Case Manager CDASS Enrollment Checklist

	YES	NO	DATE
1. Has assessment visit and assessment (100.2) been completed? ▪ *If yes, proceed to #2* ▪ *If no, schedule assessment visit and complete assessment*	☐	☐	
2. Is Client Financially Medicaid approved for LTC Medicaid Waiver Program? ▪ *If yes, proceed to #3* ▪ *If no, obtain Financial LTC Medicaid Wavier Program approval prior to proceeding. (financial approval)*	☐	☐	
3. Have you discussed service options with the Client/Legal Representative to determine what they would like, what their goals are, and what they are comfortable with? ▪ *If yes, proceed to #4* ▪ *If no, schedule assessment visit and complete assessment*	☐	☐	
4. Have <u>all</u> the following CDASS forms been completed and filed appropriately?	YES	NO	DATE
a. Physician's Attestation of Consumer Capacity (Client must be in stable health to participate in CDASS.)	☐	☐	
b. Client/Authorized Representative Responsibilities Form			
c. Authorized Representative Screening and Questionnaire (if applicable)	☐	☐	
d. Authorized Representative Designation and Affidavit (if applicable)	☐	☐	
▪ *Are all forms complete? If yes, proceed to #5* ▪ *If no, request Client/Legal Representative obtain forms* *All current, state approved forms can be found on the Consumer Direct Colorado (CDCO) website: www.consumerdirectco.com*	☐	☐	
5. Has their CDASS allocation been determined? ▪ *If yes, proceed to #6* ▪ *If no, complete the CDASS Task Worksheet and CDASS Monthly Allocation Worksheet with the Client/Legal Representative and if applicable the CDASS Authorized Representative.* **If the allocation is Over Cost Containment, complete the PAR before step #6 to ensure approval is received by The Department of Health Care Policy and Financing.**	☐	☐	
6. Has a referral for training been made to Consumer Direct Colorado and documented in Client file? ▪ *If no, complete CDASS Training & FMS Client Referral form and send to CDCO. Form can be found online https://consumerdirectco.com/*	☐	☐	

7. Have you provided a copy of the Task Worksheet and CDASS Monthly Allocation to the Client/Authorized Representative?

	YES	NO	DATE
▪ *If yes, proceed to #8* ▪ *If no, send information to Client/Authorized Representative*	☐	☐	

8. Has Consumer Direct of Colorado (CDCO) confirmed receipt of the referral within 1 business day of sending?

	YES	NO	DATE
▪ *If yes, proceed to #9* ▪ *If no, contact CDCO to confirm referral was received*	☐	☐	

9. Has a reviewed ASMP been received from CDCO?

	YES	NO	DATE
▪ *If yes, proceed to #10* ▪ *If no, contact CDCO for status*	☐	☐	

Note:

a. CDCO has 45 days to train a Client or Authorized Representative
b. The Client or Authorized Representative must complete and return the ASMP to CDCO for review
c. CDCO has 5 days to review the ASMP**. Please note CDCO reviews the ASMP to ensure each area has been addressed, but the Case Manager is responsible to review and approve the content and appropriateness of the ASMP.**

10. Has the ASMP been approved?

	YES	NO	DATE
▪ *If yes, send a copy of the approved ASMP to CDCO and proceed to #11* ▪ *If no, and you have concerns regarding the ASMP, contact the Client or Authorized Representative directly to make any adjustments*	☐	☐	

11. Has the Referral Form been sent to the chosen FMS provider?

	YES	NO	DATE
▪ *If yes, proceed to #12* ▪ *If no, complete Referral Form*	☐	☐	

Note: The following forms should be sent to the FMS provider:

a. Referral Form - use the Referral Form previously completed and sent to CDCO
b. Physician's Attestation of Consumer Capacity
c. Client/Authorized Representative Responsibilities Form
d. Authorized Representative Designation and Affidavit (if applicable)
e. Authorized Representative Screening Questionnaire (if applicable)
f. Approved ASMP (Containing Client/AR, CDCO and Case Manager signatures)

12. Has the FMS provider communicated there are a minimum of 2 attendants with approved employee applications and a CDASS start date is ready to be determined?

	YES	NO	DATE
▪ *If yes, proceed to #13* ▪ *If no, contact the FMS provider*	☐	☐	

Note: The length of time between sending the referral to the FMS provider and receiving confirmation from them that the Client and Attendants have completed the necessary paperwork will vary depending on how quickly and accurately the forms are completed and returned to the FMS provider.

13. Has the PAR been completed in the bridge for approval?

	YES	NO	DATE
▪ *If yes, proceed to #14* ▪ *If no, complete PAR and sent to Fiscal Agent for approval*	☐	☐	

14. Has the approved PAR been received and entered into the FMS portal prior to the CDASS start date?

	YES	NO	DATE
▪ *If yes, PAR entered into system* ▪ *If no, Case Manager will contact the Fiscal Agent regarding the PAR approval status and enter the approval into the FMS portal*	☐	☐	

15. Have you discontinued any existing Personal Care, Homemaking, or skilled services in coordination with the CDASS Start Date?

	YES	NO	DATE
▪ *If yes, communicate start date to Client/AR. Enrollment is complete.* ▪ *If no, send discontinuation notices to providers and call to ensure they have received them.*	☐	☐	

CDASS Specific Required Client Contact Checklist

(Refer to documentation sample for additional assistance)

First 3 months

Contacted Client in 1st Month?	**YES**	**NO**	**DATE**
▪ *If yes, have you documented summary of the contact and when it occurred?* ▪ *If no, make contact*	☐	☐	

Contacted Client in 2nd Month?	**YES**	**NO**	**DATE**
▪ *If yes, have you documented summary of the contact and when it occurred?* ▪ *If no, make contact*	☐	☐	

Contacted Client in 3rd Month?	**YES**	**NO**	**DATE**
▪ *If yes, have you documented summary of the contact and when it occurred?* ▪ *If no, make contact*	☐	☐	

Quarterly

Contacted Client For 1st Quarterly Call During Certification Period?	**YES**	**NO**	**DATE**
▪ *If yes, have you documented summary of the contact and when it occurred?* ▪ *If no, make contact*	☐	☐	

Contacted Client For 2nd Quarterly Call During Certification Period?	**YES**	**NO**	**DATE**
▪ *If yes, have you documented summary of the contact and when it occurred?* ▪ *If no, make contact*	☐	☐	

6 Month Client Contact	**YES**	**NO**	**DATE**
▪ *If yes, have you documented summary of the contact and when it occurred?* ▪ *If no, make contact* ▪ *Case Manager will review the Client's CDASS account statement through the FMS vendor for Client budget management and discuss with the Client.* ▪ *Case Manager will review and make updates with the Client regarding any changes identified for their Attendant Support Management Plan.*	☐	☐	

Annual In-Person Client Contact (reassessment)	**YES**	**NO**	**DATE**
▪ *If yes, have you documented summary of the contact and when it occurred?* ▪ *If no, make contact* ▪ *Case Manager will review the Client's CDASS account statement through the FMS vendor for Client budget management and discuss with the Client.* ▪ *Case Manager will review and make updates with the Client regarding any changes identified for their Attendant Support Management Plan.*	☐	☐	