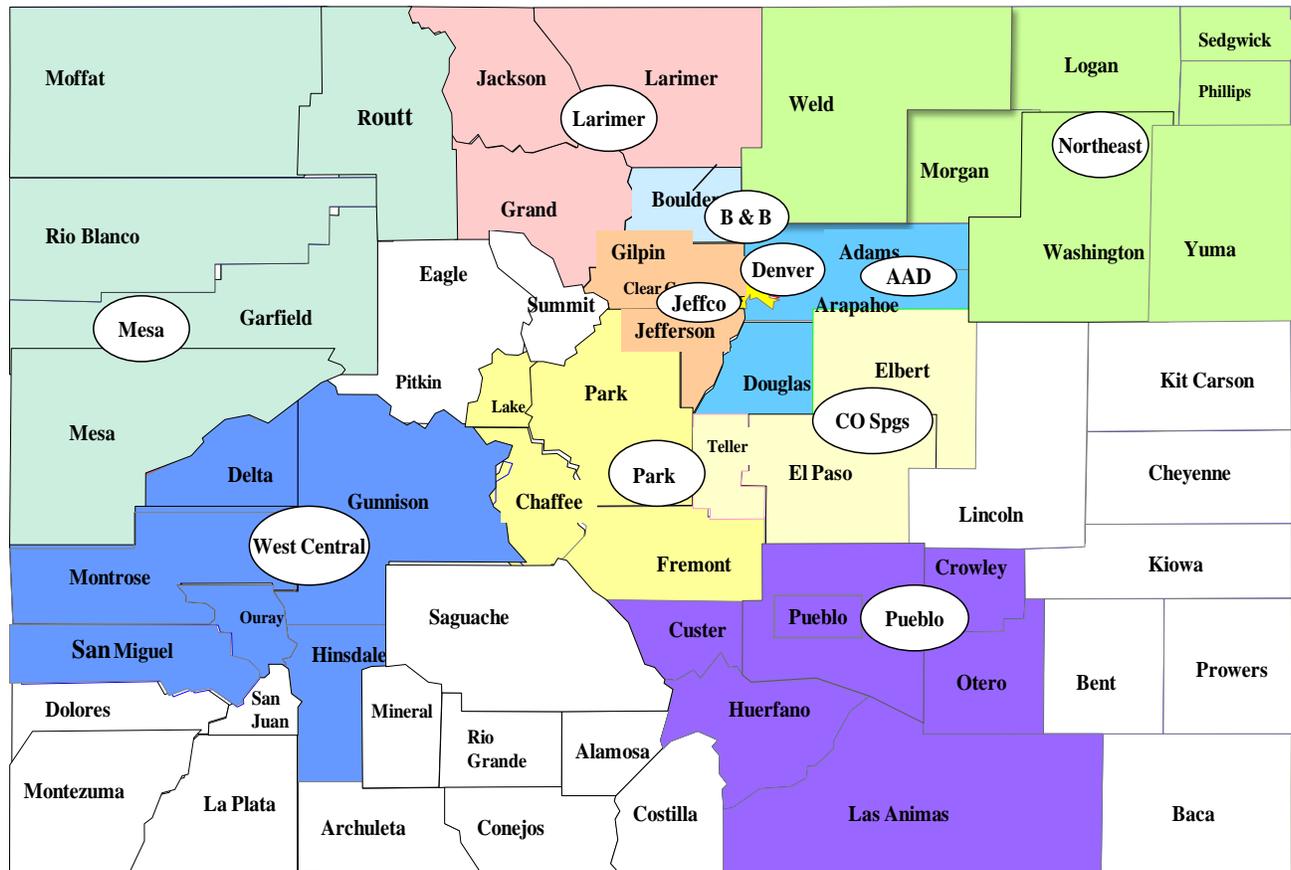


Regional Transition Committees



Regional Transition Committees

- 1 – Northeast– Weld, Morgan, Logan, Yuma, Sedgwick, Phillips
- 2 – AAD – Adams, Arapahoe, Douglas
- 3 – Denver Committee- Denver
- 4 – Jefferson – Jefferson, Gilpin, Clear Creek
- 5 – Colorado Springs– El Paso, Teller, Elbert, Fremont
- 6- Park – Park, Lake, Chaffee, Fremont
- 7 – Pueblo– Pueblo, Crowley, Otero, Huerfano, Custer, Otero, Las Animas
- 8 – Mesa – Mesa, Delta, Montrose, Moffett, Routt, Rio Blanco
- 9 –Larimer– Larimer, Jackson, Grand
- 10 –B&B - Boulder, Broomfield
- 11 – West Central – Delta, Montrose, San Miguel. Ouray, Hinsdale, Gunnison

Community Living Options Process





Colorado Department of Health Care Policy and Financing (HCPF)

Community Transition Referral Information Form

Transition Coordination Agency _____

Transition Coordinator _____

Date _____

Client Name _____

DOB _____ Diagnosis _____

Referral Type Self ____ MDS Section Q ____ Other _____ (please identify source)

Nursing Facility _____

Nursing Facility Contact Name _____

Phone Number _____ E-Mail _____

Phone Number for Client _____

Guardian Name (if applicable) _____

Contact Information _____

Medicaid Eligible () Yes () No () Pending

If Medicaid Eligible Long Term Care Medicaid () Yes () No

Nursing facility admission date _____

Physician name _____

Contact information _____

Availability of the following information:

ID () Yes () No Drivers License () Yes () No Proof of Income () Yes () No

Birth Certificate () Yes () No Social Security Card () Yes () No

Date/Time Initial Visit Scheduled _____

Resident Statement

() I will explore opportunities to make the transition to living in the community.

() I have decided not to move into the community at this time.

Signature: _____ Date: _____

Printed Name: _____

() Resident () Legal Guardian () Legal Representative

MDS-Minimum Data Set Resident Assessment and Care Screening

Section Q Return to Community Key Information

MDS 3.0 is required for all nursing facility residents upon admission, quarterly and whenever there is a significant change in condition.

The revised MDS 3.0 became effective October 1, 2010. Main advances in the revised MDS 3.0 include:

- Gives resident a voice
- Increases clinical relevance
- Increases accuracy and clarity
- Increases person-centered care and discharge planning
- Increases communication and collaboration between providers of services

Additional benefits:

- Provides new opportunities for transition collaboration
- Formalizes long-standing requirements for nursing facilities and state to ensure individuals are appropriately assessed and resident is in setting of their choice and appropriate to their needs
- Assists in relationship building between institutional and community care providers to implement care based on consumers' choices from the full array of long term care services and supports

Section Q of the MDS 3.0 includes a Return to Community question

- Every resident being assessed must be asked “Are you interested in speaking to someone about the possibility of returning to the community?”
- The intention of this question is to allow a resident his or her right to explore all community options
- Answering “Yes” is a request for more information regarding community living options and the transition process
- Answering “Yes” does not commit the resident to leave the nursing facility at a specific time

Required response to a resident answering “Yes” to the return to the community question involves the State Medicaid Agency, Nursing Facility and Local Contact Agencies.

State Medicaid Agency Responsibilities

1. Establish a State internal system of Local Contact Agencies (LCA).
2. Monitor outcome of LCA interviews.
3. Track outcomes of discharges from nursing facilities.
4. Develop protocol/procedures for resident contacts.

Nursing Facility (NF) Responsibilities

1. NF completes “Return to Community Referral” form.
2. Contact the Local Contact Agency within 10 days for those residents who answered “Yes” to the return to community question. These residents have expressed a desire to learn about possible transition back to the community and available care options and supports.
3. Consult with Local Contact Agency regarding discharge/transition potential.
4. Participant in the transition team for transitioning residents.
5. NF and LCA are expected to meaningfully engage the resident in their discharge /transition plan and collaboratively work to arrange for all of the necessary community-based long term care services and supports.

Transition Coordination Agencies (TCA) currently provide Community Transition Services to HCBS waiver clients. TCAs are the designated Local Contact Agencies in Colorado.

TCA Responsibilities

1. Meet with the resident at the nursing facility within 10 days of referral.
2. Consult with nursing facility staff regarding referral.
3. Provide community care information and transition services information to the resident, family, member or guardian.
4. Conduct transition assessment if resident chooses to explore transition options.
5. Proceed with the establish Community Transition Services procedure upon completion of transition assessment.
6. Maintain a monthly MDS referral list and submit to the State Medicaid Agency.

Nora Brahe

Transitions Administrator

Nora.brahe@state.co.us

303-866-3566

303-866-2786 FAX

September 24, 2010

Revised January 24, 2012



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Acting Executive Director

DAL #0119-1

EFFECTIVE DATE: May 1, 2011

April 11, 2011

Dear Administrator:

SUBJECT: MDS 3.0 Section Q Referral Process

DISTRIBUTION: The Department of Health Care Policy and Financing is issuing this letter to all Skilled Nursing Facilities (SNF) and Local Contact Agencies (LCA) to promote collaboration and coordination in the implementation of the MDS 3.0 Section Q Informing Long Term Care Choice initiative.

NECESSARY ACTION: Effective October 1, 2010, the staffs working in Medicaid and/or Medicare certified SNFs will begin asking residents the following question upon admission, quarterly, upon significant change, and at other regularly scheduled assessment time frames: “Do you want to talk with someone about the possibility of returning to the community?” If the answer is “yes” the facility staff will contact the State Medicaid Authority designated LCA. The following principles and protocols have been mutually identified and agreed upon by SNF and LCA representatives to guide the interaction between SNF and LCA staff as they facilitate the requirements of the MDS 3.0 Section Q referral process. These shared principles and practices are designed to promote a more collegial, effective and satisfying working relationship, so that all parties can meet their obligations with increased assurance of cordiality and professionalism in their contacts with each other.

PRINCIPLES:

1. SNF and LCA staff will demonstrate their understanding that MDS 3.0 Section Q referrals are required, time-sensitive, and inherently disruptive of normal routine and will demonstrate patience and flexibility in responding to the challenge of providing care while cooperating with MDS 3.0 Section Q referral requirements.
2. Notwithstanding their different roles, duties, and perspectives, concern for the welfare of facility residents offers enduring common ground for LCA and SNF staff.
3. The “Golden Rule” is mutually endorsed: there is a commitment to treating others with the cordiality and professionalism that each individual wishes for himself/herself.
4. All interacting participants have a role and responsibility for improving working relationships and maintaining positive working relationships.
5. There is mutual commitment to resolving miscommunications or other problems at the lowest level possible and as timely as possible.

6. There is a mutual commitment to work toward solutions.

PROTOCOLS:

When a resident answers “Yes” to the Section Q question, “Do you want to talk to someone about the possibility of returning to the community?” the following process should be followed:

1. SNF staff completes a “Return to Community Referral” form (attached).
2. SNF staff contacts the designated LCA within 10 business days to request and schedule a resident visit.
3. SNF staff will be expected to provide the following information at the time of the phone referral:
 - Legal guardian name and contact information (if applicable)
 - Durable Power of Attorney name and contact information (if applicable)
 - Availability of information contained on the following documents: ID or driver’s license, proof of income, birth certificate, and social security card
 - Confirmation of Medicaid eligibility
 - Date of SNF admission
 - Physician name and contact information
4. SNF and LCA will schedule the resident visit within 10 business days of the referral, at a time when the resident is available, and when the visit will not interfere with the resident’s preferred schedule. All involved staff will demonstrate sensitivity to the mutual need for facility care operations to continue smoothly during the referral/resident meeting process. All involved staff will be responsive, when possible, to scheduling the resident meeting process so as to minimize disruption to normal facility activities.
5. A minimum of 60 minutes will be made available for the initial resident visit and choice review.
6. LCA staff will sign in at the front desk upon arrival at the SNF.
7. Upon arrival at the facility, LCA staff and SNF staff will provide each other with the business card of the person who has been designated as the contact person for each agency, in case of a dispute or to answer questions regarding the MDS referral/resident meeting process/community transition.
8. The LCA staff person will meet with the resident privately for the initial interview.
9. At the conclusion of the interview, the LCA will ask the resident if he/she is interested in exploring opportunities to make the transition to living in the community. The resident will be asked to sign the initial interview form.
10. At the conclusion of the resident interview, LCA and SNF will meet to review the resident’s choice.

11. If necessary, an appointment to complete a community needs assessment with the resident will be scheduled.
12. Mutual respect and professionalism will be expected from all staff throughout this process.
13. LCA staff will not wear clothing that includes demeaning or disrespectful language regarding nursing facilities or nursing facility residents while conducting LCA responsibilities.
14. LCA staff will have no unsolicited interaction with other residents.
15. LCA staff can respond when a resident initiates conversation and solicits information.
16. All participants agree to assume their counterparts' concern for the safety and well-being of facility residents. Disagreements and inherent tensions in the referral/resident meeting process should not be used as the occasion to question others' good intentions in the performance of their duties.
17. All participants agree to address specific needs, requests, and behaviors as they arise within the referral/resident meeting process; and, to refrain from accusations of bad motives or negative labels regarding others' characters.

CONTACT: If you have questions, please contact Nora Brahe at 303-866-3566 or nora.brahe@state.co.us.

Sincerely,

Nora Brahe

Nora Brahe
Transitions Administrator
MDS 3.0 Section Q State Contact

Colorado Choice Transitions (CCT) Program Informed Consent for Participation

Client Name (Last, First, MI):

Medicaid #

YOU SHOULD KNOW THAT:

- The State of Colorado appreciates you being a part of this process.
- This is a very important program that helps Coloradans move from institutions back into the community.
- Participation is voluntary.
- The services available through the CCT program will help you to move from your current place into a community setting.
- You may end your participation in the program at any time. If you are in the program, someone will contact you to answer a survey.
- The Department of Health Care Policy and Financing will provide information about you to Mathematica so they can evaluate the program.
- Any information Mathematica collects about you is confidential and used only for evaluating the program.
- You must maintain Medicaid eligibility which includes functional and financial requirements.

CLIENT RESPONSIBILITIES

I understand and agree to the following conditions and responsibilities as a client in the CCT Program:

- I will move from the nursing facility, Intensive Care Facility/ Individuals with Intellectual Disabilities (ICF/IID) or hospital to a qualified community residence. A qualified community residence is:
 - Owned or leased by me or my family;
 - In the community in which no more than 4 unrelated people reside;
 - An apartment with an individual lease and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has legal control, including the ability to secure and come and go.
- I will have been in the nursing facility or ICF/IID at least 90 days, not including rehabilitation days, before I move.
- I will be eligible for Medicaid for at least 1 day prior to my move.
- I will accept services from either a Medicaid waiver, Medicaid State Plan, or

CCT demonstration program on the day I move.

- I will receive the following Community Transition Services which includes:
 - Help with moving expenses and household set-up
 - Help finding:
 - A place to live;
 - A doctor, pharmacy and other community resources; or
 - Community based services.

- My CCT Services will end on day 366.
- I will be able to stay in a Home and Community-Based Services (HCBS) waiver and state plan services as long as I meet the eligibility requirements.
- I will participate in the development of my service plan.
- I will be available to meet with my transition coordinator and case manager as required.
- I have been made aware of CCT services.
- I will be available to meet with representatives from the CCT Program for up to two years after I discharge from the long-term care facility.
- My services plan and health outcomes will be monitored by the CCT Program.
- I will notify the CCT Program if I move during the 24 months following my transition period.

COMPLAINTS AND APPEALS

Appeals of eligibility determinations shall be processed according to recipient appeal regulations at 10 C.C.R. 2505-10, Section 8.057

Contact Kathy Cebuhar CCT Community Liaison, 1570 Grant Street St., Denver, CO 80203, or by e-mail to Kathy.Cebuhar@state.co.us or by telephone at 303-866-2649

CONSENT

By signing this informed consent, you agree to participate in the Program. You will be given a signed copy of this consent form to keep.

- I agree to participate in the CCT Program.
- I understand that enrollment in the CCT Program is my choice.
- I also understand that I will be asked to participate in a Quality of Life Survey after I have been enrolled in the program.

-
- I do not want to enroll in the CCT Program at this time. I understand that I can reapply if my needs or circumstances change.
 - If you do not join the program, you may still receive HCBS waiver services as long as you meet the eligibility requirements and services are available.

Client Acknowledgement

Client Signature:	Print:	Date Signed:
Address:		Telephone No. (include area code):

Transition Coordinator

I have read and explained this document to the applicant. I believe that he/she (or the guardian, if signed) understood the document.

Signature:	Print:	Date Signed:
Address:		Telephone No. (include area code):

Legal Guardian Acknowledgement (if necessary)

Guardian Signature:	Date Signed:
Address:	
Telephone No. (include area code):	

Guardian's Responsibilities

I understand as the guardian of client who is participating in the CCT Program that I agree to the following:

- To be a resident of the State of Colorado
- To be available to participate in a service planning meeting at least annually
- To participate in discharge planning
- To comply with all probate court reporting requirements

Please describe the level of contact you have had with this client over the past six months:

<input type="checkbox"/> Face To Face Visits	If so, how many:
<input type="checkbox"/> Telephone Contacts	If so, how many:
<input type="checkbox"/> Telephone, email or other contact with the facility regarding care	If so, how many:
Legal Guardian Signature:	Date:

REVOCATION OF INFORMED CONSENT

I do hereby request that this authorization for the informed consent of: _____
Name of Client

signed by _____ on _____,
Enter Name of Person Who Signed Authorization *Enter date of Signature*

be rescinded, effective _____. I understand that any action taken on this authorization
Date

prior to the rescinded date is legal and binding.

Signature of Client/Guardian *Date* *Signature of Witness* *Date*

Relationship to Consumer

VERBAL REVOCATION

I do hereby attest to the verbal request for revocation of this authorization by _____
Name of Client/Guardian

on _____. The client and/or guardian has been informed that any action taken on this
Date

authorization prior to the rescinded date is legal and binding.

Signature of Staff *Date* *Signature of Witness* *Date*

**For Fax Submittals: Fax the completed Informed Consent form to CCT Transition Administrator, 303-866-3669.
Or scan into an encrypted e-mail to nora.brahe@state.co.us or mail to 1570 Grant St. Denver, CO. 80203**

For Official Use Only (Completed by Transition Coordinator or Case Manager)	
Estimated Date of Discharge:	Name of Facility:
Telephone No. of Facility (include area code):	Address of Facility:



CCT Uniform Service Worksheet | 2013

Community Transition Services																																		
HCPCS PROCEDURE CODE		PROCEDURE CODE DESCRIPTION																																
T2038 Coordinator <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Target Pop</th> <th style="width: 50%;">Mod</th> </tr> </thead> <tbody> <tr><td>EBD 65+</td><td>UC</td></tr> <tr><td>EBD PD</td><td>UC</td></tr> <tr><td>BI</td><td>UC</td></tr> <tr><td>MI</td><td>UC</td></tr> <tr><td>SLS</td><td>UC</td></tr> <tr><td>DD</td><td>UC</td></tr> </tbody> </table>	Target Pop	Mod	EBD 65+	UC	EBD PD	UC	BI	UC	MI	UC	SLS	UC	DD	UC	A9900 Service Items <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Target Pop</th> <th style="width: 50%;">Mod</th> </tr> </thead> <tbody> <tr><td>EBD 65+</td><td>UC</td></tr> <tr><td>EBD PD</td><td>UC</td></tr> <tr><td>BI</td><td>UC</td></tr> <tr><td>MI</td><td>UC</td></tr> <tr><td>SLS</td><td>UC</td></tr> <tr><td>DD</td><td>UC</td></tr> </tbody> </table>	Target Pop	Mod	EBD 65+	UC	EBD PD	UC	BI	UC	MI	UC	SLS	UC	DD	UC	Community Transition, waiver; per service <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">SERVICE RATE</th> </tr> </thead> <tbody> <tr> <td>Transition Coordinator - \$2,000</td> </tr> <tr> <td>Service Items - \$1,500</td> </tr> </tbody> </table>		SERVICE RATE	Transition Coordinator - \$2,000	Service Items - \$1,500
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SERVICE DEFINITION Services that are provided by a Transition Coordination Agency and include items essential to move a client from a nursing facility and establish community-based residence. Community transition services include the cost of navigation, security and utility deposits, moving expenses, one-time pest eradication, one-time cleaning expenses, and essential household furnishings such as beds, linens, utensils, pots and pans, and dishes. Items for entertainment and convenience are not included.		MINIMUM DOCUMENTATION REQUIRED <ul style="list-style-type: none"> • Community Transition Services Referral Form • Release of information (confidentiality) Form • Self-Assessment Transition Tool • Transition Assessment • Transition Plan • Transition team meeting notes • Client log notes • Authorization Request Form • Community Transition Report • Monthly Referral Log • Signed CCT Informed Consent form 																																
NOTES Services provided by a Transition Coordination Agency (TCA) to help an individual relocate to a community setting upon discharge from a Long Term Care (LTC) facility. Services extend from initial referral to CTS to 30 days after discharge from facility. CTS include the purchase of items essential to move a client from a Skilled Nursing Facility, Institute for Mental Disease, or Intermediate Care Facility – for Individuals with Intellectual Disabilities to establish a community-based residence. Examples include security and utility deposits, moving expenses, one-time pest eradication one-time cleaning expenses and essential household items such as beds, linens, utensils, pots and pans, dishes, etc.		EXAMPLE ACTIVITIES <ul style="list-style-type: none"> • Coordination of transition team • Assessment of community needs • Accessing community resources • Assistance with non-Medicaid applications • Assistance with setting up household – purchasing essential items 																																
APPLICABLE POPULATION(S) <input checked="" type="checkbox"/> Elderly <input checked="" type="checkbox"/> Physically Disabled <input checked="" type="checkbox"/> Developmentally Disabled <input checked="" type="checkbox"/> Mentally Ill		UNIT <input type="checkbox"/> Encounter <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> 15 Minutes <input type="checkbox"/> 30 Minutes <input type="checkbox"/> 1 Hour <input checked="" type="checkbox"/> Other	CAP Minimum: per transition Maximum: per transition																															



CCT Uniform Service Worksheet | 2013

ALLOWED MODE(S) OF DELIVERY	UNIT AND LIMITATIONS EXPLANATION
<input checked="" type="checkbox"/> Face-to-Face <input type="checkbox"/> Individual <input type="checkbox"/> Family (HS) <input type="checkbox"/> Video Conf <input type="checkbox"/> Group (HQ) <input type="checkbox"/> On-Site <input type="checkbox"/> Telephone <input type="checkbox"/> Family (HR) <input type="checkbox"/> Off-Site	
MINIMUM STAFF REQUIREMENTS	
<input type="checkbox"/> Peer Specialist <input type="checkbox"/> Unlicensed <input type="checkbox"/> Unlicensed EdD/ <input type="checkbox"/> QMAP <input type="checkbox"/> RN (TD) <input type="checkbox"/> PA (PA) <input checked="" type="checkbox"/> Less Than Bachelor's <input type="checkbox"/> Master's Level (HO) <input type="checkbox"/> PhD/PsyD (HP) <input type="checkbox"/> Psych Tech <input type="checkbox"/> APRN (SA) <input type="checkbox"/> MD/DO (AF) Level (HM) <input type="checkbox"/> LCSW (AJ)/LSW/ <input type="checkbox"/> Licensed EdD/ <input type="checkbox"/> LPN/LVN <input type="checkbox"/> RxN (SA) <input type="checkbox"/> Other <input type="checkbox"/> Bachelor's Level (HN) LMFT/ LPC PhD/PsyD (AH) (TE)	
PLACE OF SERVICE	
<input checked="" type="checkbox"/> CMHC <input type="checkbox"/> Cust Care <input checked="" type="checkbox"/> NF <input type="checkbox"/> Inpt PF <input type="checkbox"/> Other POS <input type="checkbox"/> Office <input type="checkbox"/> Grp Home <input checked="" type="checkbox"/> SNF <input type="checkbox"/> ER <input type="checkbox"/> Outpatient Hospital <input checked="" type="checkbox"/> Home <input type="checkbox"/> Temp Lodging <input type="checkbox"/> PF-PHP <input type="checkbox"/> ACF <input checked="" type="checkbox"/> ICF-ID <input checked="" type="checkbox"/> Inpt Hosp <input type="checkbox"/> Pharmacy	
PROVIDER QUALIFICATIONS	APPLICABLE STATUTE, LEGAL AUTHORITY, COLORADO CODE OF REGULATIONS
Providers must meet certification as required in §8.487.20 and §8.553.4.B	§5.487.20 HCBS-EBD Provider Agencies General Certification §8.553.4.B Community Transition Services §8.555 Colorado Choice Transitions, A Money Follows the Person Demonstration

Transition Coordinator Job Description

Transition Coordinator means a person employed by a Transition Coordination Agency to provide Transitional Coordination.

