



## Letter of Intent to Enroll in Colorado Choice Transitions (CCT) for Existing HCBS-DD/SLS Providers

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

Agency Website Address: \_\_\_\_\_

Contact Name for Referrals: \_\_\_\_\_

Email Address for Referrals: \_\_\_\_\_

Phone Number(s) for Referrals: \_\_\_\_\_

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

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

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

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

Indicate waiver population(s) you will serve & CCT demonstration services you intend to provide under that waiver:

**HCBS – Persons with Developmental Disabilities**

Assistive Technology, Extended

Caregiver Education

Community Transition Services

Enhanced Nursing

Home Accessibility Adaptations, Extended

Peer Mentorship

Substance Abuse Counseling, Transitional

**HCBS – Supported Living Services**

Caregiver Education

Community Transition Services

Enhanced Nursing

Home Accessibility Adaptations, Extended

Independent Living Skills Training

Substance Abuse Counseling, Transitional



**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:

Nicole Storm  
LTSS Division  
1570 Grant Street  
Denver, CO 80203

Or scan and e-mail to [Nicole.Storm@state.co.us](mailto:Nicole.Storm@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.**

\_\_\_\_\_  
Name of Agency Director/CEO (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date