COLORADO
Department of Health Care Policy & Financing

State Supported Living Services
Support Plan

Participant 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 people in the participant's household:

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

☐ Ongoing State SLS supports

Support Plan

Explain what the participant wants to achieve using the services and supports in this plan:

Explain how the services and supports will help the participant achieve what is listed above

Describe how the requested services will help reduce the participant's need for a higher level of care

- How will the services meet their health and safety needs?
- Are they at risk of becoming homeless?
- Are they at risk of needing a more restrictive place to live?

Other supports the participant has tried in the past:

☐ Natural supports

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

☐ Other insurance

☐ Other Medicaid services

☐ Other

Explain why other supports, including HCBS waivers, cannot meet the participant's needs:

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

Participant Roles and Responsibilities

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

I understand what I need to do to participate in the State SLS program. I will cooperate with my providers and case management agency and give them accurate information.

I will tell my case manager:

- If my health changes
- If someone moves in or out of my home
- If I go to the hospital, urgent care or ER
- If I move to a nursing home or Intermediate Care Facility
- If I enroll in a Home and Community-Based waiver
- If my needs change or I have a problem with my services

Case Manager Roles and Responsibilities

☐ Participant has been informed of the Case Manager's roles and responsibilities.

The Case Manager agrees to:

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

Statement of Agreement

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

OR

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

Signatures		
Participant I certify, to the best of my knowledge, all information in 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 in this Support Plan is true and complete.		
Signature:	Print Name:	Date:
Case Manager I certify, to the best of my knowledge, all information in this Support Plan is true and complete.		
Signature:	Print Name:	Date:

People who helped create this Support Plan		
Name (Please Print)	**Title**	**Relationship to Participant**

Please keep a copy of this Support Plan in the participant's file. The Department of Health Care Policy and Financing (HCPF) may ask to review the Support Plan at any time.