Informed Consent for Participation

Participant Name (Last, First, MI): _____

Health First Colorado ID # _____

Informed consent for participation is the process by which a person will learn important facts about the Colorado Choice Transitions (CCT) program. This form provides information about program eligibility requirements, and includes the rights and responsibilities of all program participants. Participation in the CCT program is voluntary and a person may decide to dis-enroll from CCT at any time.

Your Responsibilities

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

- I will move from the nursing facility or Intermediate Care Facility/ Individuals with Intellectual Disabilities (ICF/IID) to a qualified community residence. A qualified community residence is:

  - ✓ A home owned or leased by me or my family;
  - ✓ A home in which no more than 4 unrelated people reside; and
  - ✓ 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 Health First Colorado (Colorado's Medicaid Program) for at least 1 day prior to my move.
- I will accept services from either an HCBS waiver, Health First Colorado 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:
    - o A place to live; and
    - o A doctor, pharmacy and other community resources/services.

- 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.
- I will notify the CCT Program if I move during the 24 months following my transition period.

Things You Should Know:

- 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, the organization that collects data and evaluates all Money Follows the Person Rebalancing Demonstration programs.
- Any information Mathematica collects about you is confidential and used only for evaluating the program.
- You must maintain Health First Colorado eligibility which includes functional and financial requirements.
- Your CCT Services will end on day 366. You will be able to stay on a Home and Community-Based Services (HCBS) waiver and state plan services as long as you meet the eligibility requirements.
- Your services plan and health outcomes will be monitored by the CCT Program.

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.

Participant Acknowledgement

Participant Signature: _____ Date: _____

Print: _____ Phone: _____

Participant Address: _____

ADRC Options Counselor

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

Signature: _____ Date: _____

Print: _____ Phone: _____

Address: _____

Guardian's Responsibilities

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

- To be available to participate in a service planning meeting at least annually;
- To participate in discharge planning; and
- To comply with all probate court reporting requirements.

Note: It is recommended that the guardian be a resident of Colorado.

Describe the level of contact you have had with this participant over the past six months:

- Face to Face Visits — If so, how many: _____
- Telephone Contacts — If so, how many: _____
- Telephone, email or other contact with the facility regarding care — If so, how many: _____

Legal Guardian Signature: _____ Date: _____

Print: _____ Phone: _____

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. Please contact us for assistance:

Teresa Nguyen
CCT Community Liaison
1570 Grant Street
Denver, CO 80203
Telephone: 303-866-6420
E-mail: Teresa.Nguyen@state.co.us

Revocation of Informed Consent

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

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
Date

Authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Participant/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 Participant/Guardian

On _____. The participant and/or guardian has been informed that any action
Date
Taken on this authorization prior to the rescinded date is legal and binding.

_____ _____
Signature of Staff Date

_____ _____
Signature of Witness Date

Return Completed Informed Consent form to CCT Transition Administrator:

Nora Brahe
1570 Grant Street Fax: 303-866-3669
Denver, CO 80203 Encrypted e-mail: Nora.Brahe@state.co.us

For Official Use Only (Completed by Transition Coordinator or Case Manager)	
Estimated Date of Discharge:	Name of Facility:
Facility Phone (include area code):	Facility Address: