



## Request for SIS Reassessment

Member Information		
Last Name:	First Name:	M.I.:
Medicaid ID#:	SSN:	Date of Birth:

Supports Intensity Scale (SIS) Assessment Information	
Date of most recent SIS Assessment:	Algorithm Support Level:
Risk Values: <input type="checkbox"/> Extreme Safety Risk to Self <input type="checkbox"/> Public Safety Risk: Convicted <input type="checkbox"/> Public Safety Risk: Not Convicted	

Individual Services and Support Information	
Residential Setting: <input type="checkbox"/> Host Home <input type="checkbox"/> Group Home <input type="checkbox"/> 3-bed PCA <input type="checkbox"/> Own Home <input type="checkbox"/> Family Home	
HCBS Waiver:	Certification Dates:
Residential Service Agency:	Day Habilitation Agency:
Other HCBS Supports & Services:	
Summary of Current HCBS Services Utilization. If authorized services are underutilized, please explain:	

Name of individual, legal guardian, authorized representative, or family member that reviewed this information	
Name:	Relationship:
Mailing Address:	Phone:
Request initiated by: (individual, guardian, case manager, etc.):	

Case Management Information	
Case Management Agency:	
Contact Person Name:	Email:
Phone:	Date Submitted:

Indicate the reason that a new SIS assessment is being requested (10 CCR 2505-10, 8.612):

- There has been a change in the individual's life circumstances or condition resulting in the significant change to the amount of services and supports needed to keep the individual safe (Proceed to #1.)
- There is reason to believe that the results of the most recent SIS assessment do not accurately reflect the individual's support needs (Proceed to #2.)
- A complaint regarding the administration of the initial SIS assessment has been filed (Proceed to #3.)

**1. If this request is based upon a change in the individual's circumstances or condition, please describe 1) what has changed, 2) how has the change impacted the individual's needs and level of support, 3) what has been done to meet the individual's needs, and 4) when did the change occur?**

**2. If this request is based upon the belief that the results of the current SIS assessment do not accurately reflect the individual's support needs, please provide 1) a list of items on the SIS assessment believed to be inaccurately scored and 2) a description of why it is believed that they were inaccurately scored.**

**3. Please summarize the issues raised in the complaint and provide an explanation of how conducting a new SIS assessment will resolve the complaint. Indicate the date the CCB was made aware of the complaint and the steps that have been taken to resolve the complaint.**

**Please send completed form with any additional documentation to [sis\\_sl@state.co.us](mailto:sis_sl@state.co.us)**