Transition Coordinators must have received a total of 20 hours of training in the following:

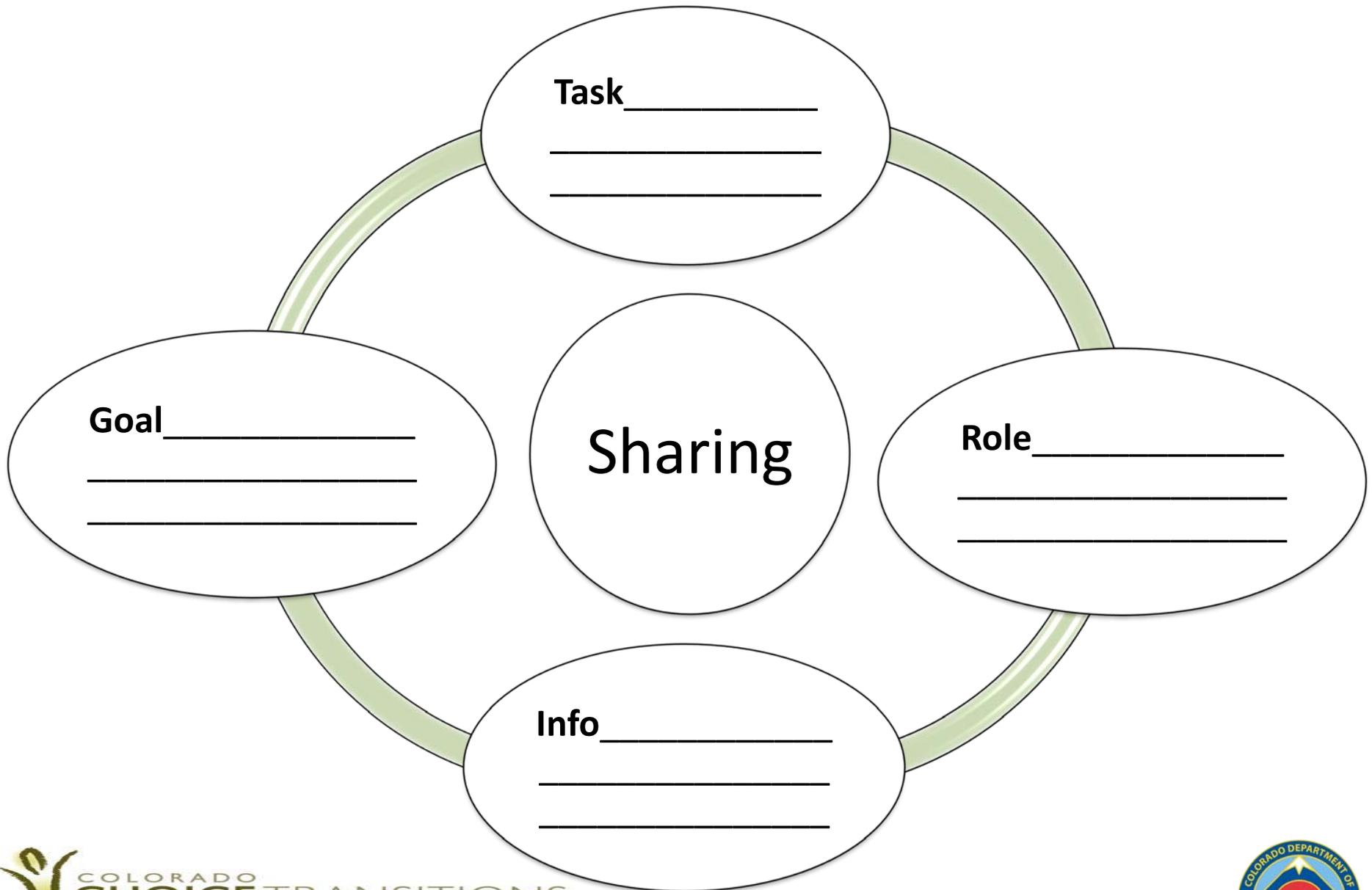
- Knowledge and experience of populations served by the TCA and the target population served by the HCBS waivers.
- Client interviewing and assessment skills.
- Intervention and interpersonal communication skills.
- Knowledge of available community resources and public assistance programs.
- Transition plan development.

Transition Coordinator Responsibilities

- Act as advocate for Medicaid LTC facility resident
- Receive referrals from facility resident, family, friends, case managers, LTC facility staff
- Provide Options Counseling to referred facility residents
- Obtain informed consent to participate in the CCT Program from the client or guardian
- Make a referral to a case management agency (CCT or CTS)
- Convene transition team
- Complete the Transition Assessment /Plan in collaboration with the transition team
- Review the Self-Assessment Transition Tool with the client and assist the client with completing questions
- Assist the resident with finding qualified housing prior to discharge (group home, assisted living apartment, subsidized housing or family home)
- Purchase household goods and assistive devices with relocation funds available through CTS benefit
- Complete other activities necessary to establishing a community residence
- Coordinate the facility discharge with the transition team
- Monitor the client for the first 30 days following the transition with the case manager (CCT or CTS)
- Complete all required document, reporting and monitoring responsibilities

The Transition Coordinator shall conduct a minimum of three on-site visits of the residence to ensure all essential furnishing utilities, community resources and services are in place. If the Transition Coordinator finds any of the supports to be insufficient for the client to successfully live in the community, the Transition Coordinator shall correct the deficiencies. The on-site visits shall occur the day of the discharge from the facility, one week and one month after transition.

Elements of Positive Interdependence





Colorado Department of Health Care Policy and Financing (HCPF)

COMMUNITY TRANSITION ASSESSMENT

1. TRANSITION COORDINATOR		c. DATE
a. LAST NAME	b. FIRST NAME	
d. CLIENT LAST NAME	e. CLIENT FIRST NAME	
f. STREET ADDRESS	g. CITY	h. ZIP
i. COUNTY	j. TELEPHONE	k. DOB
		l. GENDER

2. RACE/ETHNICITY (optional)

a. <input type="checkbox"/> White	d. <input type="checkbox"/> Hispanic or Latino	g. <input type="checkbox"/> Not Hispanic or Latino
b. <input type="checkbox"/> Black or African American	e. <input type="checkbox"/> American Indian or Alaska Native	
c. <input type="checkbox"/> Asian	f. <input type="checkbox"/> Native Hawaiian or other Pacific Islander	

3. LANGUAGE

a. <input type="checkbox"/> English	e. <input type="checkbox"/> Spoken	i. <input type="checkbox"/> Written
b. <input type="checkbox"/> Spanish	f. <input type="checkbox"/> Spoken	j. <input type="checkbox"/> Written
c. <input type="checkbox"/> Other:	g. <input type="checkbox"/> Spoken	k. <input type="checkbox"/> Written
d. <input type="checkbox"/> Other:	h. <input type="checkbox"/> Spoken	l. <input type="checkbox"/> Written

4. FAMILY/FRIEND/AUTHORIZED REPRESENTATIVE SUPPORT

a. <input type="checkbox"/> Family/friend lives close by and is supportive of transition	
b. <input type="checkbox"/> Family/friend lives close by and is not supportive of transition	
c. <input type="checkbox"/> Family/friend is available to assist in transition and continued community living	
d. <input type="checkbox"/> Family/friend is not available to assist in transition and continued community living	
e. FAMILY/FRIEND NAME	
f. FAMILY/FRIEND CONTACT PHONE	g. FAMILY/FRIEND CONTACT EMAIL

5. INCOMESOURCE AND AMOUNT (fill in amounts)

a. <input type="checkbox"/> SSI	\$	d. <input type="checkbox"/> SSDI	\$
b. <input type="checkbox"/> Social Security	\$	e. <input type="checkbox"/> Veterans	\$
c. <input type="checkbox"/> Other			

6. INSURANCE INFORMATION (fill in requested information)

a. <input type="checkbox"/> Medicaid Number:	d. <input type="checkbox"/> Medicare B
b. <input type="checkbox"/> Medicare A	e. <input type="checkbox"/> Private:
c. <input type="checkbox"/> Medicare Number:	

7. LEGAL INFORMATION

a. LEGAL GUARDIAN NAME	b. GUARDIAN'S PHONE
c. POWER OF ATTORNEY	d. MEDICAL POWER OF ATTORNEY
e. ADVANCE DIRECTIVES	
f. EMERGENCY CONTACT NAME	g. EMERGENCY CONTACT PHONE
h. PERSON IS OWN PAYEE	i. PERSON DESIRES TO BE OWN PAYEE

8. CLIENT/GUARDIAN RELATIONSHIP INFORMATION – Client Report		
a. Type of guardianship		
<input type="checkbox"/> Full Comments	<input type="checkbox"/> Limited please explain	
b. How often does the client see the guardian?	c. When was the last time the client saw the guardian?	
d. What is the nature of the guardian's visits?		
<input type="checkbox"/> Face to face Visits	If so, how many in past 6 months:	
<input type="checkbox"/> Telephone contacts	If so, how many in past 6 months:	
<input type="checkbox"/> Email or other contact	If so, how many in past 6 months:	
9. GUARDIANSHIP – Guardian Report		
Is guardian a resident of the State of Colorado Yes <input type="checkbox"/> No <input type="checkbox"/> City _____		
Is guardian able to participate in discharge planning Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is guardian available to participate in a service planning meeting at least annually Yes <input type="checkbox"/> No <input type="checkbox"/>		
Is guardian able to perform all guardian responsibilities as legally required Yes <input type="checkbox"/> No <input type="checkbox"/>		
Please describe the level of contact the guardian has had with this consumer over the past six months:		
<input type="checkbox"/> Face to face visits	If so, how many:	
<input type="checkbox"/> Telephone contacts	If so, how many:	
<input type="checkbox"/> Telephone, email or other contact with the facility regarding care	If so, how many:	
<input type="checkbox"/> Telephone, e-mail or other contact with other professionals regarding care	If so, how many:	
<input type="checkbox"/> Copies of guardianship papers obtained		
10. MEDICAL CONDITION		
a. PHYSICIAN'S NAME		b. PHONE
c. STREET ADDRESS	d. CITY	e. ZIP
f. UNDER PHYSICIAN'S CARE?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CURRENT HEALTH CONDITIONS		
g. <input type="checkbox"/> Alzheimer's Disease	m. <input type="checkbox"/> Congestive Heart Failure	s. <input type="checkbox"/> Glaucoma
h. <input type="checkbox"/> Anxiety Disorder	n. <input type="checkbox"/> Deep-vein Thrombosis	t. <input type="checkbox"/> Heart Disease
i. <input type="checkbox"/> Arthritis	o. <input type="checkbox"/> Dementia other than Alzheimer's	u. <input type="checkbox"/> Hip Fracture
j. <input type="checkbox"/> Asthma	p. <input type="checkbox"/> Depression	v. <input type="checkbox"/> Other:
k. <input type="checkbox"/> Cerebral Palsy	q. <input type="checkbox"/> Diabetes	w. <input type="checkbox"/> Other:
l. <input type="checkbox"/> Cerebrovascular Accident (Stroke)	r. <input type="checkbox"/> Emphysema (COPD)	x. <input type="checkbox"/> Other
y. History of successful management of physical health problems or illness in community.	<input type="checkbox"/> Yes <input type="checkbox"/> No	

11. ALLERGIES		
a. <input type="checkbox"/> Penicillin	c. <input type="checkbox"/> Insulin	e. <input type="checkbox"/> Anti-convulsants
b. <input type="checkbox"/> Sufa	d. <input type="checkbox"/> Iodine	f. <input type="checkbox"/> Other
12. MENTAL HEALTH		
a. <input type="checkbox"/> No Problem		
b. <input type="checkbox"/> Receiving mental health treatment	e. <input type="checkbox"/> Hospitalization:	
c. <input type="checkbox"/> Past mental health treatment	1. Dates of Hospitalization(s):	
d. <input type="checkbox"/> Has managed mental illness successfully in the past <input type="checkbox"/> Yes <input type="checkbox"/> No	f. <input type="checkbox"/> Psychoactive Medication:	
	1. Types:	
13. SUBSTANCE ABUSE		
a. <input type="checkbox"/> No Problem		
b. <input type="checkbox"/> Current Abuse	e. <input type="checkbox"/> Inpatient Treatment Dates:	
c. <input type="checkbox"/> Past Abuse	f. <input type="checkbox"/> Drug(s) of choice:	
d. <input type="checkbox"/> Risk of Relapse <input type="checkbox"/> Yes <input type="checkbox"/> No		
14. COGNITIVE OR BEHAVIOR*		
* If resident is unable to answer, get information from another source, but identify the source:		
a. <input type="checkbox"/> Memory Loss	d. <input type="checkbox"/> Behavioral Concerns, describe:	
b. <input type="checkbox"/> Anxiety	e. <input type="checkbox"/> Wandering	
c. <input type="checkbox"/> Inpatient Treatment: Dates:	f. <input type="checkbox"/> Depression	
15. OTHER DISABILITY		
a. <input type="checkbox"/> No Problem		
b. <input type="checkbox"/> Mobility	Describe:	
c. <input type="checkbox"/> Physical	Describe:	
d. <input type="checkbox"/> Hearing	Describe:	
e. <input type="checkbox"/> Vision	Describe:	
f. <input type="checkbox"/> Multiple Disability	Describe:	
g. <input type="checkbox"/> Specific Disability	Describe:	
16. ULTC 100.2 and IADL ASSESSMENT		
a. Date Completed		
b. Comments:		
17. SINGLE ENTRY POINT AGENCY		
a. CASE MANAGER'S NAME		b. CASE MANAGER'S PHONE
c. CASE MANAGEMENT AGENCY		
d. PHYSICIAN'S NAME		e. PHYSICIAN'S PHONE
18. NURSING FACILITY		
a. FACILITY NAME		b. PHONE
c. STREET ADDRESS	d. CITY	e. ZIP
f. CONTACT NAME OR TITLE		g. CONTACT PHONE
h. DATE OF CURRENT ADMISSION		
i. PREVIOUS NURSING FACILITY ADMISSION(S):		j. DATE(S)

19. CURRENT NURSING FACILITY THERAPIES

- a. Speech
 b. Occupational
 c. Respiratory
 d. Chemotherapy
 e. Dialysis
 f. Psychological
 g. Physical
 h. Radiation
 i. Cognitive
 j. Vocational Rehabilitation
 k. Physician
 l. Medication Management
 m. Physical
 n. Radiation
 o. Cognitive
 p. Social Worker or Therapist
 q. RN or CNA
 r. Secure Unit
 s. Other:
 t. Nutrition
 u. Emergency Services Used within the last six months. Number of Contacts:
 v. Reason for Contacts:

20. REASON FOR ENTERING CURRENT NURSING FACILITY (check all that apply)

a. <input type="checkbox"/> Treatment for Medical Condition	Describe: 1. <input type="checkbox"/> Condition has improved 2. <input type="checkbox"/> Receiving Treatment Duration: 3. <input type="checkbox"/> Receiving Treatment Duration: Expected Result: 4. <input type="checkbox"/> Additional Treatment is Necessary Before Transition Describe:
b. <input type="checkbox"/> Treatment for Mental Illness	Describe: 1. <input type="checkbox"/> Condition has improved 2. <input type="checkbox"/> Receiving Treatment Duration: 3. <input type="checkbox"/> Receiving Treatment Duration: Expected Result: 4. <input type="checkbox"/> Additional Treatment is Necessary Before Transition Describe:
c. <input type="checkbox"/> Treatment for Cognitive or Behavioral Disorder	Describe: 1. <input type="checkbox"/> Condition has improved 2. <input type="checkbox"/> Receiving Treatment Duration: 3. <input type="checkbox"/> Receiving Treatment Duration: Expected Result: 4. <input type="checkbox"/> Additional Treatment is Necessary Before Transition Describe:
d. <input type="checkbox"/> Health, Physical or Mental; or Personal Care Problems While in Community	1. <input type="checkbox"/> Inability of family/friends to provide personal care 2. <input type="checkbox"/> Shortage of good attendants 3. <input type="checkbox"/> Cost of paying attendants 4. <input type="checkbox"/> Lack of medical, nursing, or therapy services 5. <input type="checkbox"/> Change in health condition 6. <input type="checkbox"/> Lack of or no record of emergency contact 7. <input type="checkbox"/> Frequency of illness or hospitalization 8. <input type="checkbox"/> Difficulty of managing symptoms 9. <input type="checkbox"/> Non-compliance with medication instructions 10. <input type="checkbox"/> Specifics of medical condition (e.g., stroke, heart attack, diabetes, dementia, etc.) Describe the conditions:
e. <input type="checkbox"/> Unable to Return Home from Hospital or Rehab Facility	1. <input type="checkbox"/> Inability of family/friends to provide personal care 2. <input type="checkbox"/> Shortage of good attendants 3. <input type="checkbox"/> Cost of paying attendants 4. <input type="checkbox"/> Lack of medical, nursing, or therapy services Describe: 5. <input type="checkbox"/> Cost of medical, nursing, or therapy services 6. <input type="checkbox"/> Cost of rent or other bills 7. <input type="checkbox"/> Frequency of illness or hospitalization 8. <input type="checkbox"/> Need for home modifications 9. <input type="checkbox"/> Need for adaptive aids or mobility device(s) 10. <input type="checkbox"/> Need for adequate transportation 11. <input type="checkbox"/> Other:

f. <input type="checkbox"/> Difficulty in Maintaining Residence in the Community:	1. <input type="checkbox"/> Need for services to help maintain residence 2. <input type="checkbox"/> Need for services to help with money management or decision-making 3. <input type="checkbox"/> Concern for safety by family or friends [WHAT KIND OF SAFETY? Neglect? Unsafe environment? Health hazards?] 4. <input type="checkbox"/> Cost of rent or other bills 5. <input type="checkbox"/> Need for home modifications 6. <input type="checkbox"/> Need for adaptive aids or mobility device(s) 7. <input type="checkbox"/> Need for adequate transportation 8. <input type="checkbox"/> Other:
---	---

21. PAYEESHIP
<p>a. If you require a payee, do you have suggestions about who could be your payee?</p> <p>b. How did your payeeship change?</p> <p>c. Are you interested in learning the skills to be your own payee?</p>

21. CONSULTATIONS IN SUPPORT OF TRANSITION	
a. <input type="checkbox"/> Physician is supportive <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
b. <input type="checkbox"/> Nursing facility is supportive <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
c. <input type="checkbox"/> Mental health provider is supportive <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
d. <input type="checkbox"/> HCPF CTS Administrator Consultation (if applicable)	

