined in 10 CCR 2505-10 8.519.27.B have been met:
 - Proof of physical location
 - Proof of a 501 c (3) status as provided by the Internal Revenue Service (IRS)
 - Demonstration of two years of agency experience
 - Demonstration of no financial relationship with an agency who provides waiver services

- Demonstration of administrative capacity
- Community referral system demonstration
- Demonstration of their ability to bill, document and audit
- Demonstration that the agency has financial reserve or able to access one month of expenditures to cover agency costs
- Proof of adequate liability insurance to meet Department minimum requirements

Personnel/Staff Training

- Required training must be completed by a supervisor and transition coordinator prior to providing transition coordination services independently. Completion of training must be confirmed by Department.

Policies and Procedures

- Each policy and procedure listed below is followed by a statutory and/or rule citation for reference and guidance on, at minimum, what the agency's policies and procedures must address to comply and must be included with this application.
- The list below contains only a few of the policies and procedures the agency is required to develop, but the agency must develop all operating policies and procedures for program administration and service provision as required.
- The Department provides neither templates nor consultation on the development of policies and procedures.
- **Applicants applying to provide Targeted Case Management – Transition Coordination must have the following policies and procedures available for review at the time of application submission upon request by the Department:**

- Comprehensive Assessment and Periodic Reassessment of an individual's transition and community acclimation needs (10 CCR 2505-10 8.519.27.C)
- Development and Periodic Revision of Transition and Risk Mitigation Plans (10 CCR 2505-10 8.519.27.C)
- Referral to Community Services and Related Activities (10 CCR 2505-10 8.519.27. B and C)
- Monitoring (10 CCR 2505-10 8.519.27.C.2)
- Service and support Coordination for non-Medicaid transition related services and supports (10 CCR 2505-10 8.519.27.C.2)
- Completion of all required training within required timelines (10 CCR 2505-10 8.519.27.E)
- Any safeguards necessary to prevent Conflict of Interest between Case Management and Direct Service Provision (10 CCR 2505-10 8.519.27.G)
- Denial and Discontinuation of services (10 CCR 2505-10 8.519.27.C.4)
- Risk Incident Reporting (10 CCR 2505-10 8.519.27.F.3)



**Targeted Case Management-Transition Coordination
 Agency (TCM-TCA) Approval Application**

Agency Information

Service Agency Name:	
Phone:	Fax:
Physical Address:	
Mailing Address: <i>(if different)</i>	

Administrator/Manager/Director Information

Title	Full Legal Name:
Date of Appointment to the Position	
Email:	Phone:

Application Contact *(contact person for application questions)*

Title	Name:
Phone:	Email:

Purpose of Application

Purpose of Application: <i>(select one) drop down menu</i>
If change of ownership is selected, complete the following:
Current Owner Name:
Proposed Owner Name:
Has the agency/owner/operator ever been under prohibition or sanction from a contracting authority or licensing entity? <input type="checkbox"/> Yes* <input type="checkbox"/> No <i>*If yes, please attach an explanation to your application documents</i>
Proposed Opening/Start Date:

Business Owner

Name: <i>(Enter name EXACTLY as it is registered with the Colorado Secretary of State if applicable)</i>			
EIN/Tax ID:			
Ownership Type: <i>(select one)</i>			
Business Owner Address:			
City:	State:	Zip:	County:
Phone:		Fax:	

Date of Ownership:	From:	To: PRESENT
The following information is required for each ownership type:		
<i>Select and complete the applicable sections of the application and attach all required documents:</i>		
<input type="checkbox"/> Sole Proprietor: A notarized statement regarding lawful presence in the U.S., and Proof of Trade Name registered with the Colorado Secretary of State		
<input type="checkbox"/> Partnership: Partnership agreement, Shareholders/Owners over 5%, and Proof of filing with the Colorado Secretary of State		
<input type="checkbox"/> Limited Liability Company (LLC): Articles of Organization & Operating Agreement, Governing body & officers (if applicable), Shareholders/Owners over 5%		
<input type="checkbox"/> Corporation For-Profit: Articles of Incorporation and Bylaws, Governing body and officers, Shareholders/Owners over 5%		
<input type="checkbox"/> Corporation Non-Profit: Articles of Incorporation and Bylaws, Governing body and officers		
<input type="checkbox"/> Governmental Unit or Agency: Contact name/address/phone, Governing body and officers		

Agency Affiliations (*attach additional information if your affiliations exceed 3 agencies*) Please disclose any ownership relationships your agency has with other health care providers or agencies. List only the main offices of affiliated agencies.

