COLORADO
Department of Health Care Policy & Financing

Emergency Enrollment Request
Home and Community Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD)

Request Submitted to the Department of Health Care Policy & Financing	Date:

Member Information		
Member Name:		Date of Birth:
Community Centered Board: Select one		
Medicaid ID#:	SSN:	Medicaid Eligible: ☐ Yes ☐ No

Developmental Disability Information	
Date functional eligibility determined:	Order of selection date:
Current Waiting List Timeline: ☐ As soon as available ☐ Safety Net ☐ See Date ☐ No Record	
IQ Score:	Adaptive Behavior Score:
All Diagnoses:	
HCBS-DD Enrollment Requested By:	Anticipated Enrollment Date:

Other Assistance	
SSI/SSDI: ☐ Yes ☐ No If yes, amount:	Home Health: ☐ Yes ☐ No If yes, amount:
Housing Assistance: ☐ Yes ☐ No If yes, amount:	State FSSP: ☐ Yes ☐ No If yes, amount:
DVR:	

Current Enrollment *(complete all that apply)*	
Currently enrolled in State SLS: ☐ Yes ☐ No	Service Plan Date Span:
Currently enrolled in an HCBS Waiver: ☐ Yes ☐ No	If yes, which one: Select an HCBS Waiver
Amount of Authorized Services:	Service Plan Utilization to Date:
Support Level:	Date SIS Completed:
Current Paid Supports & Services:	
Other Private Pay or Unpaid Supports or Services:	

Current Enrollment *(complete all that apply)*	
Other Needs	
Does this person have mental health needs?: ☐ Yes ☐ No	
Is this person incarcerated?: ☐ Yes ☐ No	If Yes, where?:
	If Yes, how long?:
Is this person in respite?: ☐ Yes ☐ No	If Yes, how is it funded?:
	If Yes, how long?:
CCB Contact Information	
CCB Contact Name:	
Phone:	Email:

8.500.4 CLIENT ELIGIBILITY

To be eligible for the HCBS-DD Waiver an individual shall meet the target population criteria as follows:

1. Be determined to have a developmental disability,
2. Be eighteen (18) years of age or older,
3. Require access to services and supports twenty-four (24) hours a day,
4. Meet ICF-MR level of care as determined by the functional needs' assessment, and
5. Meet the Medicaid financial determination for LTC eligibility as specified in 10 CCR 2505-10, Section 8.100, et seq

The health and welfare of person or others is in danger (HCBS-DD, 10 CCR 2505-10, 8.500.7.F(1) due to:

Please mark all that apply to current situation

☐ **The emergency cannot be resolved in another way (HCBS-DD, 10 CCR 2505-10, 8.500.7.F(1))**

☐ **Homelessness:** The person will imminently lose his/her housing as evidenced by an eviction notice; or whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations or any other unstable or non-permanent situation; or is discharging from prison; or is in the hospital and does not have a stable housing situation to go upon discharge (HCBS-DD, 10 CCR 2505-10, 8.500.7.F(1)(a))

☐ **Abusive or neglectful situation:** The person is experiencing ongoing physical, sexual or emotional abuse or neglect in the person's present living situation and the person's health, safety or well-being is in serious jeopardy (HCBS-DD, 10 CCR 2505-10, 8.500.7.F(1)(b))

☐ **Danger to others:** The person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure safety of the person in the community (HCBS-DD, 10 CCR 2505-10, 8.500.7.F(1)(c))

☐ **Danger to self:** A person's medical, psychiatric or behavioral challenges are such that the person is seriously injuring/harming self or is in imminent danger of doing so. (HCBS-DD, 10 CCR 2505.10, 8.500.7.F(1)(d))

☐ **Loss or incapacitation of primary caregiver:** a person's primary caregiver is no longer in the person's primary residence to provide care; or the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; or the primary caregiver is age 65 years or older and continuing to provide care poses and imminent risk to the health and welfare of the person or primary caregiver; or, regardless of age and based on the recommendation of a professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare. (HCBS-DD, 10 CCR 2505.10, 8.500.7.F(1)(e))

Answer ALL of the following questions to provide information about the situation that meets the criteria for Emergency Enrollment.

Incomplete requests will be returned for completion prior to being considered.

NOTE: Answers that extend beyond the size of the space provided will not appear in print form.

1. Why is this person at risk of experiencing an emergency?

2. Why does this person require access to services and supports twenty-four (24) hours a day?

3. What has already been done to resolve the emergency?

4. What is the plan for services if the request is approved?

5. What other community resources have been explored (i.e. LTHH, CDASS, housing, other waivers)?

6. Describe any Behavioral Health involvement

7. Share any additional pertinent information

Please send completed form with any additional documentation (i.e. APS or Police Reports, Incident reports, Physician Orders etc.) to EmergencyEnrollment@state.co.us