TRANSITION PLANNING: COMMUNITY NEEDS INVENTORY

P1. HOUSING		
a. PREFERENCE FOR LIVING ARRANGEMENT		
b. <input type="checkbox"/> Alone	e. <input type="checkbox"/> With family	h. <input type="checkbox"/> With friend(s)
c. <input type="checkbox"/> With identified roommate	f. <input type="checkbox"/> With unidentified roommate	i. <input type="checkbox"/> Assisted living
d. <input type="checkbox"/> Return to previous residence	g. <input type="checkbox"/> Desired location (city, county)	
HUD SECTION 8 /HOUSING VOUCHER		
j. First month's rent	a. <input type="checkbox"/> Has	b. <input type="checkbox"/> Needs
k. Utility payments	a. <input type="checkbox"/> Has	b. <input type="checkbox"/> Needs
P2. FINANCES, ANTICIPATED RELOCATION EXPENSES		
a. <input type="checkbox"/> Moving costs	d. <input type="checkbox"/> Other: \$__	
b. <input type="checkbox"/> Rent deposit	e. <input type="checkbox"/> Other: \$__	
c. <input type="checkbox"/> Utility deposit		
P3. ACCESSABILITY REQUIREMENTS		
a. <input type="checkbox"/> Widened doors	f. <input type="checkbox"/> Bathroom handrails	k. <input type="checkbox"/> Environmental control system
b. <input type="checkbox"/> No Step entrance	g. <input type="checkbox"/> Roll-In shower	l. <input type="checkbox"/> Other:
c. <input type="checkbox"/> No stairs	h. <input type="checkbox"/> Automatic door opener	
d. <input type="checkbox"/> Entrance ramp	i. <input type="checkbox"/> Wheelchair access kitchen	
e. <input type="checkbox"/> First floor apartment	j. <input type="checkbox"/> Curb cut	
P4. PERSONAL CARE ASSISTANCE REQUIREMENTS		
a. <input type="checkbox"/> Bed or wheelchair transfer	e. <input type="checkbox"/> Cooking or eating	i. <input type="checkbox"/> Dressing change
b. <input type="checkbox"/> Walking or using wheelchair, cane, or other mobility device	f. <input type="checkbox"/> Medication administration	j. <input type="checkbox"/> Bathing, personal hygiene
c. <input type="checkbox"/> Grocery shopping	g. <input type="checkbox"/> Medication set up	k. <input type="checkbox"/> Toilet
d. <input type="checkbox"/> House cleaning	h. <input type="checkbox"/> Medication monitoring	l. <input type="checkbox"/> Other:
P5. ASSISTIVE TECHNOLOGY NEEDS		
a. <input type="checkbox"/> Mobility appliances	d. <input type="checkbox"/> Manual wheelchair	g. <input type="checkbox"/> Power wheelchair
b. <input type="checkbox"/> Shower chair	e. <input type="checkbox"/> Shower bench	h. <input type="checkbox"/> Brace(s) or Prosthetics
c. <input type="checkbox"/> Cane, walker, crutch	f. <input type="checkbox"/> Transfer equipment	i. <input type="checkbox"/> Lifting chair
P6. BED		
a. <input type="checkbox"/> Regular	c. <input type="checkbox"/> Semi-automatic	e. <input type="checkbox"/> Other:
b. <input type="checkbox"/> Therapeutic mattress	d. <input type="checkbox"/> Fully-automatic	
P7. EATING UTENSILS		
a. <input type="checkbox"/> Modified utensils	c. <input type="checkbox"/> IV supplies	d. <input type="checkbox"/> Other:
b. <input type="checkbox"/> Feeding tube		
P8. VISION		
a. <input type="checkbox"/> Glasses	b. <input type="checkbox"/> Contact lens	
P9. COMMUNICATION		
a. <input type="checkbox"/> Hearing aid(s)	c. <input type="checkbox"/> TTY	d. <input type="checkbox"/> Other:
b. <input type="checkbox"/> Modified phone		
P10. COGNITIVE OR MEMORY		
a. <input type="checkbox"/> Planner	c. <input type="checkbox"/> Programmable watch	d. <input type="checkbox"/> Other:
b. <input type="checkbox"/> Medication box		
P11. MEDICAL ALERT		
a. <input type="checkbox"/> Bracelet	c. <input type="checkbox"/> Tags	
b. <input type="checkbox"/> Other		

P12. INDEPENDENT LIVING ASSISTANCE REQUIREMENT

- | | | |
|--|--|---|
| a. <input type="checkbox"/> Managing money | c. <input type="checkbox"/> Paying bills | e. <input type="checkbox"/> Doing laundry |
| b. <input type="checkbox"/> Banking | d. <input type="checkbox"/> Other: | f. <input type="checkbox"/> Other : |

P13. FINANCES, UNPAID OR ONGOING DEBTS

- | | | |
|--|--|--|
| a. <input type="checkbox"/> Landlord \$__ | d. <input type="checkbox"/> Housing authority \$__ | g. <input type="checkbox"/> Utility bills \$__ |
| b. <input type="checkbox"/> Child support \$__ | e. <input type="checkbox"/> Mortgage \$__ | h. <input type="checkbox"/> Credit cards \$__ |
| c. <input type="checkbox"/> Other \$__ | f. <input type="checkbox"/> Other \$__ | i. <input type="checkbox"/> Other \$__ |

P14. TRANSPORTATION REQUIREMENTS OR PREFERENCES

- | | | |
|---|--|---|
| a. <input type="checkbox"/> Fixed route bus | c. <input type="checkbox"/> Personal vehicle | f. <input type="checkbox"/> Family or friends |
| b. <input type="checkbox"/> Paratransit/demand response eligibility | d. <input type="checkbox"/> Taxi | g. <input type="checkbox"/> Other: |
| | e. <input type="checkbox"/> Medical transportation | |

P15. TRANSPORTATION ASSISTANCE NEEDED

- | | | |
|---|--|--|
| a. <input type="checkbox"/> Travel training | c. <input type="checkbox"/> Paratransit scheduling | f. <input type="checkbox"/> Orientation and mobility instruction |
| b. <input type="checkbox"/> Eligibility establishment for paratransit/demand response use | d. <input type="checkbox"/> Vehicle transfer | g. <input type="checkbox"/> Other |
| | e. <input type="checkbox"/> Escort | |

P16. EMPLOYMENT

- | | | |
|---|---|--|
| a. <input type="checkbox"/> Retired | d. <input type="checkbox"/> Not employed | g. <input type="checkbox"/> Employed fulltime |
| b. <input type="checkbox"/> Interested in getting or changing job | e. <input type="checkbox"/> Not interested in getting or changing job | h. <input type="checkbox"/> Attends pre-vocational day activity or work activity program |
| c. <input type="checkbox"/> Attends sheltered workshop | f. <input type="checkbox"/> Works at home | i. <input type="checkbox"/> Other: |

P17. NEED FOR ASSISTANCE TO WORK

- | | |
|--|---|
| a. <input type="checkbox"/> Independent (with devices, if used) | c. <input type="checkbox"/> Needs help every day, but does not need continuous presence of another person |
| b. <input type="checkbox"/> Needs help weekly or less (for example, if problems arise) | d. <input type="checkbox"/> Needs continual presence of another person |

P18. PAYEESHIP

- | | |
|---|--|
| a. <input type="checkbox"/> Develop plan to transition payeeship | c. <input type="checkbox"/> Change payeeship prior to discharge |
| b. <input type="checkbox"/> Schedule meeting at Social Security | d. <input type="checkbox"/> Establish plan for client to receive check |
| e. <input type="checkbox"/> Develop plan for client to learn the skills to become own payee | |

PLAN FOR COMMUNITY LIVING

Family and Friends

1. Are visits from family and friends important to you?

Yes

No

Comment: _____

2. Do you have friends and family members that you talk to or see on a regular basis?

Yes. If so, who? _____

No

Comment: _____

If the answers to questions 1 and 2 is “No” you may skip to the **Housing Section**

3. How often do you see or talk with friends and family members?

Daily

Weekly

Other. Please explain. _____

4. Are any of your friends or family members able to make decisions for you (either medically or financially)?

Yes. If so, who? _____

No

Comment: _____

5. Do your friends or family members agree with your move to a community setting?

Yes

No - Please explain _____

Unsure - Please explain. _____

Comment: _____

6. Who is the family member or friend that you trust most to help you plan for your move? _____

7. Do you have friends or family who you can go to for help in the following areas: setting up appointments, transportation, moving you into your new home?

Yes

No

Comment: _____

Housing Choices

1. What would be your ideal living setting? Check all that apply.

Alone

With family

With a host family

With someone else

With pet

Other _____

Comment: _____

2. If you prefer to live with someone else, who would that be?

Does this person want to live with you?

Yes

No

Unsure. Please
explain _____

Comment: _____

3. Have you lived alone in the past?

Yes

No

If yes, what did you like about living alone?

What did you dislike about living alone?

4. Do you prefer to live near friends or family members?

Yes if so, who are they? _____

Where do they live? _____

No

Comment: _____

5. Would you prefer to live:

In a house

In an apartment

Other _____

Comment: _____

6. Will you need home modifications (e.g. a ramp, modified bath room)?

Yes. Describe needed modifications _____

No

Unsure. Please explain _____

Comment: _____

7. Would you prefer to live:

In town

Near a bus line

In a suburb

In a rural setting

Other _____

Comment: _____

8. Do you have funds to pay for housing?

Yes

No

Unsure

Comment: _____

9. Do you enjoy having neighbors?

Yes

No

Comment: _____

10. Would you prefer to live in a community without children?

Yes

No

Comment: _____

11. What other things are important to you in regard to housing?

12. What are your thoughts, concerns, questions about housing?

Personal Activities

1. Do you know how to use the Internet?

Yes

No

Comment: _____

2. What activities would you like to participate in when you move?

(Check all that apply.)

Go to restaurants

- Go to the movies
- Go to sporting events
- Go shopping
- Go for walks
- Go bowling
- Watch TV
- Read
- Listen to music
- Play cards or games
- Swim
- Attend community events
- Other _____

3. When you do activities, do you prefer doing them:

- Alone
- With groups
- With family or friends
- Unsure

Comment: _____

4. Do you belong to any clubs or organizations?

- No
- Yes. Which ones? _____
- I would like to get involved in clubs or organizations after I move. Which ones? _____

Comment: _____

5. Do you belong to a church, synagogue, mosque or a religious group or organization?

- No

I would like to join one after I move.

Yes. Which one? _____

Would you still like to attend services at your current place?

No

Yes

I would be willing to find another place closer to my new home

Comment: _____



Colorado Department of Health Care Policy and Financing (HCPF)

Community Transition Plan

Client Name _____

Transition Coordinator _____

Date _____ Transition Target Date: _____

Transition Intake/Assessments Attached _____ Skilled/Acute Transition () Yes () No

Discharge Collaboration with Nursing Facility () Yes () No

Physician Discharge Release () Yes () No Approved Discharge Date _____

Physician in Community Name/Contact Information _____

Housing

	Assessed Need	Roommate	HUD Section 8	Utility Deposit	Rent	Move-in Date	Address
Previous Residence							
Independent Apt							
Assisted Living							
Alternative Care Facility							
Residential Group Home							
Private with Family							
Other							

Home Modification

	Assessed Need	Provider	Needed Prior to Move In	Service Initiation Date
Widened doors				
Bathroom handrails				
Environmental control system				
No-step entrance				
Roll-in shower				
Automatic door opener				
Entrance ramp				
Curb cut				
W/C access kitchen				
Other				

Personal Care Assistance

	Assessed Need	Provider	Service Frequency	Service Initiation Date
Transfers				
Mobility				
Cooking or eating				
Toilet				
Medication set up				
Medication administration				
Medication monitoring				
Dressing change				
Bathing, personal hygiene				
Grocery shopping				

House cleaning				
Other				

Independent Living Skills

	Assessed Need	Skills Training Provider	Service Initiation Date
Money management			
Paying bills			
Managing bank account			
Travel training			
Other			

Transportation

	Assessed Need	Provider	Service Initiation Date
Fixed route bus			
Personal car			
Family/friends			
Para transit			
Taxi			
Medical transportation			
Other			

Employment Assistance

	Assessed Need	Provider	Service Initiation Date
Independent (w/devices)			
Weekly or less assistance			
Daily assistance			
Continuous assistance			
Other			

Employer _____

Assistive Technology

	Assessed Need	Needed prior to move-in	Provider	Acquisition Date
Manual wheelchair				
Power wheelchair				
Shower chair				
Shower bench				
Brace/prosthesis				
Cane, walker, crutch				
Life line				
Computer				
Transfer equipment				
Lifting chair				
Regular bed				
Fully automatic bed				
Semi automatic bed				
Therapeutic mattress				
I.V. supplies				
Feeding tube				

Modified utensils				
Glasses				
Contact lens				
Hearing aid				
TTY				
Modified phone				
Planner				
Programmable watch				
Med box				
Medical alert bracelet				
Medical alert tags				
Other				

Household Items

	Assessed Need	Needed prior to move-in	Provider	Acquisition Date
Furniture				
Bed				
Linens				
Durable medical Equipment				
Food				
House ware items				
Toiletries				
File box				
Other				
Other				
Other				

Additional Comments _____

Support/Safety

	Identified Need or Risk Factor	Risk Mitigation Plan Required	Risk Mitigation Plan Completed
Family/Friend is not available to assist in transition and continued community residence			
Has a history of not managing physical health problems or illness successfully in community			
Has had episode of not managing mental illness successfully in the community			
Hospital and/or nursing facility placement due to non-compliance with medications			
Has had frequent falls			
Has used emergency services within the last six months			
Has had frequent illness and/or medical hospitalization while in the community			
Has had prior failed episodes of living in the community			
Family has high concerns regarding safety in the community			
Has never lived alone			
Will require services from multiple service providers in the community			
Will require services from multiple service providers in the community			
Will require psychiatric services in the community and is not currently enrolled with a mental health service provider			



Colorado Department of Health Care Policy and Financing (HCPF)

Community Transitions Service Referral Tool

Service	Service Type	Referring Entity
Intensive Case Manager	Colorado Choice Transition (CCT)	Transition Coordinator
Behavioral Health Service	Colorado Choice Transition (CCT)	CCT CM
Family Services	Colorado Choice Transition (CCT)	CCT CM
Mentorship	Colorado Choice Transition (CCT)	CCT CM
Enhanced Nursing	Colorado Choice Transition (CCT)	CCT CM
Substance Abuse Counseling (Transitional)	Colorado Choice Transition (CCT)	CCT CM
Home Delivered Meals	Colorado Choice Transition (CCT)	CCT CM
Home Modification Extended	Colorado Choice Transition (CCT)	CCT CM
Assistive Technology	Colorado Choice Transition (CCT)	CCT CM
Independent Living Skills Training	Colorado Choice Transition (CCT)	CCT CM
Specialized Day Rehabilitation Services	Colorado Choice Transition (CCT)	CCT CM
Personal Emergency Response System (PERS)	HCBS-EBD, MI,DD	CCT, SEP or CCB CM
Adult Day Care	HCBS- BI, EBD, MI, PLWA,	CCT, SEP or CCB CM
Day Treatment	HCBS-BI	CCT, SEP CM
Mental Health Services	HCBS - BI	CCT, SEP CM
Behavioral Education/Management	HCBS - BI	CCT, SEP CM
Day Habilitation Services	HCBS-DD	CCT or CCB CM
Mentorship	HCBS- DD	CCT or CCB CM
Medication Reminder	HCBS- EBD, MI	CCT, SEP or CCB CM
Personal Care	HCBS- BI, DD, EBD,MI, PLWA	CCT, SEP or CCB CM
Relative Personal Care	HCBS-BI,EBD,MI,PLWA	CCT, SEP or CCB CM
Home Modification	HCBS-EBD,MI,BI	CCT, SEP or CCB CM
Home Accessibility Adaptations	HCBS-DD	CCT, SEP or CCB CM
Vehicle Modification	HCBS-DD	CCT, SEP or CCB CM
Consumer Directed Attendant Services (CDASS)	HCBS-DD,EBD,MI,PLWA	CCT, SEP or CCB CM
Non Medical Transportation	HCBS-BI,DD,EBD,MI,PLWA	CCT, SEP or CCB CM
Non Med Tran for Day Program	HCBS-BI,EBD,MI,PLWA	CCT, SEP or CCB CM
Assistive Technology	HCBS-BI,DD	CCT,SEP or CCB CM
Electronic Monitoring	HCBS-BI, EBD,MI,PLWA	CCT, SEP or CCB CM
Specialized Medical Supplies/Disposables	HCBS-DD	CCT, SEP or CCB CM
Specialized Medical Equipment	HCBS-DD	CCT, SEP or CCB CM
In-Home Support Services Health Maintenance Activities (IHSS)	HCBS-EBD,MI,PLWA	CCT, SEP or CCB CM
IHSS Personal Care Service	HCBS-EBD,MI,PLWA	CCT, SEP or CCB CM
IHSS Relative Personal Care	HCBS-EBD,MI,PLWA	CCT or SEP CM
IHSS Homemaker Services	HCBS-EBD,MI,PLWA	CCT or SEP CM
Independent Living Skills Training	HCBS-BI	CCT or SEP CM
Substance Abuse Counseling	HCBS-BI	CCT or SEP CM

Transitional Living	HCBS-BI	CCT or SEP CM
Homemaker	HCBS- DD,EBD,MI,PLWA	CCT or CCB CM
Supported Employment	HCBS-DD	CCT or CCB CM
Dental Services	HCBS-DD	CCT or CCB CM
Vision Services	HCBS-DD	CCT or CCB CM
Service	Service Type	Referring Entity
Adult Day Services	HCBS-PLWA	CCT or SEP CM
Substance Abuse Services	Medicaid State Plan	Nursing Facility (NF)
Emergency Services	Medicaid State Plan	NF
Home Health	Medicaid State Plan	NF
Physician	Medicaid State Plan	NF
Medical Transportation	Medicaid State Plan	NF
Prescription Medication	Medicaid State Plan	NF
Physical, Occupational, Speech Therapy	Medicaid State Plan	NF
Durable Medical Equipment & Disposable Supplies	Medicaid State Plan	NF
Podiatry Services	Medicaid State Plan	NF
Eyeglasses for adults after surgery	Medicaid State Plan	NF
Private Duty Nursing Services	Medicaid State Plan	NF
Program of All-Inclusive Care for the Elderly (PACE)	Medicaid State Plan	NF
Behavioral Health Organization (BHO) Services	Medicaid Managed Care Services	CCT SEP or CCB CM
Public Transportation	Community Resources	Transition Coordinator (TC)
Volunteer Opportunities	Community Resources	TC
Social Support	Community Resources	TC
Faith Community	Community Resources	TC
Housing	Community Resources	TC
Home Modification (non-waiver)	Community Resources	TC

Household Set-up

Allowable Items	Non-allowable Items
Cleaning	Cell phone
Damage & utility deposits	Convenience items
Food	Duplicate items
Furniture	Items for others
Household items	Monthly cleaning
Moving expenses	Monthly rent
Pest removal	Recreation & entertainment



Community Transition Services (CTS) Authorization Request/Cost Report

Client _____

Date _____

Transition Coordinator _____

Date _____

Allowable Items – *Enter under Item/Type of Service* Security deposit set up fees for utilities, household items, and furnishings moving expenses, health and safety assurances, food (\$100 limit)

Date	Item/Type of Service	Vendor Information	Estimated Cost	Final Cost
		Check payable to: Contact person: Address: Phone:		
		Receipts/Cancelled checks Yes No		
		Check payable to: Contact person: Address: Phone:		
		Receipts/Cancelled checks Yes No		
		Check payable to: Contact person: Address: Phone:		
		Receipts/Cancelled checks Yes No		
		Check payable to: Contact person: Address: Phone:		
		Receipts/Cancelled checks Yes No		
		Check payable to: Contact person: Address: Phone:		
		Receipts/Cancelled checks Yes No		
	Total Purchases CTS Items	T2038 U1 52		

SEP Case Manager Signature _____ Date _____

CTS AUTHORIZATION REQUEST PROCESS

Transition Coordinator

- Submits CTS Authorization Request Cost Report (AR/CR) to ICM after 30 day post transition home visit to client
- Includes copies of cancelled checks and receipts detailing items purchased
- Ensures all expenses requested are on Transition Plan

Case Manager

- Reviews Authorization Request/Cost Report
- Confirms client is established in community based residence
- Notifies TC of approval within 10 business days of receipt of AR/CR

Transition Coordinator

- Submits claim to Department's fiscal agent for reimbursement of purchases

Approval of the AR by the SEP case manager shall authorize the TCA to submit claims to the Department's fiscal agent for authorized CTS provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the TCA's use of correct billing procedures.

8.553.1.A. Incomplete ARs shall be returned to the TCA for correction within ten business days of receipt by SEP agency.



Community Transition Services (CTS) Documents

Form	Completed By	Information Source	Purpose	Destination
Transition Referral Information Form	TCA staff	Referral source	To document MDS or Medicaid phone referral. To obtain necessary information for the initial resident visit and to schedule the initial visit.	Client file
Authorization for Release of Information	Trnsition Coordinator	Client	Allows transition coordinator to give and obtain information about the client that is pertinent to transition assessment and planning	Client file
Transition Assessment	Transition Coordinator with Transition Options Team	Transition Options Team	To obtain information regarding the residents current admission, therapies, and prior community living experience. To obtain residents choice regarding interest in continued exploration of community living options. To assess for needed community resources for community-based residency.	Client file
Transition Plan	Transition Coordinator with Transition Options Team	Transition Options Team	To identify required community resource providers, service initiation and frequency. To identify required household items.	Submitted to SEP Agency Client file
Risk Mitigation Plan	Transition Coordinator with Transition Options Team	Transition Options Team	To develop plans to address and mitigate all risk factors identified on the risk assessment	Submitted to SEP Agency Client file
Authorization Request Cost Report	Transition Coordinator	Service providers	To obtain authorization from the SEP agency for payment for any purchases or deposits required to establish a community-based residence.	Submitted to SEP Agency
Community Transition Report	Community Transition Services Supervisor	Transition Coordinator	To provide participant specific information for State monitoring and reporting purposes.	Submitted to HCPF CTS Administrator by the 5th of each month
Monthly Referral Log	Community Transition Services Supervisor	Transition Coordinator	To provide MDS 3.0 and Medicaid referral and discharge information for State monitoring and reporting purposes.	Submitted to HCPF CTS Administrator by the 5th of each month



Colorado Department of Health Care Policy and Financing (HCPF)

Community Transition Services – Colorado Choice Transition (CCT) and HCBS – EBD

Authorization for Release of Information

Client Name _____

Client Address _____

Client Birth Date _____

Transition Coordination Agency (TCA) _____

I, the undersigned, hereby authorize the TCA to release and/or obtain verbal, electronic or written information regarding the above named individual with the following service providers and agencies for the purpose of transition assessment, planning, coordination/development of community resources and housing.

Name	Address/City/State/Zip	Relation to Client	Phone	Purpose	Information to be obtained	Information to be disclosed

1. I understand that the TCA cannot guarantee that the recipient will not disclose my health information to a third party. The recipient may not be subject to federal laws governing privacy of health information. I also understand that I may review the disclosed information. The TCA will not release information to any third party without written approval unless so ordered by subpoena or court order.
2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain Community Transition Services.
3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have effect on any action taken by the TCA in reliance of this Authorization before written notice is received. I further understand that I must provide any notice of revocation in writing to the TCA.
4. In addition to what is being considered, I would like my Transition Coordinator to obtain information about the following:

This release is in effect one year from this signature date or you may insert a different date _____

Signature of Client or Legal Guardian _____

Signature (and relationship if not the client)

Date



Colorado Department of Health Care Policy and Financing (HCPF)

Community Transition Report

Client Name _____
 Medicaid # _____ Non-Medicaid _____
 Transition Coordination Agency _____
 Transition Coordinator Name _____
 Nursing Facility _____
 Transition Assessment Date _____ Facility Discharge Date _____ Final Home Visit _____
 Type of Transition Community Transition Services (CTS) _____
 Colorado Choice Transitions (CCT) ___ Other ___

Transition Team Members

<input type="checkbox"/> Family/Significant Other	<input type="checkbox"/> Guardian	<input type="checkbox"/> Housing Coordinator
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Mental Health Provider	<input type="checkbox"/> Nurse
<input type="checkbox"/> Community Centered Board	<input type="checkbox"/> Area Agency on Aging	<input type="checkbox"/> Physician
<input type="checkbox"/> Ombudsman	<input type="checkbox"/> Other ILC Staff	<input type="checkbox"/>

Transition Location

<input type="checkbox"/> Independent Apartment	<input type="checkbox"/> Alternative Care Facility	<input type="checkbox"/> Family
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Residential Group Home	<input type="checkbox"/> CCT Qualified Residence

Community Transition Funds accessed for:

<input type="checkbox"/> Security Deposit	<input type="checkbox"/> Set-up Fee	<input type="checkbox"/>
<input type="checkbox"/> Household Items	<input type="checkbox"/> Furnishings	<input type="checkbox"/>
<input type="checkbox"/> Moving Expenses	<input type="checkbox"/> Food	<input type="checkbox"/>
<input type="checkbox"/> Health & Safety Assurances	<input type="checkbox"/> Home Modification	<input type="checkbox"/>

Community Supports in Place

<input type="checkbox"/> Single Entry Point	<input type="checkbox"/> Home Health Care	<input type="checkbox"/> Home Modification
<input type="checkbox"/> Mental Health Provider	<input type="checkbox"/> Family	<input type="checkbox"/> Spiritual Community
<input type="checkbox"/> Community Centered Board	<input type="checkbox"/> Personal Care	<input type="checkbox"/>
<input type="checkbox"/> Adult Day Services	<input type="checkbox"/> Homemaker	<input type="checkbox"/>
<input type="checkbox"/> Respite	<input type="checkbox"/> Electronic Monitoring	<input type="checkbox"/>

Site Visit Status

Visit	Client Status	Concerns/Complaints/Issues	Resolution
Prior to discharge			
Day of move			
1 week post discharge			
1 month post discharge			

SEP Case Manager Name _____
 Telephone Number _____
 E-Mail Address _____

TC vs ICM Roles & Responsibilities

Transition Coordinator	Intensive Case Manager
Act as advocate for Medicaid LTC facility resident	Complete intake and screening for Medicaid long-term services and supports
Identify potential facility residents that desire to return to their community	Conduct functional assessment & reassessment
Receive referrals from facility resident, family, friends, case managers, LTC facility staff	Develop HCBS/CCT care plans
Provide Options Counseling to referred facility residents	Determine functional eligibility for Medicaid LTC programs
Obtain informed consent to participate in the CCT Program from the client or guardian	Coordinate community transitions with the transitions coordinator
Make a referral to an intensive case management agency	Arrange and broker long-term care services and supports
Review the Consumer Transition Guide with the client and coach the client with completing questions	Coordinate and monitor the delivery of needed services
Convene transitions options team	Communicate with service providers regarding service delivery and concerns
Identify goals for independent living and community integration	Review and revise services, as necessary
Complete the Transition Assessment/Plan with transitions options team	Notify clients regarding any change in services
Develop Risk Mitigation Plan	Notify clients when services are denied, suspended, terminated, or reduced
Assist the resident with finding qualified housing (group home, assisted living, apartment, subsidized housing or family home)	Document, report, and resolve client complaints and concerns and critical incidents
Purchase household goods and assistive devices with relocation funds available through CTS benefit	Report abuse, neglect, mistreatment, and exploitation to the appropriate authority
Complete other activities necessary to establishing a community residence	Monitor Risk Mitigation Plan and adjust if necessary
Coordinate the facility discharge with the transition team	Monitor acquisition of independent living skills and progress toward independent living skills and community integration
Monitor the client for the first 30 days following the transition with the intensive case manager	Coordinate the transition to another case manager if necessary upon disenrollment from the CCT program and enrollment into a traditional HCBS program





Colorado Department of Health Care Policy and Financing (HCPF)

Community Transition Risk Mitigation Plan

	Identified Risk	Prevention Strategy Service/Support Type & Schedule	Monitoring and Reporting Plan	Risk Incident Response Plan
	Mental Health – capacity/cognition, depression screening, dementia screening, psychiatric hospitalization, suicide gestures/attempts, psycho-social stressors			
	Health and Wellness communication, seizures, skin integrity, sleep disturbance, preventive screenings, dental care, vision, hearing, bladder/bowel			
	Medication medication reviewed periodically, compliance, interactions and adverse reactions, emergency medication use			
	Nutrition choking, swallowing, diet compliance,			

	Identified Risk	Prevention Strategy Service/Support Type & Schedule	Monitoring and Reporting Plan	Risk Incident Response Plan
	Behavior Related aggressive behavior, self-injurious, substance use/abuse, unsafe/criminal sexual behavior, law breaking behavior, fire fascination/setting			
	Personal Safety risk of falls/mobility level, emotional or physical abuse, financial exploitation, caregiver stress/neglect, service refusal/interfering, social isolation			
	Environment unsanitary/unsafe housing, unsafe neighborhood, multi-client household			
	Resources Lack of adequate supports/services			
	Other history of unsuccessful transitions			



Colorado Department of Health Care Policy and Financing (HCPF)

Community Transition Participant Risk Agreement

Risk Assessment is an important part of the assessment and service planning process. This agreement serves as documentation of a conversation through which the individual or his/her legal representative have been presented with the potential risks identified through the assessment process, the source of those risks, the alternatives available to address the risks identified and an acknowledgement by the individual or his/her legal representative that the identified risks exist and the individual has agreed to assume these risks I order to return to the community

Name of Participant _____

Name of individuals involved in the risk identification and reduction discussion _____

Identifying and mitigating risks

My risk and choice regarding that risk	Negative outcomes that may result from this risk	Alternative things that I can do to prevent negative outcomes from this risk

I understand the risks identified above and the alternatives available to address the risks associated with my decisions. I have developed the attached risk mitigation plan with my transition options team and assume any risk that is not addressed by the services provided through the Colorado Choice Transitions program.

Participant/Legal Representative

Date

Case Manager

Date

Emergency Back-up Considerations

Communication needs	Emergency contacts
Diagnoses/medical conditions	Inventory of durable medical equipment
Disaster plan	Medical information
	Prevention of abuse, neglect & exploitation

Emergency Contact Form

Name _____
Relationship _____
Phone Number _____

Emergency Numbers

- 911
- Non-Emergency Police _____
- Poison Control _____
- Local Red Cross Office _____

Personal Information

Your Name _____ Date of Birth _____

Age _____ Phone Number _____

Address _____

Home Health Provider _____

Phone Number _____

Case Manager _____

Phone Number _____

Transition Coordinator _____

Phone Number _____

Trusted Person _____

Phone Number _____

Name and phone number of a person who has your Medical Durable Power of Attorney for Health Care Directives

Name _____

Phone Number _____



CCT Uniform Service Worksheet | 2013

Intensive Case Management																	
HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION																
T1016 <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Target Pop</th> <th style="width: 50%;">Mod</th> </tr> </thead> <tbody> <tr> <td>EBD</td> <td>UC</td> </tr> <tr> <td>EBD PD</td> <td>UC</td> </tr> <tr> <td>MI</td> <td>UC</td> </tr> <tr> <td>BI</td> <td>UC</td> </tr> <tr> <td>DD</td> <td>UC</td> </tr> <tr> <td>SLS</td> <td>UC</td> </tr> </tbody> </table>	Target Pop	Mod	EBD	UC	EBD PD	UC	MI	UC	BI	UC	DD	UC	SLS	UC	Case management, each 15 minutes. <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">SERVICE RATE</th> </tr> </thead> <tbody> <tr> <td>\$21.10</td> </tr> </tbody> </table>	SERVICE RATE	\$21.10
Target Pop	Mod																
EBD	UC																
EBD PD	UC																
MI	UC																
BI	UC																
DD	UC																
SLS	UC																
SERVICE RATE																	
\$21.10																	
SERVICE DEFINITION	MINIMUM DOCUMENTATION REQUIREMENTS																
<p>Case management services to assist clients in assessing needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition and independent living goals.</p>	<ul style="list-style-type: none"> • Client demographic information • Duration of each contact • Each contact with and on behalf of client • Nature and extent of service • Date and place of service delivery • Mode of contact (face-to-face/telephone) • Issues addressed (CCT services, family, income/ support, legal, medication, educational, housing, interpersonal, medical/dental/behavioral health, vocational, behavioral services, other client issues) • Client's response • Progress toward care plan goals and objectives • Type of activity and specific functions <ul style="list-style-type: none"> ○ Assessment ○ Care plan indicating that client was provided choice ○ Referrals ○ Monitoring and follow-up ○ Critical Incidents • Conflict mitigation 																
NOTES	EXAMPLE ACTIVITIES																
<p><i>Case management involves linking the consumer to the direct delivery of needed services, but is not itself the direct delivery of a service to which the consumer has been referred.</i> Weekly contacts are required for the duration of the assigned client's enrollment. Weekly contacts can either be home visits or telephone calls based on necessity. On the date of discharge, the case manager is required to conduct a home visit with the client and transition coordinator to ensure the client is safe, confirm the start of services and to alleviate any concerns the client may</p>	<ul style="list-style-type: none"> • Confirm CCT eligibility requirements by verifying client had qualified nursing home stay and moved to a qualified community residence. • Assess the need for service(s), identifying and investigating available resources, explaining options to participant and assisting with referral and procurement of services. • Contact with clients' family members or informal supports to assist client with accessing services. 																

<p>have with their transition. Case manager is required to conduct a check-in with the client 48 hours post-discharge. Three additional home visits are required in the first month of program enrollment. Best practice is joint visit between the transition coordination agency and the case management agency within 30 days of discharge. All critical incidents will be reported via the department approved process and investigated. Necessary follow-up to remediate the situation will be at the discretion of the case manager. Hospitalizations and reinstitutionalizations should be documented as soon as possible to adjust CCT enrollment period. Services assist individuals' access to needed long-term services and supports (LTSS), Medicaid State Plan services, non-Medicaid supports and services to support clients in their return to the community from institutional placement, and to aid the client in attaining their transition and independent living goals identified in the Consumer Transition Guides. Case managers are expected to coordinate with other local agencies, such as Mental Health Centers, for the purpose of joint service planning and the arrangement of services. Case Manager is responsible for:</p> <ul style="list-style-type: none"> • Assessing needs; • Determining eligibility; • Service planning and authorization; • Care coordination; • Risk mitigation; • Service monitoring; • Monitoring the health, welfare and safety of the client; and • Promotion of client's self-advocacy. 	<ul style="list-style-type: none"> • Conduct home visits and telephone calls for the purpose of monitoring and reassessing the health, welfare and safety of the client to determine appropriateness of services and client satisfaction. • Report, investigate and remediate critical incidents. • Develop risk mitigation plan with client to prevent reinstitutionalization and critical incidents. Modify as needed particularly following a discharge after reinstitutionalization or after a critical incident. • Coordinate care with mental health centers for clients with mental illness. • Assess and monitor progress with achieving goals and increased independence. • Seek input from medical and service providers to inform assessment and monitoring activities. • Verify with client that he/she is making medical appointments. • Resource development to ensure client has access to providers and services. 	
APPLICABLE POPULATION(S)	UNIT	CAP
<input checked="" type="checkbox"/> Elderly <input checked="" type="checkbox"/> Developmentally Disabled <input checked="" type="checkbox"/> Physically Disabled <input checked="" type="checkbox"/> Mentally Ill	<input type="checkbox"/> Encounter <input checked="" type="checkbox"/> 15 Minutes <input type="checkbox"/> Day <input type="checkbox"/> 30 Minutes <input type="checkbox"/> Month <input type="checkbox"/> 1 Hour <input type="checkbox"/> Other	Minimum: Maximum:
ALLOWED MODE(S) OF DELIVERY	UNIT AND LIMITATIONS EXPLANATION	
<input checked="" type="checkbox"/> Face-to-Face <input type="checkbox"/> Individual <input type="checkbox"/> Family (HS) <input checked="" type="checkbox"/> Video Conf <input type="checkbox"/> Group (HQ) <input checked="" type="checkbox"/> On-Site <input checked="" type="checkbox"/> Telephone <input type="checkbox"/> Family (HR) <input type="checkbox"/> Off-Site	The designated unit is 15 minutes. A 15 minute unit is being used as a result of a change to Targeted Case Management in July of 2009, when DDD switched from a per member per month methodology to a 15 minute unit and rate to satisfy CMS concerns.	



CCT Uniform Service Worksheet | 2013

MINIMUM STAFF REQUIREMENTS	
<input type="checkbox"/> Peer Specialist	<input type="checkbox"/> Unlicensed
<input type="checkbox"/> Less Than Bachelor's Level (HM)	<input type="checkbox"/> Unlicensed EdD/ PhD/PsyD (HP)
<input checked="" type="checkbox"/> Bachelor's Level (HN)	<input type="checkbox"/> QMAP
<input type="checkbox"/> Master's Level (HO)	<input type="checkbox"/> Psych Tech
<input type="checkbox"/> LCSW (AJ)/LSW/ LMFT/ LPC	<input type="checkbox"/> RN (TD)
<input type="checkbox"/> Licensed EdD/ PhD/PsyD (AH)	<input type="checkbox"/> APRN (SA)
	<input type="checkbox"/> LPN/LVN
	<input type="checkbox"/> RxN (SA)
	<input type="checkbox"/> PA (PA)
	<input type="checkbox"/> MD/DO (AF)
	<input type="checkbox"/> Other _____
ADDITIONAL STAFF REQUIREMENTS	
Degree must be a health, human service, social work or related field. Minimum two years case management experience working with long-term services and supports in the geographic region of the case management agency. Two years case management experience can be substituted for a Bachelor's level degree.	
PLACE OF SERVICE (POS)	
<input checked="" type="checkbox"/> CMHC	<input type="checkbox"/> Cust Care
<input checked="" type="checkbox"/> Office	<input checked="" type="checkbox"/> NF
<input type="checkbox"/> Outpatient Hospital	<input checked="" type="checkbox"/> Grp Home
<input type="checkbox"/> ACF	<input checked="" type="checkbox"/> SNF
	<input checked="" type="checkbox"/> Home
	<input checked="" type="checkbox"/> Temp Lodging
	<input checked="" type="checkbox"/> ICF-MR
	<input checked="" type="checkbox"/> Inpt Hosp
	<input checked="" type="checkbox"/> Inpt PF
	<input checked="" type="checkbox"/> ER
	<input checked="" type="checkbox"/> Other POS
	<input checked="" type="checkbox"/> PF-PHP
	<input type="checkbox"/> _____Community_
	<input checked="" type="checkbox"/> Pharmacy
PROVIDER QUALIFICATIONS	APPLICABLE STATUTE, LEGAL AUTHORITY, COLORADO CODE OF REGULATIONS
Provider must currently provide case management to specified target populations served through CCT and administer Medicaid HCBS waiver programs for one or more of the target populations. Case management services will be provided by Community Centered Boards (CCBs) or Single Entry Point Agencies.	<p>§8.487.20 HCBS-EBD Provider Agencies General Certification</p> <p>§8.555 Colorado Choice Transitions, A Money Follows the Person Demonstration</p>

CCT ICM Responsibilities

Referral

- Client selects Intensive Case Management Agency
- ICM is assigned and meets with the resident
- ICM explains his/her role in the CCT program

Transition Process

- Joins the client's Transition Options Team
- Reviews the client's universal LTC assessment tool (ULTC 100.2)
- Conducts a new ULTC 100.2 if needed
- Participates in assessment process

After Transition

- Conducts home visit with the transition coordinator on the date of discharge to:
 - Confirm the start of services,
 - Ensure clients are safe,
 - Identify and address any unanticipated concerns, issues or problems clients may have with transition
- Completes check-in with the client by phone 48 hours after discharge and conducts any necessary follow-up activities needed
- Makes 3 additional home visits in the first month that clients are enrolled in the program to provide support for success with community living

- Has weekly contacts with clients, family members, guardians or other designated representative for the duration of their enrollment in the CCT program to:
 - Monitor services and the health, welfare and safety of clients,
 - Review functional status,
 - Conduct any necessary follow-up activities
- Ensures independent living in the community
- Revises service plan as needed based on weekly contacts
- Monitors progress toward acquisition of required skills to remain in community with traditional HCBS services

CCT Demonstration Services

Community
Transition
Services

Intensive Case
Management

Independent
Living Skills
Training

Substance Abuse
Counseling,
Transitional

Assistive
Technology,
Extended

Home
Modifications,
Extended

Transitional
Behavioral
Health Supports

Caregiver
Education

Dental Services

Enhanced
Nursing

Home Delivered
Meals

Vision Services

Peer Mentorship

Transitional
Specialized Day
Rehabilitation

CCT Demonstration Services

CCT Demonstration Services will complement existing HCBS services in one of five waivers: Elderly, Blind and Disabled, Persons with Brain Injury, Persons with Developmental Disabilities, Community Mental Health Supports, and Supported Living Services. Demonstration services will be available for 365 day post-transition to the community. The services are defined as:

Assistive Technology, Extended means devices, items, pieces of equipment, or product system used to increase, maintain, or improve functional capabilities of clients and training in the use of the technology when the cost is not otherwise covered through the State Plan durable medical equipment benefit or home modification waiver benefit or available through other means.

Transitional Behavioral Health Supports means services by a paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community.

Caregiver Education Services means educational and coaching services that assist clients and family members to recruit other family members and friends to form an informal caregiver network to share caregiving responsibilities.

Community Transition Services means services as defined at Section 8.553.

Dental Extended Services means dental services that are inclusive of diagnostic, preventive, periodontal and prosthodontic services, as well as basic restorative and oral surgery procedures to restore the client to functional dental health and not available through the Medicaid State Plan.

Enhanced Nursing Services means medical care coordination provided by a nurse for medically complex clients who are at risk for negative health outcomes associated with fragmented medical care and poor communication between primary care physicians, nursing staff, case managers, community-based providers and specialty care providers.

Home Delivered Meals means nutritious meals delivered to homebound clients who are unable to prepare their own meals and have no outside assistance.

Home Modifications, Extended means physical adaptations to the home, required by the client's plan of care, necessary to ensure the health, welfare, safety and independence of the client above and beyond the cost of caps that exist in applicable Home and Community-Based (HCBS) waivers.

Independent Living Skills Training means services designed to improve or maintain a client's physical, emotional, and economic independence in the community with or without supports.

Intensive Case Management means case management services to assist clients' access to needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition goals.

Peer Mentorship Services means services provided by peers to promote self-advocacy among clients by instructing, providing experiences, modeling successful, problem-solving and advising on issues and topics related to community living.

Transitional Specialized Day Rehabilitation means services offered in a group setting designed and directed at the development and maintenance of the client's ability to independently, or with support, sustain himself/herself physically, emotionally and economically in the community.

Substance Abuse, Transitional means enhanced individual or group substance abuse counseling, behavioral interventions, or consultations to address issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's sobriety. Services can be provided in the home or office setting.

Vision Services means services that include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems when not available through the Medicaid State Plan.

HCBS Waivers

PERSONS with BRAIN
INJURY

COMMUNITY
MENTAL HEALTH
SUPPORTS

PERSONS who are
ELDERLY, BLIND, AND
DISABLED (AGE 18 –
64)

PERSONS who are
ELDERLY, BLIND, AND
DISABLED (AGE 65+)

SUPPORTED LIVING
SERVICES

PERSONS with
DEVELOPMENTAL
DISABILITIES

CCT-Persons with Brain Injury (BI) Waiver Demonstration Services

- Caregiver Education
- Community Transition Services
- Dental Services
- Enhanced Nursing
- Home Delivered Meals
- Home Modifications, Extended
- Intensive Case Management
- Peer Mentorship
- Transitional Specialized Day Rehabilitation Services
- Vision Services

CCT-Community Mental Health Supports (CMHS) Waiver Demonstration Services

- Assistive Technology, Extended
- Caregiver Education
- Community Transition Services
- Dental Services
- Enhanced Nursing
- Home Delivered Meals
- Home Modifications, Extended
- Independent Living Skills Training
- Intensive Case Management
- Peer Mentorship
- Substance Abuse Counseling, Transitional
- Transitional Behavioral Health Supports
- Transitional Specialized Day Rehabilitation Services
- Vision Services

CCT-Persons with Developmental Disabilities (DD) Waiver Demonstration Services

- Assistive Technology, Extended
- Community Transition Services, Coordinator
- Community Transition Services, Items Purchased
- Enhanced Nursing
- Home Modifications, Extended
- Intensive Case Management
- Peer Mentorship
- Substance Abuse Counseling, Transitional, Group

CCT-Elderly Blind & Disabled (EBD) Waiver Demonstration Services

- Assistive Technology, Extended
- Caregiver Education
- Community Transition Services
- Dental Services
- Enhanced Nursing
- Home Delivered Meals
- Home Modifications, Extended
- Independent Living Skills Training
- Intensive Case Management
- Peer Mentorship
- Substance Abuse Counseling, Transitional
- Transitional Behavioral Health Supports
- Transitional Specialized Day Rehabilitation Services
- Vision Services

CCT-Supported Living Services (SLS) Waiver Demonstration Services

- Caregiver Education
- Community Transition Services
- Enhanced Nursing
- Home Modifications, Extended
- Independent Living Skills Training
- Intensive Case Management
- Substance Abuse Counseling, Transitional
-

COLORADO CHOICE TRANSITIONS SAMPLE SERVICE PLAN

IDENTIFYING INFORMATION

Client Name (Last, First, MI)	Staffing Date ____/____/____ Dates Covered / / THRU / /
Medicaid ID #	
Legal Guardian(s) Name:	

CCT Plan of Care

Services	Frequency	Revisions	Frequency	Service Goals
<input type="checkbox"/> Community Transition Services Provider	_____ Pre-Transition Services _____ Transition Services _____ Total Units	Reason Provider: Date ____/____/____	_____ Pre-Transition Services _____ Transition Services _____ Total Units	

CCT Services

Services	Frequency	Revisions	Frequency	Service Goals
<input type="checkbox"/> Intensive Case Management Provider(s):	_____ Units/Week _____ Total Units	Reason Provider: Date ___/___/___	_____ Units/Week _____ Total Units	
<input type="checkbox"/> Provider(s):	List items, total units, costs and expected dates of purchase:	Reason Provider: Date ___/___/___	_____ Item/Procedure _____ Cost _____ Total Units	

CCT Services

CCT Services				
Services	Frequency	Revisions	Frequency	Service Goals
<input type="checkbox"/> Provider(s):	_____ Units/Week _____ Total Units	Reason Provider: Date ___/___/___	_____ Units/Week _____ Total Units	
<input type="checkbox"/> Provider(s):	List items, total units, costs and expected dates of purchase:	Reason Provider: Date ___/___/___	_____ Item/Procedure _____ Cost _____ Total Units	

CCT Services

Services	Frequency	Revisions	Frequency	Service Goals
<input type="checkbox"/> Provider(s):	___ Individual _____ Units/Week _____ Total Units ___ Group _____ Units/Week _____ Total Units	Reason Provider: Date ___/___/___	___ Individual _____ Units/Week _____ Total Units ___ Group _____ Units/Week _____ Total Units	
<input type="checkbox"/> Provider(s):	___ RN _____ Units/Week _____ Total Units ___ LPN _____ Units/Week _____ Total Units	Reason Provider: Date ___/___/___	___ RN _____ Units/Week _____ Total Units ___ LPN _____ Units/Week _____ Total Units	

CCT Services

CCT Services				
Services	Frequency	Revisions	Frequency	Service Goals
<input type="checkbox"/> Provider(s):	_____ Units/Week _____ Total Units	Reason Provider: Date ___/___/___	_____ Units/Week _____ Total Units	
<input type="checkbox"/> Provider(s):	_____ Units/Week _____ Total Units	Reason Provider: Date ___/___/___	_____ Units/Week _____ Total Units	

CCT Services

Services	Frequency	Revisions	Frequency	Service Goals
<input type="checkbox"/> Provider(s):	List modifications, total units, costs and expected dates of purchase:	Reason Provider: Date ___/___/___	List modifications, total units, costs and expected dates of purchase:	
<input type="checkbox"/> Provider(s):	_____ Units/Week _____ Total Units	Reason Provider: Date ___/___/___	_____ Units/Week _____ Total Units	

CONTINGENCY PLAN

Identify a back-up plan to address contingencies such as “emergencies” that put a participant’s health and welfare at risk.

Emergencies include the failure of a family member, support worker, or caregiver to appear when scheduled to provide necessary services when the absence of the services presents a risk to the participant.

CLIENT GOAL

My goals for this Plan of Care (monthly)

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

CCT - Persons with Brain Injury Demonstration



CCT-UC

PA Number being revised:

Revision? Yes No

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE
		<input type="checkbox"/> M <input type="checkbox"/> F	
5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)	
		8. DATES COVERED	
		From:	Through:

STATEMENT OF REQUESTED SERVICES

9. Qualified Services Description	10. Modifier	11. Max. # Units	12. Cost Per Unit	13. Total \$ Authorized	14. Comments:
S5102 Adult Day Services (UC)					
T2029 Assistive Technology, per purchase (UC)					
H0025 Behavioral Programming (UC)					
H2018 Day Treatment (UC)					
S5165 Home Modifications (UC)					
T2013 Independent Living Skills Training (ILST) (UC)					
H0004 Mental Health Counseling, Family (UC)	HR				
H0004 Mental Health Counseling, Group (UC)	HQ				
H0004 Mental Health Counseling, Individual (UC)					
A0100 Non-Medical Transportation, Taxi (UC)					
A0120 Non-Medical Transportation, Mobility Van (UC)					
A0130 Non-Medical Transportation, Wheelchair Van (UC)					
T1019 Personal Care (UC)	TG				
S5160 Personal Emergency Response System (PERs), Install/Purchase (UC)					
S5161 PERs, Monitoring (UC)					
T1019 Relative Personal Care (UC)	HR, TG				
H0045 Respite Care, NF (UC)					
S5150 Respite Care, In Home (UC)					
T1006 Substance Abuse Counseling, Family (UC)	HR, HF				
H0047 Substance Abuse Counseling, Group (UC)	HQ, HF				
H0047 Substance Abuse Counseling, Individual (UC)	HF				
T2033 Supported Living Program (UC)					
T2016 Transitional Living, per day (UC)					
Demonstration Services Description					
S5110 Caregiver Education (UC)					
T2038 Community Transition Services, Coordinator (UC)					
A9900 Community Transition Services, Items Purchased (UC)					
D2999 Dental (UC)					
T1002 Enhanced Nursing, RN (UC)					
S5170 Home Delivered Meals (UC)					
S5165 Home Modifications, Extended (UC)	KG				
T1016 Intensive Case Management (UC)					
H2015 Peer Mentorship (UC)					
S5101 Transitional Specialized Day Rehabilitation Services (UC)					
V2799 Vision (UC)					

15a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)	\$0.00	15c. Subtotal
15b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)	\$0.00	\$0.00
16. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)		\$0.00
17. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT SERVICES EXPENDITURES + HOME HEALTH EXPENDITURES)		\$0.00
18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)		
19. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)		\$0.00
A. Monthly State Cost Containment Amount		\$0.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling		\$0.00

20. Immediately prior to CCT Services enrollment, this client lived in a long term care facility? Yes No

21. CASE MANAGER NAME	22. AGENCY	23. PHONE #	24. EMAIL	25. DATE
26. CASE MANAGER'S SUPERVISOR NAME	27. AGENCY	28. PHONE #	29. EMAIL	30. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

32. CASE PLAN: Approved Date: _____ Denied Date: _____ Return for correction- Date: _____

33. REGULATION(S) upon which Denial or Return is based:

34. DEPARTMENT APPROVAL SIGNATURE: _____ 35. DATE: _____

36. CCT-BI-CE CCT-BI-300

Colorado Choice Transitions (CCT) PAR Completion Instructions
FORM MUST BE COMPLETED ELECTRONICALLY OR IN BLACK BALLPOINT - PLEASE PRINT

Complete this form for Prior Authorization Requests for CCT-BI. Submit the PAR per the instructions listed at the bottom.

Complete the Revision section at the top of the form only if you are revising a current approved PAR.

For PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were approved on the original PAR.

Complete the following required fields:

1. **Client Name:** Enter the client's name.
2. **Client ID:** Enter the client's Medical Assistance Program ID number.
3. **Sex:** Check M or F.
4. **Birthdate:** Enter the client's date of birth.
5. **Requesting Provider #:** Enter the requesting provider's Medical Assistance Program provider number.
6. **Client's County:** Enter the client's county of residence.
7. **Case Number (for Agency use) - Optional:** Enter the agency's case number for this PAR.
8. **Dates Covered (From and Through):** Enter the PAR start date and PAR end date.
9. **Description:** List of approved procedure codes of qualified and demonstration services.
10. **Modifier:** Enter HB, TT, TN modifiers as applicable for Non-Medical Transportation (to and from Adult Day).
11. **Max # Units:** Enter the number of units next to the services for which you are requesting reimbursement.
12. **Cost Per Unit:** Enter the cost per unit of service.
13. **Total \$ Authorized:** The total dollar amount automatically populates.
14. **Comments - Optional:** Enter any additional useful information. For example, if a service is authorized for different dates than in Box 8, please include the HCPC and date span here.
- 15a. **Total Authorized CCT Qualified Services Expenditures:** Total automatically populates.
- 15b. **Total Authorized CCT Demonstration Service Expenditures:** Total automatically populates.
- 15c. **Subtotal of CCT Qualified and Demonstration Services:** Subtotal automatically populates.
16. **Plus Total Authorized Home Health Expenditures** (Sum of Authorized Home Health Services during the HCBS Care Plan Period): Enter the total Authorized Home Health expenditures.
17. **Equals Client's Maximum Authorized Cost:** The CCT Expenditures + Home Health Expenditures automatically populates.
18. **Number of Days Covered:** The number of days covered automatically populates.
19. **Average Cost Per Day:** The client's maximum authorized cost divided by number of days in the care plan period automatically populates.
- 19a. **Monthly State Cost Containment Amount:** Enter the monthly state cost containment amount for the relevant level of care.
- 19b. **Divided by 30.42 days = Daily Cost Containment Ceiling:** The daily cost containment ceiling automatically populates.
20. **Immediately prior to CCT enrollment, this client lived in a long term care facility:** Check Yes or No.
21. **Case Manager Name:** Enter the name of the Case Manager.
22. **Agency:** Enter the name of the agency.
23. **Phone #:** Enter the phone number of the Case Manager.
24. **Email:** Enter the email address of the Case Manager.
25. **Date:** Enter the date completed.
26. **Case Manager Supervisors Name:** Enter the name of the Case Manager's Supervisor.
27. **Agency:** Enter the name of the agency.
28. **Phone #:** Enter the phone number of the Case Manager's Supervisor.
29. **Email:** Enter the email address of the Case Manager's Supervisor.
30. **Date:** Enter the date completed.

"DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY". This is for Department use only.

Send only **New, Continued Stay Review (CSR)**, and **Revised PARs** to:

Encrypted Email:
CCTPars@state.co.us

Fax:
303-866-2786

Mail:
The Colorado Department of Health Care Policy and
Financing
Attn: Long Term Services and Supports Division
1570 Grant St.
Denver, CO 80203-1818

Note: Any PAR for the CCT Demonstration Project sent directly to the fiscal agent for the Colorado Medical Assistance Program will be returned to the case manager.

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT



CCT - Community Mental Health Supports Demonstration

CCT-UC

PA Number being revised:

Revision? Yes No

1. CLIENT NAME		2. CLIENT ID		3. SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. BIRTHDATE	
5. REQUESTING PROVIDER #		6. CLIENT'S COUNTY		7. CASE NUMBER (AGENCY USE)		8. DATES COVERED From: _____ Through: _____	

STATEMENT OF REQUESTED SERVICES

9. Qualified Services Description	10. Modifier	11. Max # Units	12. Cost Per Unit	13. Total \$ Authorized	14. Comments:
S5105 Adult Day Services, Basic (UC)					
S5105 Adult Day Services, Specialized (UC)	TF				
T2031 Alternative Care Facility (ACF) (UC)					
T2025 Consumer Directed Attendant Support Services (CDASS) (UC)					
T2040 CDASS Per Member/ Per Month (PM/PM) (UC)					
S5165 Home Modifications (UC)					
S5130 Homemaker (UC)					
T2029 Medication Reminder, Install/Purchase (UC)					
S5185 Medication Reminder, Monitoring (UC)					
A0100 Non-Medical Transportation, Taxi (UC)					
A0120 Non-Medical Transportation, Mobility Van (UC)					
A0130 Non-Medical Transportation, Wheelchair Van (UC)					
T1019 Personal Care (UC)					
S5160 Personal Emergency Response System (PERs) Install/Purchase (UC)					
S5161 PERs, Monitoring (UC)					
T1019 Relative Personal Care (UC)	HR				
H0045 Respite Care, NF (UC)					
S5151 Respite Care, ACF (UC)					
Demonstration Services Description					
T2029 Assistive Technology, Extended (UC)					
S5110 Caregiver Education (UC)					
T2038 Community Transition Services, Coordinator (UC)					
A9900 Community Transition Services, Items Purchased (UC)					
D2999 Dental (UC)					
T1002 Enhanced Nursing, RN (UC)					
S5170 Home Delivered Meals (UC)					
S5165 Home Modifications, Extended (UC)	KG				
H2014 Independent Living Skills Training (ILST) (UC)					
T1016 Intensive Case Management (UC)					
H2015 Peer Mentorship (UC)					
H0047 Substance Abuse Counseling, Transitional, Group (UC)	HF, HQ				
H0047 Substance Abuse Counseling, Transitional, Individual (UC)	HF				
H0025 Transitional Behavioral Health Supports (UC)					
S5101 Transitional Specialized Day Rehabilitation Services (UC)					
V2799 Vision (UC)					

15a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF A QUALIFIED SERVICES)	\$0.00	15c. Subtotal
15b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)	\$0.00	\$0.00

16. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)-
Excludes In-Home Support Services amounts \$0.00

17. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES) \$0.00

18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)

19. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period) \$0.00

A. Monthly State Cost Containment Amount	\$5,361.22
B. Divided by 30.42 days = Daily Cost Containment Ceiling	\$176.24

20. CDASS (amounts must match client's allocation worksheet)	Effective Date:	Monthly Allocation Amt:	\$0.00	Monthly Admin Fee:	\$0.00
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21. Immediately prior to CCT enrollment, this client lived in a long term care facility? Yes No

22. CASE MANAGER NAME	23. AGENCY	24. PHONE #	25. EMAIL	26. DATE
27. CASE MANAGER'S SUPERVISOR NAME	28. AGENCY	29. PHONE #	30. EMAIL	31. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

32. CASE PLAN: Approved Date: _____ Denied Date: _____ Return for correction- Date: _____

33. REGULATION(S) upon which Denial or Return is based:

34. DEPARTMENT APPROVAL SIGNATURE: _____ 35. DATE: _____

36. CCT-MI-CE CCT-MI-300

Colorado Choice Transitions (CCT) PAR Completion Instructions
FORM MUST BE COMPLETED ELECTRONICALLY OR IN BLACK BALLPOINT- PLEASE PRINT

Complete this form for Prior Authorization Requests for CCT-CMHS. Submit the PAR per the instructions listed at the bottom.

Complete the Revision section at the top of the form only if you are revising a current approved PAR.

For PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were approved on the original PAR.

Complete the following required fields:

1. **Client Name:** Enter the client's name.
2. **Client ID:** Enter the client's Medical Assistance Program ID number.
3. **Sex:** Check M or F.
4. **Birthdate:** Enter the client's date of birth.
5. **Requesting Provider #:** Enter the requesting provider's Medical Assistance Program provider number.
6. **Client's County:** Enter the client's county of residence.
7. **Case Number (for Agency use) - Optional:** Enter the agency's case number for this PAR.
8. **Dates Covered (From and Through):** Enter the PAR start date and PAR end date.
9. **Description:** List of approved procedure codes of qualified and demonstration services.
10. **Modifier:** Enter HB, TT, TN modifiers as applicable for Non-Medical Transportation (to and from Adult Day).
11. **Max # Units:** Enter the number of units next to the services for which you are requesting reimbursement.
12. **Cost Per Unit:** Enter the cost per unit of service.
13. **Total \$ Authorized:** The total dollar amount authorized for the service automatically populates.
14. **Comments -Optional:** Enter any additional useful information. For example, if a service is authorized for different dates than in Box 8, please include the HCPC and date span here.
- 15a. **Total Authorized CCT Qualified Service Expenditures:** Total automatically populates.
- 15b. **Total Authorized CCT Demonstration Service Expenditures:** Total automatically populates.
- 15c. **Subtotal of CCT Qualified and Demonstration Services:** Subtotal automatically populates.
16. **Plus Total Authorized Home Health Expenditures (Sum of Authorized Home Health Services during the HCBS Care Plan Period):** Enter the total Authorized Home Health expenditures.
17. **Equals Client's Maximum Authorized Cost:** The CCT Expenditures + Home Health Expenditures automatically populates.
18. **Number of Days Covered:** The number of days covered automatically populates.
19. **Average Cost Per Day:** The client's maximum authorized cost divided by number of days in the care plan period automatically populates.
- 19a. **Monthly State Cost Containment Amount:** The monthly state cost containment amount automatically populates.
- 19b. **Divided by 30.42 days = Daily Cost Containment Ceiling:** The daily cost containment ceiling automatically populates.
20. **CDASS:** Enter CDASS information. (All CDASS information must be entered into PPL's web portal.)
21. **Immediately prior to CCT enrollment, this client lived in a long term care facility:** Check Yes or No.
22. **Case Manager Name:** Enter the name of the Case Manager.
23. **Agency:** Enter the name of the agency.
24. **Phone #:** Enter the phone number of the Case Manager.
25. **Email:** Enter the email address of the Case Manager.
26. **Date:** Enter the date completed.
27. **Case Manager's Supervisor Name:** Enter the name of the Case Manager's Supervisor.
28. **Agency:** Enter the name of the agency.
29. **Phone #:** Enter the phone number of the Case Manager's Supervisor.
30. **Email:** Enter the email address of the Case Manager's Supervisor.
31. **Date:** Enter the date completed.

"DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY". This is for Department use only.

Send only New, Continued Stay Review (CSR), and Revised PARs to:

Encrypted Email:
CCTPars@state.co.us

Fax:
303-866-2786

Mail:
The Colorado Department of Health Care Policy and
Financing
Attn: Long Term Services and Supports Division
1570 Grant St.
Denver, CO 80203-1818

Note: Any PAR for the CCT Demonstration Project sent directly to the fiscal agent for the Colorado Medical Assistance Program will be returned to the case manager.

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING



REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT
CCT - Persons with Developmental Disabilities Demonstration

CCT-UC
 PA Number being revised:
 Revision? Yes No

1. CLIENT NAME _____ 2. CLIENT ID _____ 3. SEX M F 4. BIRTHDATE: _____
 5. SUPPORT LEVEL (1-7) 1 2 3 4 5 6 7
 6. REQUESTING PROVIDER # _____ 7. CLIENT'S COUNTY _____ 8. CASE NUMBER (AGENCY USE) _____ 9. DATES COVERED
 From: _____ Through: _____

STATEMENT OF REQUESTED SERVICES

10. Qualified Services Description	11. Support Level	12. Modifier	13. Max # Units	14. Cost Per Unit	15. Total \$ Authorized	16. Comments:
Behavioral Services						
H2019 Line Services (UC)						
H2019 Behavioral Consultation (UC)		HI, TG				
H2019 Behavioral Counseling, Individual (UC)		TF, TG				
H2019 Behavioral Counseling, Group (UC)		TF, HQ				
T2024 Behavioral Plan Assessment (UC)		HI				
Day Habilitation						
T2021 Specialized Day Habilitation (UC)	-----					
T2021 Supported Community Connections (UC)	-----					
Dental						
D2999 Dental, Basic/ Preventive (UC)						
D2999 Dental, Major (UC)		TF				
Non-Medical Transportation						
T2003 To/From Day Program, Mileage Range (UC)	-----					
T2004 Other (Public Conveyance) (UC)						
Pre-Vocational Services						
T2015 Pre-Vocational Services (UC)	-----					
Residential Services						
T2016 Group Home (UC)	-----					
T2016 Personal Care Alternative (UC)	-----					
T2016 Host Home (UC)	-----					
Supported Employment						
T2019 Supported Employment, Individual, All Levels (1-6) (UC)		HI				
T2019 Supported Employment, Group (UC)	-----					
H2023 Job Development, Individual (UC)	Level 1-2					
H2023 Job Development, Individual (UC)	Level 3-4	HI				
H2023 Job Development, Individual (UC)	Level 5-6	TF				
H2023 Job Development, Group, All Levels (1-6) (UC)		HQ				
H2024 Job Placement, Individual, All Levels (1-6) (UC)						
H2024 Job Placement, Group, All Levels (1-6) (UC)		HQ				
Specialized Medical Equipment						
T2028 Specialized Medical Equipment, Disposable (UC)						
T2029 Specialized Medical Equipment (UC)						
V2799 Vision (UC)						
Demonstration Services Description						
T2029 Assistive Technology, Extended (UC)						
S5110 Caregiver Education (UC)						
T2038 Community Transition Services, Coordinator (UC)						
A9900 Community Transition Services, Items Purchased (UC)						
T1002 Enhanced Nursing, RN (UC)						
S5165 Home Accessibility Adaptations, Extended (UC)		KG				
T1016 Intensive Case Management (UC)						
H2015 Peer Mentorship (UC)						
H0047 Substance Abuse Counseling, Transitional, Group (UC)		HF, HQ				
H0047 Substance Abuse Counseling, Transitional, Individual (UC)		HF				

17a. TOTAL AUTHORIZED CCT QUALIFIED SERVICES EXPENDITURES (SUM OF QUALIFIED SERVICES) **\$0.00** 17c. Subtotal
 17b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICES EXPENDITURES (SUM OF DEMONSTRATION SERVICES) **\$0.00**
 18. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD) **\$0.00**
 19. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES) **\$0.00**
 20. NUMBER OF DAYS COVERED (FROM FIELD 9 ABOVE)
 21. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period) **\$0.00**
 22. Immediately prior to CCT enrollment, this client lived in a long term care facility? Yes No

23. CASE MANAGER NAME _____ 24. AGENCY _____ 25. PHONE # _____ 26. EMAIL _____ 27. DATE _____
 28. CASE MANAGER'S SUPERVISOR NAME _____ 29. AGENCY _____ 30. PHONE # _____ 31. EMAIL _____ 32. DATE _____

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

33. CASE PLAN: Approved Date: _____ Denied Date: _____ Return for correction- Date: _____
 34. REGULATION(S) upon which Denial or Return is based: _____
 35. DEPARTMENT APPROVAL SIGNATURE: _____ 36. DATE: _____
 37. CCT-DD-CE CCT-DD-300

Colorado Choice Transitions (CCT) PAR Completion Instructions
FORM MUST BE COMPLETED ELECTRONICALLY OR IN BLACK BALLPOINT- PLEASE PRINT

Complete this form for Prior Authorization Requests for CCT-DD. Submit the PAR per the instructions listed at the bottom.

Complete the Revision section at the top of the form only if you are revising a current approved PAR.

For PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were approved on the original PAR.

