

Participant Directed Programs Policy Collaborative  
Draft Recommendation - Stable Health  
February 27, 2013

Work Plan Task – Change the physician statement of consumer capability to better define “stable health” and to provide more detail on what skills one needs to manage care.

### **Physician Statement of Consumer Capability**

Stable health means a condition of health that necessitates a predictable pattern of attendant support, allowing for variation consistent with a medically determinable progression or variation of disability or illness.

### **10 CCR 2505-10**

Section 8.510.1 - Stable health means a medically predictable progression or variation of disability or illness.

Section 8.510.2.A (6) - Document a pattern of stable health that necessitates a predictable pattern of attendant support and appropriateness of CDASS services.

### **Recommendation**

The Department should adopt the following form, which was modified based on stakeholder and physician input:

## Physician Attestation of Consumer Capacity

The following client is interested in directing his or her own services through Consumer Directed Attendant Support Services (CDASS) under a Colorado Medicaid Home and Community Based Services waiver. The client will be responsible for selecting, training and directing attendants to provide personal care, homemaker and/or health maintenance (skilled) care. To qualify for the benefit the client's primary care physician shall either attest to the client's capacity to direct care with sound judgment or recommend the client utilize an authorized representative.

NOTE: Sections of the Nurse Practice Act and Nurse Aide legislation do not apply to CDASS (25.5-6-1101 C.R.S.)

Section I: Client Information Section							
Client Medicaid Number:							
Last Name: _____		First Name: _____			Middle Initial: _____		
Street _____							
Address: _____		City: _____		State: _____		Zip: _____	
Date of _____		Birth: _____		Telephone: _____		Male <input type="checkbox"/> Female <input type="checkbox"/>	

Section II: Medical Information	
<p><b>The following questions address the stability of the client's medical condition. Only those clients whose health conditions are considered stable are eligible to participate in CDASS. Stable health is defined as a medically predictable progression or variation of a disability or illness.</b></p>	
<p>Is the client's health condition stable, as defined above?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>Please provide information about the client's medical condition.</b></p> <p>Comments: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<p><b>Please answer the following questions. Answering 'NO' to any question below will require the client to use an authorized representative to direct his or her services. It does not preclude the client from participating in CDASS.</b></p>	
<p>Does this client have the capacity to develop and maintain budgets, establish attendant wage schedules and adjust them as necessary to remain within defined limits?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does this client have the capacity to understand and monitor conditions of basic health, and recognize how, when, and where to seek appropriate medical assistance (for example: If the client has a respiratory condition and developed shortness of breath, would he or she know who to contact)?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does this client have the capacity to direct care including the ability to train attendant(s) on the skilled/unskilled procedures or services needed (for example: training attendants on lifting and transferring needs or how to provide respiratory care)?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Does this client have the capacity to interview, select, discipline, dismiss, and otherwise manage attendants in a manner consistent with labor and employment laws? Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section III: Medical Provider**

Attesting Physician Name:		License #	
Phone:			
Address:			
City:		State:	
		Zip:	
Name of Person Completing this Form:		Date Completed:	
Signature of Attesting Physician:			
Medical Provider Comments: (optional)			