COLORADO
Department of Health Care Policy & Financing

Health First COLORADO
Colorado's Medicaid Program

In-Home Support Services (IHSS) - Shared Responsibilities Plan

Member Name:	Health First Colorado ID:

Responsibilities of IHSS Agency

Agency Name:	Agency Phone:

IHSS agencies are responsible for everything in this list. Members and authorized representatives **cannot give the IHSS permission to ignore any of these responsibilities**.

- Provide 24-hour back-up service for scheduled visits to members at any time an attendant is not available.
- Ensure that adequate staffing is available. Staffing must include backup attendants to ensure necessary services will be provided in accordance with the Care Plan.
- Counsel attendants and staff on difficult cases and potentially dangerous situations.
- Verify the attendant follows all tasks set forth in the Care Plan.
- Administer a skills validation test for attendants who will perform Health Maintenance Activities.
- Provide in-home supervision for the member as recommended by their Licensed Medical Professional and as agreed upon by the member or their Authorized Representative.
- Manage all claims, billing, and payment of attendants. The IHSS is the attendant's legal employer.
- Provide the member with Independent Living Core Services. Train, oversee, and supervise attendants using licensed health care professionals.

Participant Directed Services

Members and authorized representatives can choose self-direction for anything in the list below. Please check the box next to the item you would like to self-direct. If no boxes are checked, the Agency accepts accountability and responsibility for all items in the list.

- ☐ Present or recruit potential attendants.
- ☐ Interview potential attendants.
- ☐ Train attendants to meet the member's needs.
- ☐ Dismiss attendants who are not meeting the member's needs.
- ☐ Schedule attendants in accordance with the care plan.
- ☐ Supervise attendants; ensure services provided are safe, accurate and effective.
- ☐ Request a reassessment if the member's level of care or service needs change.

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Care Planning

As part of this Shared Responsibilities Plan, identify who will take part in this collaborative process with the IHSS Agency and Case Manager. Both boxes may be checked for each item.

IMPORTANT – If the member's treating medical professional has indicated "NO" to Question 2 of Statement of Consumer Capacity on the member's Physician Attestation of Consumer Capacity Form, the **member will require an authorized representative to direct** care planning.

	Member/Legal Guardian	Authorized Representative
Develop a care plan that meets all the member's functional and medical needs	☐	☐
Maintain regular communication about member satisfaction with services and updates regarding member health and service needs	☐	☐

Collaborate to mediate care plan disputes	☐	☐

Authorized Representative Information and Affidavit		
Refer to the member's Physician Attestation of Consumer Capacity. If the member's Licensed Medical Professional has identified that the member must have an authorized representative, one must be identified, and enter contact information in this section. If the member's Licensed Medical Professional states the member may direct their own services, the member may still choose to have an authorized representative.		
Name:	Date of Birth:	Last 4 digits of SSN:
Address:	City:	State/Zip:
Email:	Home Phone:	Cell Phone:
☐ Please contact me via email or text message with updates (standard carrier rates may apply)		
I hereby agree to serve as the Authorized Representative for the aforementioned member and understand my responsibilities and duties. In addition, I certify that: a) I am at least eighteen years of age; b) I have not been convicted of any crime involving exploitation, abuse or assault on another person; and c) I do not have a mental, emotional or physical condition that could result in harm to the member.		
Authorized Representative Signature:		Date:

Member/Legal Guardian Signature		
Person completing this form: ☐ Member ☐ Legal Guardian (If legal guardian, please submit documentation)		
Member/Legal Guardian Signature:		Date:
In case of the member's inability to sign, another person may witness the member's mark above.		
Witness Name:	Witness Signature:	Date:

IHSS Agency Signature	
Agency Name:	
Agency Representative Signature:	Date:

Additional Comments (optional)