Complete the following required fields:

1. **Client Name:** Enter the client's name.
2. **Client ID:** Enter the client's Medical Assistance Program ID number.
3. **Sex:** Check M or F.
4. **Birthdate:** Enter the client's date of birth.
5. **Support Level:** Indicate the required level of support.
6. **Requesting Provider #:** Enter the requesting provider's Medical Assistance Program provider number.
7. **Client's County:** Enter the client's county of residence.
8. **Case Number (for Agency use) - Optional:** Enter the agency's case number for this PAR.
9. **Dates Covered (From and Through):** Enter the PAR start date and PAR end date.
10. **Description:** List of approved procedure codes of qualified and demonstration services.
11. **Support Level:** Select service support level from the drop down box when instructed.
12. **Modifier:** Some modifiers automatically populate, while others will already be on the PAR or will require data entry by the case manager.
13. **Max # Units:** Enter the number of units next to the services for which you are requesting reimbursement.
14. **Cost Per Unit:** Enter the cost per unit of service.
15. **Total \$ Authorized:** The total dollar amount authorized for the service automatically populates.
16. **Comments -Optional:** Enter any additional useful information. For example, if a service is authorized for different dates than in Box 9, please include the HCPC and date span here.
- 17a. **Total Authorized CCT Qualified Services Expenditures:** Total automatically populates.
- 17b. **Total Authorized CCT Demonstration Service Expenditures:** Total automatically populates.
- 17c. **Subtotal of CCT Qualified and Demonstration Services:** Subtotal automatically populates.
18. **Plus Total Authorized Home Health Expenditures (Sum of Authorized Home Health Services during the HCBS Care Plan Period):** Enter the total Authorized Home Health expenditures.
19. **Equals Client's Maximum Authorized Cost:** The sum of the CCT Expenditures + Home Health Expenditures automatically populates.
20. **Number of Days Covered:** The number of days covered automatically populates.
21. **Average Cost Per Day:** The client's maximum authorized cost divided by number of days in the care plan period automatically populates.
22. **Immediately prior to CCT enrollment, this client lived in a long term care facility:** Check Yes or No.
23. **Case Manager Name:** Enter the name of the Case Manager.
24. **Agency:** Enter the name of the agency.
25. **Phone #:** Enter the phone number of the Case Manager.
26. **Email:** Enter the email address of the Case Manager.
27. **Date:** Enter the date completed.
28. **Case Manager's Supervisor Name:** Enter the name of the Case Manager's Supervisor.
29. **Agency:** Enter the name of the agency.
30. **Phone #:** Enter the phone number of the Case Manager's Supervisor.
31. **Email:** Enter the email address of the Case Manager's Supervisor.
32. **Date:** Enter the date completed.

"DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY". This is for Department use only.

Send only **New, Continued Stay Review (CSR), and Revised PARs** to:

Encrypted Email:
CCTPars@state.co.us

Fax:
 303-866-2786

Mail:
 The Colorado Department of Health Care Policy and Financing
 Attn: Long Term Services and Supports Division
 1570 Grant St.
 Denver, CO 80203-1818

Note: Any PAR sent for the CCT Demonstration Project directly to the fiscal agent for the Colorado Medical Assistance Program will be returned to the case manager.

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT
CCT- Persons who are Elderly, Blind, and Disabled Demonstration,
18-64



CCT-UC
 PA Number being revised:
 Revision? Yes No

1. CLIENT NAME		2. CLIENT ID		3. SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. BIRTHDATE	
5. REQUESTING PROVIDER #		6. CLIENT'S COUNTY		7. CASE NUMBER (AGENCY USE)		8. DATES COVERED From: _____ Through: _____	

STATEMENT OF REQUESTED SERVICES

9. Qualified Services Description	10. Modifier	11. Max # Units	12. Cost Per Unit	13. Total \$ Authorized	14. Comments:
S5105 Adult Day Services, Basic (UC)					
S5105 Adult Day Services, Specialized (UC)	TF				
T2031 Alternative Care Facility, (ACF) (UC)					
T2025 Consumer Directed Attendant Support Services (CDASS) (UC)					
T2040 CDASS Per Member/ Per Month (PM/PM) (UC)					
S5165 Home Modifications (UC)					
S5130 Homemaker (UC)					
H0038 IHHS Health Maintenance Activities (UC)					
S5130 IHHS Homemaker (UC)	KX				
T1019 IHHS Personal Care (UC)	KX				
T1019 IHHS Relative Personal Care (UC)	HR, KX				
S5185 Medication Reminder, Monitoring (UC)					
T2029 Medication Reminder, Install/Purchase (UC)					
A0100 Non-Medical Transportation, Taxi (UC)					
A0120 Non-Medical Transportation, Mobility Van (UC)					
A0130 Non-Medical Transportation, Wheelchair Van (UC)					
T1019 Personal Care (UC)					
S5160 Personal Emergency Response System (PERs) Install/Purchase (UC)					
S5161 PERs, Monitoring (UC)					
T1019 Relative Personal Care (UC)	HR				
H0045 Respite Care, NF (UC)					
S5150 Respite Care, In Home (UC)					
S5151 Respite Care, ACF (UC)					
Demonstration Services Description					
T2029 Assistive Technology, Extended (UC)					
S5110 Caregiver Education (UC)					
T2038 Community Transition Services, Coordinator (UC)					
A9900 Community Transition Services, Items Purchased (UC)					
D2999 Dental (UC)					
T1002 Enhanced Nursing, RN (UC)					
S5170 Home Delivered Meals (UC)					
S5165 Home Modifications, Extended (UC)	KG				
H2014 Independent Living Skills Training (ILST) (UC)					
T1016 Intensive Case Management (UC)					
H2015 Peer Mentorship (UC)					
H0047 Substance Abuse Counseling, Transitional, Group (UC)	HF, HQ				
H0047 Substance Abuse Counseling, Transitional, Individual (UC)	HF				
H0025 Transitional Behavioral Health Supports (UC)					
S5101 Transitional Specialized Day Rehabilitation Services (UC)					
V2799 Vision (UC)					

15a. TOTAL AUTHORIZED CCT QUALIFIED SERVICES EXPENDITURES (SUM OF QUALIFIED SERVICES)				\$0.00	15c. Subtotal
15b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICES EXPENDITURES (SUM OF DEMONSTRATION SERVICES)				\$0.00	\$0.00
16. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts				\$0.00	
17. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES)				\$0.00	
18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)					
19. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)				\$0.00	
A. Monthly State Cost Containment Amount				\$5,082.88	
B. Divided by 30.42 days = Daily Cost Containment Ceiling				\$167.09	
20. CDASS (amounts must match client's allocation worksheet)		Effective Date:	Monthly Allocation Amt:	\$0.00	Monthly Admin Fee: \$0.00

21. Immediately prior to CCT enrollment, this client lived in a long term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No					
22. CASE MANAGER NAME		23. AGENCY		24. PHONE #	
25. EMAIL		26. DATE			
27. CASE MANAGER'S SUPERVISOR NAME		28. AGENCY		29. PHONE #	
30. EMAIL		31. DATE			

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

32. CASE PLAN: <input type="checkbox"/> Approved Date: _____		<input type="checkbox"/> Denied Date: _____		Return for correction- Date: _____	
33. REGULATION(S) upon which Denial or Return is based:					
34. DEPARTMENT APPROVAL SIGNATURE:				35. DATE:	
36. <input type="checkbox"/> CCT-PD-CE <input type="checkbox"/> CCT-PD-300					

Colorado Choice Transitions (CCT) PAR Completion Instructions
FORM MUST BE COMPLETED ELECTRONICALLY OR IN BLACK BALLPOINT- PLEASE PRINT

Complete this form for Prior Authorization Requests for CCT-EBD-PD-18-64. Submit the PAR per the instructions listed at the bottom.

Complete the Revision section at the top of the form only if you are revising a current approved PAR.

For PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were approved on the original PAR.

Complete the following required fields:

1. **Client Name:** Enter the client's name.
2. **Client ID:** Enter the client's Medical Assistance Program ID number.
3. **Sex:** Check M or F.
4. **Birthdate:** Enter the client's date of birth.
5. **Requesting Provider # :** Enter the requesting provider's Medical Assistance Program provider number.
6. **Client's County:** Enter the client's county of residence.
7. **Case Number (for Agency use) - Optional:** Enter the agency's case number for this PAR.
8. **Dates Covered (From and Through):** Enter the PAR start date and PAR end date.
9. **Description:** List of approved procedure codes of qualified and demonstration services.
10. **Modifier:** Enter HB, TT, TN modifiers as applicable for Non-Medical Transportation (to and from Adult Day).
11. **Max # Units:** Enter the number of units next to the services for which you are requesting reimbursement.
12. **Cost Per Unit:** Enter the cost per unit of service.
13. **Total \$ Authorized:** The total dollar amount authorized for the service automatically populates.
14. **Comments - Optional:** Enter any additional useful information. For example, if a service is authorized for different dates than in Box 8, please include the HCPC and date span here.
- 15a. **Total Authorized CCT Qualified Service Expenditures:** Total automatically populates.
- 15b. **Total Authorized CCT Demonstration Service Expenditures:** Total automatically populates.
- 15c. **Subtotal of CCT Qualified and Demonstration Services:** Subtotal automatically populates.
16. **Plus Total Authorized Home Health Expenditures (Sum of Authorized Home Health Services during the HCBS Care Plan Period):** Enter the total Authorized Home Health expenditures.
17. **Equals Client's Maximum Authorized Cost:** The CCT Expenditures + Home Health Expenditures automatically populates.
18. **Number of Days Covered:** The number of days covered automatically populates.
19. **Average Cost Per Day:** The client's maximum authorized cost divided by number of days in the care plan period automatically populates.
20. **CDASS:** Enter CDASS information. (All CDASS information must be entered into PPL's web portal.)
21. **Immediately prior to CCT enrollment, this client lived in a long term care facility:** Check Yes or No.
22. **Case Manager Name:** Enter the name of the Case Manager.
23. **Agency:** Enter the name of the agency.
24. **Phone #:** Enter the phone number of the Case Manager.
25. **Email:** Enter the email address of the Case Manager.
26. **Date:** Enter the date completed.
27. **Case Manager's Supervisor Name:** Enter the name of the Case Manager's Supervisor.
28. **Agency:** Enter the name of the agency.
29. **Phone #:** Enter the phone number of the Case Manager's Supervisor.
30. **Email:** Enter the email address of the Case Manager's Supervisor.
31. **Date:** Enter the date completed.

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Send only New, Continued Stay Review (CSR), and Revised PARs to:

Encrypted Email:
CCTPars@state.co.us

Fax:
303-866-2786

Mail:
The Colorado Department of Health Care Policy and
Financing
Attn: Long Term Services and Supports Division
1570 Grant St.
Denver, CO 80203-1818

Note: Any PAR for the CCT Demonstration Project sent directly to the fiscal agent for the Colorado Medical Assistance Program will be returned to the case manager.

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

CCT- Persons who are Elderly, Blind, and Disabled Demonstration, 65+



CCT-UC

PA Number being revised:

Revision? Yes No

1. CLIENT NAME		2. CLIENT ID		3. SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. BIRTHDATE	
5. REQUESTING PROVIDER #		6. CLIENT'S COUNTY		7. CASE NUMBER (AGENCY USE)		8. DATES COVERED From: _____ Through: _____	

STATEMENT OF REQUESTED SERVICES

9. Qualified Services Description	10. Modifier	11. Max # Units	12. Cost Per Unit	13. Total \$ Authorized	14. Comments:
S5105 Adult Day Services, Basic (UC)					
S5105 Adult Day Services, Specialized (UC)	TF				
T2031 Alternative Care Facility (ACF) (UC)					
T2025 Consumer Directed Attendant Support Services (CDASS) (UC)					
T2040 CDASS Per Member/ Per Month (PM/PM) (UC)					
S5165 Home Modifications (UC)					
S5130 Homemaker (UC)					
H0038 IHHS Health Maintenance Activities (UC)					
S5130 IHHS Homemaker (UC)	KX				
T1019 IHHS Personal Care (UC)	KX				
T1019 IHHS Relative Personal Care (UC)	HR, KX				
T2029 Medication Reminder, Install/Purchase (UC)					
S5185 Medication Reminder, Monitoring (UC)					
A0100 Non-Medical Transportation, Taxi (UC)					
A0120 Non-Medical Transportation, Mobility Van (UC)					
A0130 Non-Medical Transportation, Wheelchair Van (UC)					
T1019 Personal Care (UC)					
S5160 Personal Emergency Response System (PERs) Install/Purchase (UC)					
S5161 PERs, Monitoring (UC)					
T1019 Relative Personal Care (UC)	HR				
H0045 Respite Care, NF (UC)					
S5150 Respite Care, In Home (UC)					
S5151 Respite Care, ACF (UC)					
Demonstration Services Description					
T2029 Assistive Technology, Extended (UC)					
S5110 Caregiver Education (UC)					
T2038 Community Transition Services, Coordinator (UC)					
A9900 Community Transition Services, Items Purchased (UC)					
D2999 Dental (UC)					
T1002 Enhanced Nursing, RN (UC)					
S5170 Home Delivered Meals (UC)					
S5165 Home Modifications, Extended (UC)	KG				
H2014 Independent Living Skills Training (ILST) (UC)					
T1016 Intensive Case Management (UC)					
H2015 Peer Mentorship (UC)					
H0047 Substance Abuse Counseling, Transitional, Group (UC)	HF, HQ				
H0047 Substance Abuse Counseling, Transitional, Individual (UC)	HF				
H0025 Transitional Behavioral Health Supports (UC)					
S5101 Transitional Specialized Day Rehabilitation Services (UC)					
V2799 Vision (UC)					

15a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)	\$0.00	15c. Subtotal
15b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)	\$0.00	\$0.00

16. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts \$0.00

17. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES) \$0.00

18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)

19. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period) \$0.00

A. Monthly State Cost Containment Amount \$5,082.88

B. Divided by 30.42 days = Daily Cost Containment Ceiling \$167.09

20. CDASS (amounts must match client's allocation worksheet)	Effective Date:	Monthly Allocation Amt:	\$0.00	Monthly Admin Fee: \$	\$0.00
--	-----------------	-------------------------	--------	-----------------------	--------

21. Immediately prior to CCT enrollment, this client lived in a long term care facility? Yes No

22. CASE MANAGER NAME	23. AGENCY	24. PHONE #	25. EMAIL	26. DATE
27. CASE MANAGER'S SUPERVISOR NAME	28. AGENCY	29. PHONE #	30. EMAIL	31. DATE

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

32. CASE PLAN: Approved Date: _____ Denied Date: _____ Return for correction- Date: _____

33. REGULATION(S) upon which Denial or Return is based:

34. DEPARTMENT APPROVAL SIGNATURE: _____ 35. DATE: _____

36. CCT-ELD-CE CCT-ELD300

Colorado Choice Transitions (CCT) PAR Completion Instructions
FORM MUST BE COMPLETED ELECTRONICALLY OR IN BLACK BALLPOINT- PLEASE PRINT

Complete this form for Prior Authorization Requests for CCT-EBD-65+. Submit the PAR per the instructions listed at the bottom.

Complete the Revision section at the top of the form only if you are revising a current approved PAR.

For PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were approved on the original PAR.

Complete the following required fields:

1. **Client Name:** Enter the client's name.
2. **Client ID:** Enter the client's Medical Assistance Program ID number.
3. **Sex:** Check M or F.
4. **Birthdate:** Enter the client's date of birth.
5. **Requesting Provider #:** Enter the requesting provider's Medical Assistance Program provider number.
6. **Client's County:** Enter the client's county of residence.
7. **Case Number (for Agency use) - Optional:** Enter the agency's case number for this PAR.
8. **Dates Covered (From and Through):** Enter the PAR start date and PAR end date.
9. **Description:** List of approved procedure codes of qualified and demonstration services.
10. **Modifier:** Enter HB, TT, TN modifiers as applicable for Non-Medical Transportation (to and from Adult Day).
11. **Max # Units:** Enter the number of units next to the services for which you are requesting reimbursement.
12. **Cost Per Unit:** Enter the cost per unit of service.
13. **Total \$ Authorized:** The total dollar amount authorized for the service automatically populates.
14. **Comments - Optional:** Enter any additional useful information. For example, if a service is authorized for different dates than in Box 8, please include the HCPC and date span here.
- 15a. **Total Authorized CCT Qualified Service Expenditures:** Total automatically populates.
- 15b. **Total Authorized CCT Demonstration Service Expenditures:** Total automatically populates.
- 15c. **Subtotal of CCT Qualified and Demonstration Services:** Subtotal automatically populates.
16. **Plus Total Authorized Home Health Expenditures (Sum of Authorized Home Health Services during the HCBS Care Plan Period):** Enter the total Authorized Home Health expenditures.
17. **Equals Client's Maximum Authorized Cost:** The sum of the CCT Expenditures + Home Health Expenditures automatically populates.
18. **Number of Days Covered:** The number of days covered automatically populates.
19. **Average Cost Per Day:** The client's maximum authorized cost divided by number of days in the care plan period automatically populates.
20. **CDASS:** Enter CDASS information. (All CDASS information must be entered into PPL's web portal.)
21. **Immediately prior to CCT enrollment, this client lived in a long term care facility:** Check Yes or No.
22. **Case Manager Name:** Enter the name of the Case Manager.
23. **Agency:** Enter the name of the agency.
24. **Phone #:** Enter the phone number of the Case Manager.
25. **Email:** Enter the email address of the Case Manager.
26. **Date:** Enter the date completed.
27. **Case Manager's Supervisor Name:** Enter the name of the Case Manager's Supervisor.
28. **Agency:** Enter the name of the agency.
29. **Phone #:** Enter the phone number of the Case Manager's Supervisor.
30. **Email:** Enter the email address of the Case Manager's Supervisor.
31. **Date:** Enter the date completed.

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CCTPars@state.co.us

Fax:
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Mail:
The Colorado Department of Health Care Policy
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Attn: Long Term Services and Supports Division
1570 Grant St.
Denver, CO 80203-1818

Note: Any PAR for the CCT Demonstration Project sent directly to the fiscal agent for the Colorado Medical Assistance Program will be returned to the case manager.

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REQUEST FOR ADULT HCBS PRIOR APPROVAL AND COST CONTAINMENT

CCT - Supported Living Services Demonstration



CCT-UC

PA Number being revised:

Revision? Yes No

1. CLIENT NAME		2. CLIENT ID		3. SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. BIRTHDATE:	
6. REQUESTING PROVIDER #		7. CLIENT'S COUNTY		8. CASE NUMBER (AGENCY USE)		9. DATES COVERED	
						From: Through:	

STATEMENT OF REQUESTED SERVICES

10. Qualified Services Description	11. Support Level	12. Modifier	13. Total # Units Authorized	14. Cost Per Unit	15. Total \$ Authorized	16. Comments:
T2035 Assistive Technology (UC) *						
H2021 Mentorship (UC)						
T1019 Personal Care (UC)		TF				
S5161 Personal Emergency Response (PERs) (UC)						
T2039 Vehicle Modifications (UC) *						
V2799 Vision (UC) *						
Behavioral Services						
H2019 Line Services (UC)						
H2019 Behavioral Consultation (UC)		HI, TG				
H2019 Behavioral Counseling, Group (UC)		TF, HQ				
H2019 Behavioral Counseling, Individual (UC)		TF, TG				
T2024 Behavioral Plan Assessment (UC)		HI				
Day Habilitation						
T2021 Specialized Day Habilitation (UC)	-----					
T2021 Supported Community Connections (UC)	-----					
Dental						
D2999 Dental, Basic/ Preventive Services (UC) *						
D2999 Dental, Major Services (UC) *		TF				
Homemaker						
S5130 Homemaker, Basic (UC)		TF				
S5130 Homemaker, Enhanced (UC)		HI				
S5165 Home Accessibility Adaptations (UC) *						
Non-Medical Transportation						
T2003 To/From Day Program, Mileage Range (UC) *	-----					
T2003 Mileage Not Day Program (UC) *		HB				
T2004 Other (Public Conveyance) (UC) *						
Pre-Vocational Services						
T2015 Pre-Vocational Services (UC)	-----					
Professional Services						
97124 Massage Therapy (UC)						
G0176 Movement Therapy, Bachelors Degree (UC)		HN				
G0176 Movement Therapy, Masters Degree (UC)						
S8940 Hippotherapy, Group (UC)		HQ				
S8940 Hippotherapy, Individual (UC)						
S5199 Rec Pass, Access Fee (UC)						
Respite Care						
T2036 Respite Camp (UC)						
S5151 Respite Care, Group (UC)		HQ				
S5150 Respite Care, Individual, 15 Minutes (UC)						
S5151 Respite Care, Individual, Day (UC)						
Specialized Medical Equipment and Supplies						
T2028 Specialized Medical Equipment and Supplies, Disposable (UC)						
T2029 Specialized Medical Equipment (UC)						
Supported Employment						
T2019 Supported Employment, Individual, All Levels (1-6) (UC)		HI				
T2019 Supported Employment, Group (UC)	-----					
H2023 Job Development, Individual (UC)	Level 1-2					
H2023 Job Development, Individual (UC)	Level 3-4	HI				
H2023 Job Development, Individual (UC)	Level 5-6	TF				
H2023 Job Development, Group, All Levels (UC)		HQ				
H2024 Job Placement, Individual, All Levels (1-6) (UC)						
H2024 Job Placement, Group, All Levels (1-6) (UC)		HQ				
Demonstration Services Description						
S5110 Caregiver Education (UC)						
T2038 Community Transition Services, Coordinator (UC) *						
A9900 Community Transition Services, Items Purchased (UC) *						
T1002 Enhanced Nursing, RN (UC)						
S5165 Home Accessibility Adaptations, Extended (UC) *		KG				
H2014 Independent Living Skills Training (ILST) (UC)						
T1016 Intensive Case Management (UC) *						
H0047 Substance Abuse Counseling, Transitional, Group (UC)		HF, HQ				
H0047 Substance Abuse Counseling, Transitional, Individual (UC)		HF				

17a. TOTAL AUTHORIZED CCT QUALIFIED SERVICE EXPENDITURES (SUM OF QUALIFIED SERVICES)				\$0.00	17c. Subtotal
17b. TOTAL AUTHORIZED CCT DEMONSTRATION SERVICE EXPENDITURES (SUM OF DEMONSTRATION SERVICES)				\$0.00	\$0.00
18. TOTAL WITHIN SPAL EXPENDITURES (SUM OF ALL SPAL SERVICES IN COLUMN 15 ABOVE)				\$0.00	
19. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)				\$0.00	
20. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (CCT EXPENDITURES + HOME HEALTH EXPENDITURES)				\$0.00	
21. NUMBER OF DAYS COVERED (FROM FIELD 9 ABOVE)					
22. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)				\$0.00	
23. Immediately prior to CCT Services enrollment, this client lived in a long term care facility?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
24. CASE MANAGER NAME	25. AGENCY	26. PHONE #	27. EMAIL	28. DATE	
29. CASE MANAGER'S SUPERVISOR NAME	30. AGENCY	31. PHONE #	32. EMAIL	33. DATE	
* Outside of Service Plan Authorization Limit (SPAL)					
DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY					
33. CASE PLAN: <input type="checkbox"/> Approved Date: _____ <input type="checkbox"/> Denied Date: _____ Return for correction- Date: _____					
34. REGULATION(S) upon which Denial or Return is based: _____					
35. DEPARTMENT APPROVAL SIGNATURE: _____				36. DATE: _____	
37. <input type="checkbox"/> CCT-SLS-CE <input type="checkbox"/> CCT-SLS300					

Colorado Choice Transitions (CCT) PAR Completion Instructions

FORM MUST BE COMPLETED ELECTRONICALLY OR IN BLACK BALLPOINT- PLEASE PRINT

Complete this form for Prior Authorization Requests for CCT-SLS. Submit the PAR per the instructions listed at the bottom.

