



**Letter of Intent to enroll in Colorado Choice Transitions (CCT) for existing HCBS-EBD/CMHS/BI Providers**

**Service Agency Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Mailing Address (if different):** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Phone Number(s):** \_\_\_\_\_

**Service Agency Provider Number and Provider Type:** \_\_\_\_\_

**Please indicate all counties in your service area:** \_\_\_\_\_

**Below please check the box indicating the waiver population you will serve and each CCT demonstration service you intend to provide under that waiver:**

<input type="checkbox"/> <b>HCBS – Persons who are Elderly, Blind, and Disabled</b>	
<input type="checkbox"/> Assistive Technology, Extended	<input type="checkbox"/> Independent Living Skills Training
<input type="checkbox"/> Caregiver Education	<input type="checkbox"/> Peer Mentorship
<input type="checkbox"/> Community Transition Services	<input type="checkbox"/> Substance Abuse Counseling, Transitional
<input type="checkbox"/> Dental Service	<input type="checkbox"/> Transitional Behavioral Health Supports
<input type="checkbox"/> Enhanced Nursing	<input type="checkbox"/> Transitional Specialized Day Rehabilitation Services
<input type="checkbox"/> Home Delivered Meals	<input type="checkbox"/> Vision Services
<input type="checkbox"/> Home Modifications, Extended	
<input type="checkbox"/> <b>HCBS – Community Mental Health Supports</b>	
<input type="checkbox"/> Assistive Technology, Extended	<input type="checkbox"/> Independent Living Skills Training
<input type="checkbox"/> Caregiver Education	<input type="checkbox"/> Peer Mentorship
<input type="checkbox"/> Community Transition Services	<input type="checkbox"/> Substance Abuse Counseling, Transitional
<input type="checkbox"/> Dental Service	<input type="checkbox"/> Transitional Behavioral Health Supports
<input type="checkbox"/> Enhanced Nursing	<input type="checkbox"/> Transition Specialized Day Rehabilitation
<input type="checkbox"/> Home Delivered Meals	<input type="checkbox"/> Vision Services
<input type="checkbox"/> Home Modifications, Extended	
<input type="checkbox"/> <b>HCBS – Persons with Brain Injury</b>	
<input type="checkbox"/> Caregiver Education	<input type="checkbox"/> Home Modifications, Extended
<input type="checkbox"/> Community Transition Services	<input type="checkbox"/> Peer Mentorship
<input type="checkbox"/> Dental Services	<input type="checkbox"/> Transitional Specialized Day Rehabilitation Services
<input type="checkbox"/> Enhanced Nursing	<input type="checkbox"/> Vision Services
<input type="checkbox"/> Home Delivered Meals	

**HCBS Case Management Agencies ONLY** - In order to provide Intensive Case Management, providers must currently provide Medicaid HCBS case management to specified target populations served through CCT and administer adult HCBS waiver programs for one or more of the target populations.

**Intensive Case Management**

Please return this letter of intent and all supporting documentation to Nicholas Clark at 1570 Grant Street Denver, CO 80203 or scan and e-mail to [nicholas.clark@state.co.us](mailto:nicholas.clark@state.co.us).

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

The service agency assures:

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

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

\_\_\_\_\_ Cooperation with Federal and State auditing authorities.

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

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Name of Agency Director/CEO (Print)

Signature

Date