COLORADO
Department of Health Care Policy & Financing

Revised: 042016

Letter of Intent to Enroll in Colorado Choice Transitions (CCT)

Service Agency Name: _____

Agency Website Address: _____

Contact Name for Referrals: _____

Email Address for Referrals: _____

Phone Number(s) for Referrals: _____

Address: _____

Mailing Address (if different): _____

Please indicate all counties in your service area: _____

_____

This Letter of Intent is meant to indicate the CCT member(s) you will serve in addition to the Qualified Services. Please select the appropriate Demonstration Services you intend to provide:

HCBS-CCT Waiver for Persons with Brain Injury (CCT-BI)

Qualified Services

- ☐ Adult Day Services
- ☐ Specialized Medical Equipment and Supplies/Assistive Devices
- ☐ Behavioral Management
- ☐ Consumer Directed Attendant Support Services (CDASS)
- ☐ Day Treatment
- ☐ Home Modifications
- ☐ Independent Living Skills Training
- ☐ Mental Health Counseling
- ☐ Non-medical transportation
- ☐ Personal care
- ☐ Personalized Emergency Response System
- ☐ Respite care
- ☐ Substance Abuse Counseling
- ☐ Supported Living Program
- ☐ Transitional Living

Demonstration Services

- ☐ Assistive Technology, Extended
- ☐ Caregiver Education
- ☐ Community Transition Services
- ☐ Home Delivered Meals
- ☐ Intensive Case Management
- ☐ Peer Mentorship

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HCBS-CCT Waiver for Persons who are Elderly, Blind, and Disabled (CCT-EBD)

Qualified Services

- ☐ Adult Day Services
- ☐ Alternative Care Facilities
- ☐ Consumer Directed Attendant Support Services (CDASS)
- ☐ Home Modification
- ☐ Homemaker Services
- ☐ In Home Support Services (IHSS)
- ☐ Medication Reminder
- ☐ Non-medical Transportation
- ☐ Personal Care
- ☐ Personal Emergency Response System
- ☐ Respite Care

Demonstration Services

- ☐ Caregiver Education
- ☐ Community Transition Services
- ☐ Home Delivered Meals
- ☐ Independent Living Skills Training
- ☐ Intensive Case Management
- ☐ Peer Mentorship
- ☐ Transitional Behavioral Health Supports

HCBS-CCT Waiver for Community Mental Health Supports (CCT-CMHS)

Qualified Services

- ☐ Adult Day
- ☐ Alternative Care Facilities
- ☐ Consumer Directed Attendant Support Services (CDASS)
- ☐ Home Modifications
- ☐ Homemaker Services
- ☐ Non-medical Transportation
- ☐ Personal Care
- ☐ Personal Emergency Response System
- ☐ Respite Care
- ☐ Specialized Medical Equipment

Demonstration Services

- ☐ Caregiver Education
- ☐ Community Transition Services
- ☐ Home Delivered Meals
- ☐ Independent Living Skills Training
- ☐ Intensive Case Management
- ☐ Peer Mentorship

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HCBS-CCT Supported Living Services (CCT-SLS)

Qualified Services	
☐ Assistive Technology	☐ Non-medical Transportation
☐ Behavioral Services	☐ Personal Care Services
☐ Day Habilitation	☐ Personalized Emergency Response System
☐ Dental Services	☐ Professional Services
☐ Supported Employment	☐ Respite Therapy
☐ Prevocational Services	☐ Specialized Medical Equipment and Supplies
☐ Home Modifications	☐ Vehicle Modifications
☐ Homemaker Services	☐ Vision Services
☐ Mentorship	

Demonstration Services	
☐ Assistive Technology, Extended	☐ Independent Living Skills Training
☐ Caregiver Education	☐ Intensive Case Management
☐ Community Transition Services	

HCBS-CCT Persons with Developmental Disabilities (CCT-DD)

Qualified Services	
☐ Behavioral Services	☐ Residential Services
☐ Day Habilitation	☐ Specialized Medical Equipment and Supplies
☐ Dental Services	☐ Supported Employment
☐ Non-medical Transportation	☐ Vision Services
☐ Prevocational Services	

Demonstration Services	
☐ Assistive Technology, Extended	☐ Intensive Case Management
☐ Caregiver Education	☐ Peer Mentorship
☐ Community Transition Services	

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Agency Assurances – Please initial each assurance after it has been met.

The service agency assures:

_____ All staff members, including director, meet the minimum provider qualifications for the service(s) to be provided and outlined in the Services and Supports Desk Reference on file with the Department and available online (www.colorado.gov/hcpf/CCT). All direct care staff have completed the required training prior to unsupervised contact with clients. Criminal background and references have been checked and are available for review.

_____ All of the information submitted to the Department of Health Care Policy and Financing in support of its request for program approval is accurate. The agency will notify the Department of Health Care Policy and Financing of any change or reconfiguration to the program(s) and seek new program approval, if needed, prior to implementation of a change.

_____ Cooperation with Federal and State auditing authorities.

I certify that I have read and agree to fully comply with the administrative rules regulating the CCT program. Furthermore, I certify all information and/or documentation provided as part of this application is accurate and all assurances have been met. Required documentation is on file at the agency's administrative office and available for review.

Name of Agency Director/CEO (Print) Signature Date