Complete the Revision section at the top of the form only if you are revising a current approved PAR.

For PAR revisions you must add the number of units being requested to the original number of units approved and include all services that were

Complete the following required fields:

1. **Client Name:** Enter the client's name.
2. **Client ID:** Enter the client's Medical Assistance Program ID number.
3. **Sex:** Check M or F.
4. **Birthdate:** Enter the client's date of birth.
5. **Support Level:** Indicate the required level of support.
6. **Requesting Provider #:** Enter the requesting provider's Medical Assistance Program provider number.
7. **Client's County:** Enter the client's county of residence.
8. **Case Number (for Agency use) - Optional:** Enter the agency's case number for this PAR.
9. **Dates Covered (From and Through):** Enter the PAR start date and PAR end date.
10. **Description:** List of approved procedure codes of qualified and demonstration services.
11. **Support Level:** Select service support level from the drop down box when instructed.
12. **Modifier:** Some modifiers automatically populate, while others will already be on the PAR or will require data entry by the case manager.
13. **Total # Units Authorized:** Enter the number of units next to the services for which you are requesting reimbursement.
14. **Cost Per Unit:** Enter the cost per unit of service.
15. **Total \$ Authorized:** The total dollar amount authorized for the service automatically populates.
16. **Comments - Optional:** Enter any additional useful information. For example, if a service is authorized for different dates than in Box 9, please
- 17a. **Total Authorized CCT Qualified Service Expenditures:** Total automatically populates.
- 17b. **Total Authorized CCT Demonstration Service Expenditures:** Total automatically populates.
- 17c. **Subtotal of CCT Qualified and Demonstration Services:** Subtotal automatically populates.
18. **Total SPAL Expenditures:** Total automatically populates and equals the sum of SPAL services.
19. **Plus Total Authorized Home Health Expenditures (Sum of Authorized Home Health Services during the HCBS Care Plan Period):** Enter the
20. **Equals Client's Maximum Authorized Cost:** The sum of the CCT Expenditures + Home Health Expenditures automatically populates.
21. **Number of Days Covered:** The number of days covered from Field 9 automatically populates.
22. **Average Cost Per Day:** The client's maximum authorized cost divided by number of days in the care plan period automatically populates.
23. **Immediately prior to CCT enrollment, this client lived in a long term care facility:** Check Yes or No.
24. **Case Manager Name:** Enter the name of the Case Manager.
25. **Agency:** Enter the name of the agency.
26. **Phone #:** Enter the phone number of the Case Manager.
27. **Email:** Enter the email address of the Case Manager.
28. **Date:** Enter the date completed.
29. **Case Manager's Supervisor Name:** Enter the name of the Case Manager's Supervisor.
30. **Agency:** Enter the name of the agency.
31. **Phone #:** Enter the phone number of the Case Manager's Supervisor.
32. **Email:** Enter the email address of the Case Manager's Supervisor.
33. **Date:** Enter the date completed.

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Denver, CO 80203-1818

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CCT Staff Contacts

For General
Questions:

Kathy Cebuhar, Community Liaison

Kathy.Cebuhar@state.co.us

303-866-2649 phone

Tim Cortez, Project Director

Tim.Cortez@state.co.us

303-866-3011 phone

For Transitions
Questions:

Nora Brahe, Transitions Administrator

Nora.Brahe@state.co.us

303-866-3566 phone

For Provider &
Policy
Questions:

Nicole Storm, Project Manager

Nicole.storm@state.co.us

303-866-2858 phone

Web: Colorado.gov/hcpf/CCT Email: CCT@hcpf.state.co.us



Colorado Choice Transitions

Colorado Choice Transitions

Colorado Choice Transitions, a [Money Follows the Person](#) initiative (MFP), is a federal grant to build and improve on the infrastructure supporting home and community-based services (HCBS) for people of *all ages* with long-term care (LTC) needs. The vision is to transform long-term care services and supports from institutionally-based and provider-driven care to person-centered, consumer-directed and community-based care. Colorado received \$22 million for five years from the Centers for Medicare and Medicaid Services (CMS) in April 2011. Transitions are designed to move Medicaid clients out of long-term care-based facilities into community living using traditional waiver services and additional enhanced home and community-based services.

How do I qualify?

- You must meet Long-Term Care Medicaid eligibility requirements.
- You must currently reside in a long-term care facility for a period of no less than ninety (90) consecutive days.
- You must be moving to qualified housing.

What are the goals of CCT?

- Facilitate and sustain the transition of 500 Medicaid-eligible clients from long term care facilities to the community with the appropriate amount of supports and services.
- Enhance and improve quality of life.
- Support long-term care facilities in the implementation of Section Q requirements, which assists clients in exploring their community-based long-term options.
- Improve access to an array of HCBS services.
- Increase housing options for people with all types of disabilities.
- Streamline and improve the navigation of the long-term care system to allow clients to more easily access supports and services.

What Does the Funding Cover?

Qualified HCBS services on the following waivers are available to CCT participants:

- Persons with Brain Injury
- Community Mental Health Supports
- Persons who are Developmentally Disable
- Persons who are Elderly, Blind and Disabled
- Supported Living Services



Colorado Choice Transitions

The enhanced home and community-based demonstration services available to CCT participants will include:

- Assistive Technology
- Behavioral Health Support
- Caregiver Support Services
- Community Transition Services
- Dental Services
- Enhanced Nursing Services
- Substance Abuse Counseling (Transitional)
- Extended Home Modifications
- Independent Living Skills Training
- Intensive Case Management
- Mentorship Services
- Specialized Day Rehabilitation
- Home Delivered Meals
- Vision Services

Timeline

- The grant began April 1, 2011 and runs through March 31, 2016.
- The first year of the grant was spent establishing the infrastructure to launch and manage the CCT program.
- Community transitions through CCT are anticipated to begin in early 2013.

How Can I Get Involved?

Please contact us at CCT@hcpf.state.co.us for questions, feedback or comments. Visit our website for program information <http://www.colorado.gov/hcpf/CCT>.

Program Contact:

[Kathy Cebuhar](#), Community Liaison
303-866-2649

Media Contact:

[Rachel Reiter](#)
303-866-3921

8.555 COLORADO CHOICE TRANSITIONS (CCT), A MONEY FOLLOWS THE PERSON DEMONSTRATION

8.555.1 DEFINITIONS OF DEMONSTRATION SERVICES PROVIDED

Assistive Technology means devices, items, pieces of equipment, or product system used to increase, maintain, or improve functional capabilities of clients and training in the use of the technology when the cost is not otherwise covered through the State Plan durable medical equipment benefit or home modification waiver benefit or available through other means.

Behavioral Health Support means services by a paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community.

Caregiver Support Service means educational and coaching services that assist clients and family members to recruit other family members and friends to form an informal caregiver network to share caregiving responsibilities.

Community Transition Services means services as defined at 10 CCR 2505-10, Section 8.553.

Dental Services means dental services that are inclusive of diagnostic, preventive, periodontal and prosthodontic services, as well as basic restorative and oral surgery procedures to restore the client to functional dental health and not available through the Medicaid State Plan.

Enhanced Nursing Services means medical care coordination provided by a nurse for medically complex clients who are at risk for negative health outcomes associated with fragmented medical care and poor communication between primary care physicians, nursing staff, case managers, community-based providers and specialty care providers.

Home Delivered Meals means nutritious meals delivered to homebound clients who are unable to prepare their own meals and have no outside assistance.

Extended Home Modifications means physical adaptations to the home, required by the client's plan of care, necessary to ensure the health, welfare, safety and independence of the client above and beyond the cost of caps that exist in applicable Home and Community-Based (HCBS) waivers.

Independent Living Skills Training means services designed to improve or maintain a client's physical, emotional, and economic independence in the community with or without supports.

Intensive Case Management means case management services to assist clients' access to needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition goals.

Mentorship Services means services provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to community living, describing real-world

experiences as example and modeling successful community living and problem-solving.

Specialized Day Rehabilitation means services offered in a group setting designed and directed at the development and maintenance of the client's ability to independently, or with support, sustain himself/herself physically, emotionally and economically in the community.

Substance Abuse (Transitional) means enhanced individual or group substance abuse counseling, behavioral interventions, or consultations to address issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's sobriety. Services can be provided in the home or office setting.

Vision Services means services that include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems when not available through the Medicaid State Plan.

8.555.2 GENERAL DEFINITIONS

Demonstration services means services unique to the CCT program and provided during a client's enrollment in the demonstration program.

Medically complex means one or more medical conditions that are persistent and substantially disabling or life threatening and meets the following conditions:

1. Requires treatment and services across a variety of domains of care;
2. Is associated with conditions that have severe medical or health-related consequences;
3. Affects multiple organ systems;
4. Requires coordination and management by multiple specialties; and
5. Treatments carry a risk of serious complications.

Operational Protocol means the Centers for Medicare and Medicaid Services (CMS) approved policy and procedures manual for the CCT Program. The Operational Protocol (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. The Operational Protocol is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the Operational Protocol from the Department.

Paraprofessional means a person with a Bachelor's Degree in psychology, social work or other human service related field who is employed by a mental health provider; is supervised by a Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Psychologist; and has experience

with facilitating the implementation of a behavioral management plan among families, a client, providers and other members of a support system for the client.

Qualified institution means a nursing facility; intermediate care facilities for people with intellectual disabilities (ICF/ID); or institutions for mental diseases (IMDs), which include Psychiatric Hospitals only to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

Qualified residence means a home owned or leased by the client or the client's family member; a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside; or an apartment with an individual lease, eating, sleeping, cooking and bathing areas, lockable access and egress, and not associated with the provision or delivery of services.

Qualified services mean services that are provided through an existing HCBS waiver and may continue if needed by the client and if the client continues to meet eligibility for HCBS at the end of his or her enrollment in CCT.

Transition Assessment/Plan means an assessment of client needs completed by a transition coordinator prior to a transition and the corresponding plan developed by the coordinator to meet the needs of the client in a community-setting post-transition.

8.555.3 LEGAL BASIS

The Colorado Choice Transitions (CCT) program is created through a Money Follows the Person (MFP) grant award authorized by section 6071 of the Deficit Reduction Act of 2005. Section 2403 of Patient Protection and Affordable Care Act extended the program through September 30, 2016. The United States Department of Health and Human Services awarded the MFP demonstration grant to Colorado. This demonstration program is administered by the Centers for Medicare and Medicaid Services (CMS). The MFP statute provides waiver authority for four provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of the demonstration. These provisions are:

1. Statewideness (Section 1902(a)(1) of the Social Security Act) - in order to permit implementation of a State initiative in a selected area or areas of the State.
2. Comparability (Section 1902(a)(10)(B) - in order to permit a State initiative to assist a selected category or categories of individuals enrolled in the demonstration.
3. Income and Resource Eligibility (Section 1902(a)(10)(C)(i)(III) – in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.

4. Provider agreement (Section 1902(a)(27)) - in order to permit a State to implement self-direction services in a cost-effective manner for purposes of this demonstration program.

CCT is designed to complement the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD); Home and Community Based Services for People with Brain Injury (HCBS-BI); Home and Community Based Services for Community Mental Health Supports (HCBS-CMHC); Home and Community Based Services for the Developmentally Disabled (HCBS-DD); and Home and Community Based Services for Supported Living Services (HCBS-SLS) programs. These waivers are authorized through Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n). Title 42 of the United States Code, Section 1396n (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. The Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

8.555.4 SCOPE AND PURPOSE

- 8.555.4.A. The CCT program assists clients currently residing in qualified institutions with exploring their community-based options for long term supports and services and transitioning to a community setting with services and supports if they choose to transition; if the right services and supports can be arranged in the community to ensure the health, welfare and safety of the client; and if willing and qualified providers are available to deliver services.
- 8.555.4.B. The CCT program strengthens the transition process for residents of qualified institutions and provides additional supports and services for a successful transition. These additional supports and services are demonstration services.
- 8.555.4.C. Clients may be enrolled in the CCT program for 365 days. Days in a hospital or qualified institution for a period of less than 30 days during the enrollment period will not count towards the 365 days.
- 8.555.4.D. CCT clients will be concurrently enrolled in the CCT program and one of the following waivers:
 1. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) (10. C.C.R. 2505-10, Section 8.485);

2. Home and Community Based Services for People with Brain Injury (HCBS-BI) (10 CCR 2505-10, Section 8.515.00);
3. Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS) (10 CCR 2505-10, Section 8.509);
4. Home and Community Based Services for the Developmentally Disabled (HCBS-DD) (10 CCR 2505-10, Section 8.500); and
5. Home and Community Based Services for Supported Living Services (HCBS-SLS) (10 CCR 2505-10, Section 8.500.90).

8.555.4.E. At the end of the enrollment period for CCT, case managers will dis-enroll clients from the CCT program.

1. Demonstration services will discontinue at the end of the CCT enrollment period.
2. If clients continue to meet eligibility requirements for one of the waivers listed in 8.555.4.D., case managers will arrange for the continuation of qualified HCBS services after the CCT period ends through the appropriate HCBS waiver.

8.555.5 CLIENT ELIGIBILITY

8.555.5.A. ELIGIBLE PERSONS

CCT services shall be offered only to persons who meet all of the following eligibility requirements:

1. Clients shall be aged 18 years or older.
2. Clients shall have resided in a qualified institution for a period of 90 days. Days in a nursing facility for a rehab stay will not count towards the 90 days.
3. Clients shall be enrolled in Medicaid for at least one day prior to transition from a qualified institution.
4. Clients shall reside in a qualified residence post-transition.
5. Clients shall meet criteria of a targeted population which includes persons with mental illness, brain injury, physical disabilities or intellectual disabilities and the elderly.
6. Clients shall meet the eligibility requirements for the appropriate HCBS waiver programs listed in Section 8.555.4.D. in which they will be enrolled post-transition.
7. Clients concurrently enrolled in the HCBS-BI program and CCT shall be in the age range of 18-64 rather than 16-64 as specified in the HCBS-BI eligibility requirements.

8.555.5.B. FINANCIAL ELIGIBILITY

Clients must meet the financial eligibility requirements specified at 10 CCR 2505-10, Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.555.5.C. LEVEL OF CARE CRITERIA

Clients shall require long term support services at a level comparable to services typically provided in a nursing facility or ICF/ID in accordance with the waiver to which they will enroll upon transition.

8.555.5.D. NEED FOR CCT SERVICES

1. Only clients who have agreed to accept demonstration and qualified services as soon as all other eligibility criteria have been met are eligible for the CCT program.
 - a. Case management is a CCT service but case management shall not be used to satisfy this requirement.
 - b. The desire or need for any Medicaid services other than CCT demonstration services, as listed at Section 8.555.1, or qualified services offered through one of the waiver programs listed in Section 8.555.4.D. shall not satisfy this eligibility requirement.
2. Once enrolled, clients who have not received demonstration or qualified services for a period greater than 30 consecutive days shall be discontinued from the program.

8.555.5.E. EXCLUSIONS

1. Clients who are residents of nursing facilities, other qualified institutions or hospitals are not eligible to receive CCT or waiver services except for transition coordination or case management services in preparation of discharge.
2. CCT clients readmitted to a qualified institution or hospital may not receive CCT services while admitted except for transition coordination or case management services in preparation for discharge.
 - a. CCT clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the CCT program but may have the option to re-enroll upon discharge provided they continue to meet all eligibility requirements.
 - b. CCT clients entering a nursing facility for Respite Care as a qualified HCBS waiver service shall not be discontinued from the CCT program.

3. Clients who reside in a residence that is not a qualified residence as defined in Section 8.555.2 are not eligible for CCT services.
4. Certain demonstration services may not be available to clients for certain waivers if those demonstration services are similar to or are the same as services already offered through the waiver in which the client will enroll upon discharge.

8.555.5.F. COST CONTAINMENT AND SERVICE ADEQUACY

1. The client shall not be eligible for the CCT program if:
 - a. The Department or its agent determines that the client's needs cannot be met within the specific Cost Containment requirements set for the waiver in which they will enroll upon discharge.
 - b. The transition assessment reveals that the client's needs are more extensive than CCT demonstration services or HCBS qualified services are able to support and/or that the client's health and safety cannot be assured in a community setting.
2. In the event that the Department or its agent denies or reduces the request for services prior to transition, the case manager shall provide the client with the client's appeal rights pursuant to Section 8.555.12.
3. The client may be eligible for continuation with an HCBS waiver program following the CCT enrollment period if the case manager at reassessment determines that qualified services are able to support the client's needs and the client's health and safety can be assured in a community setting with HCBS services.
 - a. If the case manager expects that the services required to support the client's needs will exceed the Cost Containment requirements for the waiver in which the client is enrolled, the Department or its agent will review the service plan to determine if the client's request for services is appropriate and justifiable based on the client's condition.
 - i) The client may request of the case manager that existing qualified services remain intact during this review process. CCT demonstration services will still end on the 365th day of the client's enrollment in the CCT program.
 - ii) In the event that the request for services is denied by the Department or its agent, the case manager shall provide the client with:
 - 1) The client's appeal rights pursuant to Section 8.555.12; and

- 2) Alternative options to meet the client's needs that may include, but are not limited to, nursing facility or ICF/ID placement.

8.555.6 CCT ENROLLMENT

- 8.555.6.A. Clients shall demonstrate by signature that he or she provides consent to participate in the CCT demonstration program; understands the roles and responsibilities of the client, case manager and transition coordinator; and agrees to participate in the program evaluation activities.
- 8.555.6.B. Guardians shall demonstrate by signature that he or she provides consent for the client to participate in the CCT demonstration program; understands the roles and responsibilities of the client, case manager and transition coordinator; and agrees to participate in the program evaluation activities.
- 8.555.6.C. Transition coordinators and case managers will ensure that clients meet all eligibility requirements identified in Section 8.555.5 prior to enrollment.
- 8.555.6.D. Transition coordinators shall complete the Department approved Transition Assessment and Plan for each client within 10 days of the initial meeting with the client.
- 8.555.6.E. Transition coordinators and case managers will follow all steps and processes stated in Section B.1, Enrollment and Eligibility, and Section B.2, Informed Consent and Guardianship, of the CCT Operational Protocol to complete the transition process and enrollment of the CCT client.
- 8.555.6.F. Transition coordinators shall act in accordance with Department guidance and the requirements established in 10 C.C.R. 2505-10, Section 8.553.

8.555.7 START DATE FOR SERVICES

- 8.555.7.A. The start date of eligibility for CCT services shall not precede the date that all of the requirements at Section 8.555.5 have been met.
- 8.555.7.B. The first date for which CCT services may be reimbursed shall be the date of discharge from a qualified institution.
- 8.555.7.C. Transition coordination services and case management services may be offered prior to the client's transition in preparation of the transition to a community setting. Other services may be provided pre-transition with Departmental approval if the service is necessary for transition. Services shall be billed retroactively upon the date of discharge or up to 120 days after discharge.

8.555.8 CASE MANAGEMENT FUNCTIONS

- 8.555.8.A. The requirements at 10 CCR 2505-10, Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the CCT program and the HCBS-EBD, HCBS-CMHS or HCBS-BI waiver programs. Case managers for these waivers shall comply with these requirements and the CCT-specific requirements in the rest of this section.
- 8.555.8.B. The requirements at 10 CCR 2505-10, Section 8.760 shall apply to the Case Management Agencies performing the case management functions of the CCT program and the HCBS-SLS or HCBS-DD programs. Case managers for these waivers shall comply with these requirements and the CCT-specific requirements in the rest of this section.
- 8.555.8.C. The case manager is responsible for:
1. Assessing needs;
 2. Determining CCT and waiver program eligibility;
 3. Service planning and authorization;
 4. Arranging services;
 5. Identifying potential risks for reinstitutionalization;
 6. Implementing strategies with the client and family to mitigate risks;
 7. Monitoring services;
 8. Monitoring the health, welfare and safety of the client; and
 9. Promotion of client's self-advocacy.
- 8.555.8.D. The case manager shall conduct a home visit with the transition coordinator on the date of discharge to:
1. Confirm the start of services;
 2. Ensure clients are safe; and
 3. Identify and address any unanticipated concerns, issues and problems clients may have with the transition.
- 8.555.8.E. The case manager shall conduct a check-in with the client by phone 48 hours after discharge and conduct any necessary follow-up activities needed.
- 8.555.8.F. The case manager shall conduct three additional home visits in the first month that clients are enrolled in the program to provide support for success with community living.

8.555.8.G. The case manager shall have weekly contacts with clients, family members, guardians or other designated representative for the duration of their enrollment in the CCT program to monitor services and the health, welfare and safety of the clients; to review functional status; and to conduct any necessary follow-up activities necessary to ensure independent living in the community.

Contacts may either be phone contacts or home visits based on necessity.