Agency Name:	
Address:	
Provider ID:	Phone:
List of services:	

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Address:	
Provider ID:	Phone:
Please disclose any ownership relationships your agency has with other health care providers or agencies. List only the main offices of affiliated agencies:	
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Address:	
Provider ID:	Phone:
Please disclose any ownership relationships your agency has with other health care providers or agencies. List only the main offices of affiliated agencies:	
List of services:	

Building Ownership (ownership information for the administrative office location)

Are the owners of the agency and the building the same? Yes No

If NO, complete the items below and attach a current lease agreement

Owner of Building

Building Owner Address:

Building Owner Phone:

Lease Agreement

From:

To:

Targeted Case Management-Transition Coordination Agency (TCM-TCA) Service Area

Select ALL COUNTIES which this agency intends to provide services

<input type="checkbox"/>	Adams	<input type="checkbox"/>	Denver	<input type="checkbox"/>	Kit Carson	<input type="checkbox"/>	Phillips
<input type="checkbox"/>	Alamosa	<input type="checkbox"/>	Dolores	<input type="checkbox"/>	La Plata	<input type="checkbox"/>	Pitkin
<input type="checkbox"/>	Arapahoe	<input type="checkbox"/>	Douglas	<input type="checkbox"/>	Lake	<input type="checkbox"/>	Prowers
<input type="checkbox"/>	Archuleta	<input type="checkbox"/>	Eagle	<input type="checkbox"/>	Larimer	<input type="checkbox"/>	Pueblo
<input type="checkbox"/>	Baca	<input type="checkbox"/>	El Paso	<input type="checkbox"/>	Las Animas	<input type="checkbox"/>	Rio Blanco
<input type="checkbox"/>	Bent	<input type="checkbox"/>	Elbert	<input type="checkbox"/>	Lincoln	<input type="checkbox"/>	Rio Grande
<input type="checkbox"/>	Boulder	<input type="checkbox"/>	Fremont	<input type="checkbox"/>	Logan	<input type="checkbox"/>	Routt
<input type="checkbox"/>	Broomfield	<input type="checkbox"/>	Garfield	<input type="checkbox"/>	Mesa	<input type="checkbox"/>	Saguache
<input type="checkbox"/>	Chaffee	<input type="checkbox"/>	Gilpin	<input type="checkbox"/>	Mineral	<input type="checkbox"/>	San Juan
<input type="checkbox"/>	Cheyenne	<input type="checkbox"/>	Grand	<input type="checkbox"/>	Moffat	<input type="checkbox"/>	San Miguel
<input type="checkbox"/>	Clear Creek	<input type="checkbox"/>	Gunnison	<input type="checkbox"/>	Montezuma	<input type="checkbox"/>	Sedgwick
<input type="checkbox"/>	Conejos	<input type="checkbox"/>	Hinsdale	<input type="checkbox"/>	Montrose	<input type="checkbox"/>	Summit
<input type="checkbox"/>	Costilla	<input type="checkbox"/>	Huerfano	<input type="checkbox"/>	Morgan	<input type="checkbox"/>	Teller
<input type="checkbox"/>	Crowley	<input type="checkbox"/>	Jackson	<input type="checkbox"/>	Otero	<input type="checkbox"/>	Washington
<input type="checkbox"/>	Custer	<input type="checkbox"/>	Jefferson	<input type="checkbox"/>	Ouray	<input type="checkbox"/>	Weld
<input type="checkbox"/>	Delta	<input type="checkbox"/>	Kiowa	<input type="checkbox"/>	Park	<input type="checkbox"/>	Yuma

Training

Supervisors and Transition Coordinators must complete, and document required trainings within 90 days of hire and prior to providing transition coordination services independently (10 CCR 2505-10 8.5.19.27.E)

Signatures

C Suite level signature indicates compliance with the above rules.

- C Suite level refers to the executive-level managers within an agency to include chief executive officer (CEO), chief financial officer (CFO), chief operating officer (COO), and chief information officer (CIO)

I certify that I have read and am familiar with all rules and statutes regulating developmental disabilities services, and I agree to fully comply with them. Furthermore, I certify all information provided as part of this application is accurate, and all conditions have been met. Documentation that demonstrates all conditions have been met is on file at the agency's administrative office and is available for review upon request.

Service Agency:

C Suite Level Signature:

Date: