COLORADO
Department of Health Care Policy & Financing

State Supported Living Services
Support Plan

Individual's Information	
Name:	Date of Birth:
Home Address:	
Phone:	Email:

Living situation:

☐ Group Home ☐ Host Home ☐ Discharge from ICF/nursing home

☐ Discharge from Hospital ☐ Living independently ☐ Family Home

☐ Experiencing homelessness ☐ Other:_____

List all others with whom the individual resides:

Name	**Relationship**

Name of Authorized Representative and/or Legal Guardian:

☐ Authorized Representative ☐ Legal Guardian ☐ N/A	Phone:

Developmental Disability Determination Date:

Support Plan	
☐ Initial ☐ Annual ☐ Revision	**Staffing Date:**
Start Date:	End Date:

Support Categories that will be authorized (choose all that apply):

☐ Supports for individuals waiting for HCBS waiver enrollment

☐ Supports for individuals experiencing temporary hardships

☐ Supporting independence in the community

☐ On-going State SLS supports

Support Plan

Explain what the individual wants to achieve by utilizing State SLS services and supports:

Explain how State SLS Services and Supports will help the individual achieve the identified outcome(s):

Describe how the need for a higher level of care will be alleviated,

- Address all health or safety issues,
- Indicate if the person is at risk of becoming homeless.
- Identify if the individual is at risk of needing a more restrictive setting.

Other supports that have been attempted:

☐ Natural supports

☐ Community/third party resources (Food banks, LEAP, SNAP benefits, etc.)

☐ Other insurance

☐ Other Medicaid services

☐ Other

Explain why other sources of supports, including HCBS waivers, cannot meet the individual's needs:

Authorized Services			
Service Authorized and Service Category	**Frequency of Service**	**Date Span**	**Total Amount Authorized**

Individual seeking Services Roles and Responsibilities

☐ Individual has been informed of their roles and responsibilities for participation in the State SLS program.

I agree to participate in the coordination of my services and will be responsible to:

- Give accurate information to my case manager.
- Assist in promoting my own independence.
- Cooperate with my providers and case management agency.
- Notify my case manager of changes in my support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) placements.
- Notify my case manager if I enroll in a Home and Community Based waiver.
- Notify my case manager of any changes in my care needs and/or problems with services.

Case Manager Roles and Responsibilities

☐ Individual has been informed of the State SLS Case Manager's roles and responsibilities.

The Case Manager agrees to:

- Coordinate needed services.
- Communicate with service providers regarding service delivery, and concerns.
- Review and revise services, as necessary.
- Notify clients regarding any change in services.
- Notify clients when services are denied, suspended, terminated, or reduced.
- Document, report, and resolve client complaints and concerns.
- Report abuse, neglect, mistreatment, and exploitation to the appropriate authority.

Statement of Agreement

☐ Individual/Guardian indicates that he/she agrees with the information in the Support Plan and agrees to receive services accordingly.

OR

☐ Individual/Guardian acknowledges that they are choosing not to sign the Support Plan agreement.

Signatures		
Individual I certify, to the best of my knowledge, all information on this support plan is true and complete.		
Signature:	Print Name:	Date:
☐ Authorized Representative ☐ Legal Guardian ☐ N/A I certify, to the best of my knowledge, all information on this support plan is true and complete.		
Signature:	Print Name:	Date:
Case Manager I certify, to the best of my knowledge, all information on this support plan is true and complete.		
Signature:	Print Name:	Date:

Individuals Who Assisted in Developing the Support Plan		
Name (Please Print)	**Title**	**Relationship to State SLS Participant**

Please retain a copy of this in the individual's file to make available upon request by the Department.