8.555.8.H. The case manager shall revise the service plan as needed based on the weekly contacts or as otherwise needed due to change in the client's condition.

8.555.8.I. The case manager shall review the client's most recent ULTC 100.2 and update the ULTC 100.2 assessment if a change in functional status or a significant change impacting eligibility has occurred, in accordance with 10 CCR 2505-10, Section 8.401.1.

8.555.8.J. The case manager in accordance with Section B.10, Continuity of Care Post Demonstration, in the CCT Operational Protocol shall begin preparing clients for dis-enrollment from the CCT program 90 days prior to the end of the clients' CCT enrollment period and arrange for the continuation of HCBS services if the clients continue to meet the eligibility requirements for a waiver listed at 8.555.4.D.

8.555.9 SERVICE PLAN

8.555.9.A. The service plan will be developed with input from the transition coordinator, staff from the discharging facility, the resident wanting to transition and others at the invitation of the client or guardian.

8.555.9.B. The transition assessment/plan, the client's level of functioning, service needs, available resources and potential funding resources will inform the development of the service plan.

8.555.9.C. The Transition Administrator at the Department shall approve the service plan before the transition occurs.

8.555.9.D. The service plan shall:

1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver qualified services, CCT demonstration services or through other means;
2. Identify risks to reinstitutionalization and outline a contingency plan identifying paid and unpaid supports and services necessary to mitigate the risk.
3. Be in accordance with the rules, policies and procedures related to service plans established by the Division for Developmental Disabilities if clients are enrolled in the

HCBS-SLS (10 CCR 2505-10, Section 8.500.95) or -DD waivers (10 CCR 2505-10, Section 8.500.6);

4. Be in accordance with the rules, policies and procedures established related to service plans by the Department of Health Policy and Financing for clients enrolled in the HCBS-EBD (10 CCR 2505-10, Section 8.486.51), -CMHS (10 CCR 2505-10, Section 8.509.31.D.) or -BI waivers (10 CCR 2505-10, Section 8.515.30.E.);
5. Be in accordance with the rules, policies and procedures of the CCT Operational Protocol; and
6. Include updates and revisions when warranted by changes in the client's needs or conditions.

8.555.9.E. The service plan shall document that the client has been offered a choice:

1. Between community-based services or institutional care;
2. Between the CCT Program or a traditional HCBS Waiver;
3. Among qualified and demonstration services; and
4. Among qualified providers.

8.555.9.F. A new service plan will be developed each time a client is reinstitutionalized and plans to return to a community setting. The service plan shall address the reasons for the client's reinstitutionalization.

8.555.10 PROVIDER REIMBURSEMENT

8.555.10.A. All CCT demonstration and qualified services must be prior authorized by the Department or its agent.

8.555.10.B. The Department shall develop the Prior Authorization Request (PAR) form to be completed by case managers who shall comply with all applicable regulations when completing the form.

8.555.10.C. The Department or its agent shall determine if the services requested are:

1. Consistent with the client's documented medical condition and functional capacity;
2. Reasonable in amount, scope, frequency, and duration;
3. Not duplicative of the other services included in the client's service plan;
4. Not for services for which the client is receiving funds to purchase; and

5. Do not total more than 24 hours per day of care.
- 8.555.10.D. The services requested on the PAR must meet all criteria listed at 8.555.10.C for the Department or its agent to approve the request.
 - 8.555.10.E. If the Department or its agent determines that the services requested on the PAR do not meet the criteria at 8.555.10.C., the Department or its agent shall deny the PAR and work with the case management agency to submit a revised request.
 1. If services are reduced or denied through a revised PAR, the case manager shall provide the client with the client's appeal rights pursuant to Section 8.555.12.
 - 8.555.10.F. The prior authorization of services does not constitute an entitlement to those services, and does not guarantee payment.
 - 8.555.10.G. The PAR start date shall not precede the start date of CCT eligibility in accordance with Section 8.555.7.
 - 8.555.10.H. The PAR end date shall not exceed the end date of the initial CCT enrollment period, which cannot exceed 365 calendar days.
 - 8.555.10.I. Revisions to the PAR that are requested six months or more after the end date of CCT enrollment shall be disapproved.
 - 8.555.10.J. Prior to the end date, case managers shall establish a new CCT enrollment period and create a new PAR to reflect any days during the initial enrollment period that a client entered a hospital, nursing home, ICF/ID or other long term care institution for a period less than 30 days to ensure the client has a full 365 days of CCT enrollment in the community.
 1. The numbers of days for the new enrollment period and PAR shall be equal to the numbers of days that the client was placed in an institution and shall commence on the first day after the end date of the initial enrollment period.
 - 8.555.10.K. Prior Authorization Requests for clients enrolled in the HCBS-DD waiver shall be completed in accordance with Section 8.500.12
 - 8.555.10.L. Prior Authorization Requests for clients enrolled in the HCBS-SLS waiver shall be completed in accordance with Section 8.500.101.
 - 8.555.10.M. The PAR for qualified and demonstration services shall be sent to the Transition Administrator at the Department for approval.
 - 8.555.10.N. Approval of the PAR by the Department shall authorize providers of CCT services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. However, a PAR does not guarantee payment.

8.555.10.O. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

8.555.10.P. Payment for CCT Services

1. Payment for CCT services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.
 - a. Rates for Behavioral Health Support, Caregiver Support Service, Enhanced Nursing Services, Home Delivered Meals, Independent Living Skills Training, Intensive Case Management, Mentorship Service, Specialized Day Rehabilitation, Substance Abuse Counseling (Transitional) are reimbursed on a fee-for-service basis and payment is based on the rate for each service found on the Departments statewide fee schedule.
 - b. The statewide fee schedule for these services are reviewed annually and published in the provider billing manual.
 - c. Payment for Assistive Technology, Dental Services, Extended Home Modifications and Vision services are reimbursed the billed cost but cannot exceed the Department established maximums.
2. Payment for CCT services is also conditional upon:
 - a. The client's eligibility for CCT services;
 - b. The provider's certification status; and
 - c. The submission of claims in accordance with proper billing procedures.

8.555.11 PROVIDER AGENCIES

8.555.11.A. CCT providers providing demonstration services to clients enrolled in CCT and HCBS-EBD, -BI, or -MI shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.487.

8.555.11.B. CCT providers providing demonstration services to clients enrolled in CCT and HCBS-DD shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.500.9.

8.555.11.C. CCT providers providing demonstration services to clients enrolled in CCT and HCBS-SLS shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.500.98.

8.555.11.D. CCT providers of specific demonstration services must comply with any additional certification standards or conditions contained in Appendix L of the CCT Operational Protocol. Appendix L (2012) is hereby incorporated by reference in this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These materials are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. The Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

8.555.12 APPEAL RIGHTS

8.555.12.A. Case management agencies shall follow the rules for notification and appeals established for the waiver in which the client will enroll upon discharge.

1. For clients enrolled on HCBS-EBD, -BI and -CMHS, the case management agencies or utilization review contractor shall provide notification of adverse actions and appeals rights in accordance with 8.393.28.A.
2. For clients enrolled on HCBS-DD, the case management agencies shall provide notification of adverse actions and appeal rights in accordance with 8.500.16.
3. For clients enrolled on HCBS-SLS, the case management agencies shall provide notification of adverse actions and appeal rights in accordance with 8.500.106.

Housing Counseling Agencies COLORADO

Agency Name: COMMUNITY RESOURCE AND HOUSING DEVELOPMENT CORPORATION- ALAMOSA

Phone: 719-589-1680

Toll Free:

Fax: 719-589-1688

Email: arturo@crhdc.org

Address: 1016 West Avenue, Box 1
ALAMOSA, Colorado 81101-3052

Counseling Services: - Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops

Languages: - English
- Spanish

Affiliation: COMMUNITY RESOURCES AND HOUSING DEVELOPMENT CORPORATION

Website: www.crhdc.org

Agency Name: CITY OF AURORA COMMUNITY DEVELOPMENT DIVISION

Phone: 303-739-7900

Toll Free:

Fax: 303-739-7925

Email: aormsby@auroragov.org

Address: 9898 E. Colfax Ave.
AURORA, Colorado 80010-5012

Counseling Services: - Fair Housing Pre-Purchase Education Workshops
- Financial Management/Budget Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
- Rental Housing Counseling

Languages: - English
- Spanish

Affiliation:

Website: <http://www.ci.aurora.co.us>

Agency Name: BOULDER COUNTY HOUSING AUTHORITY

Phone: 720-564-2279

Toll Free:

Fax: 303-441-1537

Email: hcinfo@bouldercounty.org

Address: 2525 13th Street unit 204
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- Financial Management/Budget Counseling
- Home Improvement and Rehabilitation Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
- Rental Housing Counseling

Languages: - English
- Spanish

Affiliation:

Website: <http://www.bouldercountyhc.org>

Agency Name: UPPER ARKANSAS AREA COUNCIL OF GOVERNMENTS

Phone: 719-269-7687

Toll Free:

Fax: 719-275-2907

Email: lyost@uaacog.com

Address: 3224 Independence Rd Unit A
Canon City, Colorado 81212-6314

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- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops

Languages: - ASL
- English
- Spanish

Affiliation:

Website: <http://www.uaacog.com>

Agency Name: CCCS OF GREATER DALLAS-COLORADO SPRINGS

Phone: 719-576-0909

Toll Free: 800-798-3328
Fax: 719-576-3756
Email: housingteam@cccs.net
Address: 1233 Lake Plaza Dr., Suite A
COLORADO SPRINGS, Colorado 80906-3567
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- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
- Rental Housing Counseling
Languages: - English
Affiliation: CCCS OF GREATER DALLAS, INC.
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Agency Name: CCCS OF GREATER DALLAS-COLORADO SPRINGS NORTH
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Toll Free: 800-249-2227
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COLORADO SPRINGS, Colorado 80918-4057
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- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
- Rental Housing Counseling
- Services for Homeless Counseling
Languages: - English
Affiliation: CCCS OF GREATER DALLAS, INC.
Website: <http://www.cccs.net>

Agency Name: ADAMS COUNTY HOUSING AUTHORITY
Phone: 303-227-2075
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- Financial Management/Budget Counseling
- Home Improvement and Rehabilitation Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
- Rental Housing Counseling
- Rental Housing Workshops
- Services for Homeless Counseling
Languages: - English
- French
- Spanish
Affiliation:
Website: <http://www.adamscountyhousing.com>

Agency Name: COLORADO HOUSING ASSISTANCE CORPORATION
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Email: chac01@aol.com
Address: 670 Santa Fe Dr
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- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
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Website: <http://www.coloradohousingassistance.org>

Agency Name: DEL NORTE NEIGHBORHOOD DEVELOPMENT CORPORATION (NDC)
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- Home Improvement and Rehabilitation Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
Languages: - English
- Spanish
Affiliation: NATIONAL COUNCIL OF LA RAZA
Website: <http://www.delnortendc.org>

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Counseling Services: - Financial Management/Budget Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
Languages: - English
- Spanish
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Affiliation:
Website: <http://n/a>

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- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Rental Housing Counseling
Languages: - English
- Spanish
Affiliation: MONEY MANAGEMENT INTERNATIONAL INC.
Website: <http://www.moneymanagement.org>

Agency Name: NACA (NEIGHBORHOOD ASSISTANCE CORPORATION OF AMERICA) DENVER, CO
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- Financial Management/Budget Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
Languages: - English
Affiliation: NACA (NEIGHBORHOOD ASSISTANCE CORPORATION OF AMERICA)
Website: <http://www.naca.com>

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- Home Improvement and Rehabilitation Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling

- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
Languages: - English
- Spanish
Affiliation: STRUCTURED EMPLOYMENT ECONOMIC DEVELOPMENT CO
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Counseling Services: - Financial Management/Budget Counseling
- Home Improvement and Rehabilitation Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Reverse Mortgage Counseling
Languages: - English
- Spanish
Affiliation:
Website: www.nedenverhousing.org

Agency Name: SOUTHWEST IMPROVEMENT COUNCIL
Phone: 303-934-0923
Toll Free:
Fax: 303-934-0035
Email: janswic@hotmail.com
Address: 1000 South Lowell Blvd.
DENVER, Colorado 80219-3339
Counseling Services: - Financial Management/Budget Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Rental Housing Counseling
Languages: - English
- Other
- Spanish
- Vietnamese
Affiliation:
Website: <http://swic-denver.org>

Agency Name: SUMMIT COUNTY FAMILY RESOURCE CENTER
Phone: 970-262-3888-322
Toll Free:
Fax: 970-513-1167
Email: robertm@summitfirc.org
Address: 103 Main Street
Dillon, Colorado 80435
Counseling Services: - Rental Housing Counseling
- Services for Homeless Counseling
Languages: - English
- Spanish
Affiliation:
Website: www.summitfirc.org

Agency Name: HOUSING SOLUTIONS FOR THE SOUTHWEST
Phone: 970-259-1086
Toll Free:
Fax:
Email: tmiller@swhousingsolutions.org
Address: 295 Girard St
DURANGO, Colorado 81303-6828
Counseling Services: - Fair Housing Pre-Purchase Education Workshops
- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
- Rental Housing Counseling
- Services for Homeless Counseling
Languages: - English
Affiliation:
Website: <http://www.asite.com>

Agency Name: BROTHERS REDEVELOPMENT, INC.
Phone: 303-202-6340
Toll Free:

Fax:
Email: shannon@brothersredevelopment.org
Address: 2250 Eaton St
EDGEWATER, Colorado 80214-1276
Counseling Services: - Fair Housing Pre-Purchase Education Workshops
- Financial Management/Budget Counseling
- Home Improvement and Rehabilitation Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops
- Rental Housing Counseling
Languages: - English
- Spanish
Affiliation:
Website: <http://www.asite.com>

Agency Name: GREENPATH DEBT SOLUTIONS
Phone: 888-860-4167
Toll Free: 888-860-4167
Fax:
Email: housingdepartment@greenpath.com
Address: 1247 Riverside Ave
FORT COLLINS, Colorado 80524-3218
Counseling Services: - Financial Management/Budget Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Services for Homeless Counseling
Languages: - English
- Spanish
Affiliation: GREENPATH, INC.
Website: <http://www.greenpath.com>

Agency Name: NEIGHBOR TO NEIGHBOR
Phone: 970-488-2364
Toll Free:
Fax:
Email: Inichols@n2n.org
Address: 1550 Blue Spruce Dr
Fort Collins, Colorado 80524-2015
Counseling Services: - Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Rental Housing Counseling
Languages: - English
Affiliation:
Website: <http://www.asite.com>

Agency Name: NORTHEAST COLORADO HOUSING, INC.
Phone: 970-542-1221
Toll Free:
Fax: 970-542-1222
Email: nechi@qwestoffice.net
Address: 801 S. West Street, 25
FORT MORGAN, Colorado 80701-4068
Counseling Services: - Fair Housing Pre-Purchase Education Workshops
- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
Languages: - English
- Spanish
Affiliation:
Website: n/a

Agency Name: TRI-COUNTY HOUSING & COMMUNITY DEVELOPMENT CORPORATION
Phone: 719-263-5168
Toll Free:
Fax:
Email: acctg@tchcdc.org
Address: 34385 State Highway 167
PO Box 87
Fowler, Colorado 81039-9749
Counseling Services: - Financial Management/Budget Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
Languages: - English
- Spanish
Affiliation:

Website: <http://www.asite.com>

Agency Name: NEIGHBOR TO NEIGHBOR
Phone: 970-484-7498
Toll Free:
Fax: 970-488-2355
Email: contact@n2n.org
Address: Murphy Center
242 Conifer St.
Ft Collins, Colorado 80524
Counseling Services: - Rental Housing Counseling
Languages: - English
- Spanish
Affiliation: NEIGHBOR TO NEIGHBOR
Website: <http://www.n2n.org>

Agency Name: GRAND JUNCTION HOUSING AUTHORITY
Phone: 970-245-0388-227
Toll Free:
Fax: 970-254-8347
Email: acase@gjha.org
Address: 1011 N 10th St
Grand Junction, Colorado 81501-3166
Counseling Services: - Financial Management/Budget Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
Languages: - ASL
- English
- Spanish
Affiliation:
Website: <http://www.gjha.org>

Agency Name: GREENPATH DEBT SOLUTIONS
Phone: 888-860-4167
Toll Free: 888-860-4167
Fax:
Email: housingdepartment@greenpath.com
Address: 918 Thirteenth St
Suite 5
GREELEY, Colorado 80631-4667
Counseling Services: - Financial Management/Budget Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Services for Homeless Counseling
Languages: - English
- Spanish
Affiliation: GREENPATH, INC.
Website: <http://www.greenpath.com>

Agency Name: MONEY MANAGEMENT INTERNATIONAL HIGHLANDS RANCH
Phone: 866-232-9080
Toll Free: 866-232-9080
Fax: 866-921-5129
Email: counselinginfo@moneymanagement.org
Address: 7120 E County Line Rd
Highlands Ranch, Colorado 80126+3926
Counseling Services: - Financial Management/Budget Counseling
- Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Rental Housing Counseling
Languages: - English
- Spanish
Affiliation: MONEY MANAGEMENT INTERNATIONAL INC.
Website: <http://www.moneymanagement.org>

Agency Name: DOUGLAS COUNTY HOUSING PARTNERSHIP
Phone: 303-784-7824
Toll Free:
Fax: 303-814-2966
Email: bosborn@douglas.co.us
Address: 9350 Heritage Hills Circle
LONETREE, Colorado 80124-5518
Counseling Services: - Mortgage Delinquency and Default Resolution Counseling
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Rental Housing Workshops
Languages: - English
Affiliation:

Agency Name: GREENPATH DEBT SOLUTIONS

Phone: 888-860-4167

Toll Free: 888-860-4167

Fax:

Email: housingdepartment@greenpath.com

Address: 2919 West 17th Ave
#109

LONGMONT, Colorado 80503-1650

- Counseling Services:**
- Financial Management/Budget Counseling
 - Mortgage Delinquency and Default Resolution Counseling
 - Pre-purchase Counseling
 - Services for Homeless Counseling

Languages:

- English
- Spanish

Affiliation: GREENPATH, INC.

Website: <http://www.greenpath.com>

Agency Name: NEIGHBOR TO NEIGHBOR

Phone: 970-663-4163

Toll Free:

Fax: 970-663-2860

Email: contact@n2n.org

Address: 565 North Cleveland Avenue

LOVELAND, Colorado 80537-5580

- Counseling Services:**
- Mortgage Delinquency and Default Resolution Counseling
 - Pre-purchase Counseling
 - Pre-purchase Homebuyer Education Workshops
 - Rental Housing Counseling

Languages:

- English

Affiliation: NEIGHBOR TO NEIGHBOR

Website: <http://www.n2n.org>

Agency Name: CATHOLIC CHARITIES OF THE DIOCESE OF PUEBLO, CO

Phone: 719-544-4233

Toll Free: 800-303-4690

Fax: 719-544-4215

Email: jmhoney@pueblocharities.org

Address: 429 W 10th St Ste 101

Pueblo, Colorado 81003-2941

- Counseling Services:**
- Financial Management/Budget Counseling
 - Financial, Budgeting and Credit Repair Workshops
 - Mortgage Delinquency and Default Resolution Counseling
 - Rental Housing Counseling
 - Services for Homeless Counseling

Languages:

- English
- Spanish

Affiliation: CATHOLIC CHARITIES USA

Website: <http://www.pueblocharities.org>

Agency Name: CCCS OF GREATER DALLAS-PUEBLO

Phone: 719-542-6620

Toll Free: 888-218-5741

Fax: 719-542-7057

Email: housingteam@cccs.net

Address: 200 West 1st Street, Suite 302

PUEBLO, Colorado 81003-3262

- Counseling Services:**
- Financial Management/Budget Counseling
 - Mortgage Delinquency and Default Resolution Counseling
 - Non-Delinquency Post Purchase Workshops
 - Pre-purchase Counseling
 - Pre-purchase Homebuyer Education Workshops
 - Predatory Lending Education Workshops
 - Rental Housing Counseling
 - Services for Homeless Counseling

Languages:

- English

Affiliation: CCCS OF GREATER DALLAS, INC.

Website: <http://www.cccs.net>

Agency Name: NEIGHBORWORKS OF PUEBLO

Phone: 719-544-8078

Toll Free:

Fax:

Email: rgodfrey@nwpueblo.org

Address: 1241 E Routt Ave

PUEBLO, Colorado 81004-2908

- Counseling Services:**
- Fair Housing Pre-Purchase Education Workshops
 - Financial Management/Budget Counseling
 - Mortgage Delinquency and Default Resolution Counseling

- Non-Delinquency Post Purchase Workshops
- Pre-purchase Counseling
- Pre-purchase Homebuyer Education Workshops
- Predatory Lending Education Workshops

Languages: - English

Affiliation:

Website: <http://www.nwpueblo.org>

Agency Name: COMMUNITY RESOURCES AND HOUSING DEVELOPMENT CORPORATION

Phone: 303-428-1448

Toll Free:

Fax:

Email: arturo@crhdc.org

Address: 7305 Lowell Blvd Unit 200
Westminster, Colorado 80030+1709

- Counseling Services:**
- Financial Management/Budget Counseling
 - Home Improvement and Rehabilitation Counseling
 - Mortgage Delinquency and Default Resolution Counseling
 - Non-Delinquency Post Purchase Workshops
 - Pre-purchase Counseling
 - Pre-purchase Homebuyer Education Workshops
 - Predatory Lending Education Workshops
 - Rental Housing Counseling

Languages: - English

- Spanish

Affiliation:

Website: <http://www.asite.com>

Agency Name: MONEY MANAGEMENT INTERNATIONAL WESTMINSTER

Phone: 866-232-9080

Toll Free: 866-232-9080

Fax: 866-921-5129

Email: counselinginfo@moneymanagement.org

Address: 9101 Harlan St Unit 150
Westminster, Colorado 80031+2925

- Counseling Services:**
- Financial Management/Budget Counseling
 - Mortgage Delinquency and Default Resolution Counseling
 - Pre-purchase Counseling
 - Pre-purchase Homebuyer Education Workshops
 - Rental Housing Counseling

Languages: - English

- Spanish

Affiliation: MONEY MANAGEMENT INTERNATIONAL INC.

Website: <http://www.moneymanagement.org>