CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS)
ATTENDANT SUPPORT MANAGEMENT PLAN (ASMP)

Member Information					
Member Name:		Medicaid ID #:			
Address:		City:		Zip:	
Phone:		E-mail:			
Authorized Representative's (AR) Contact Information (optional)					
Rep Name:		Relationship to Member:			
Address:		City:		Zip:	
Phone:		E-mail:			
Single Entry Point (SEP) Case Manager Contact Information					
SEP Case Manager Name:		SEP Agency Name:			
Phone:		E-mail:			
Financial Management Services Agency Selection					
FMS Agency (please check one): ☐ Palco ☐ Public Partnerships (PPL)					

PART ONE - CARE NEEDS

Information about me, my supports and my needs:

Information about any support or accomodation I need for communication:

PART TWO - Needed Attendant Support

I (or my Authorized Representative) have the ability to train my Attendants to perform all of the activities listed below:

TASKS	SUN	MON	TUES	WED	THUR	FRI	SAT	Weekly Minutes
Homemaker Services: please list estimated time (in minutes) to be completed on tasks each day.								
Floor Care								
Bathroom Cleaning								
Kitchen Cleaning								
Trash Removal								
Meal Preparation								
Dishwashing								
Bed Making								
Laundry								
Dusting								
Shopping								
Total daily Homemaker minutes:								Weekly Total
Personal Care Services: please list estimated time (in minutes) to be completed on tasks each day.								
Eating								
Respiratory Assistance								
Skin Care Maintenance								
Bladder/Bowel Care								
Hygiene								
Dressing								
Transfers								
Mobility								
Positioning								
Medication Reminders								
Medical Equipment								
Bathing								
Accompanying								
Protective Oversight								
Total daily Personal Care minutes:								Weekly Total

Note: Total weekly minutes for each service category (Homemaker, Personal Care and Health Maintenance) are rounded upward to nearest 1/4 hour.

TASKS	SUN	MON	TUES	WED	THUR	FRI	SAT	Weekly Minutes
Health Maintenance* Services: please list estimated time (in minutes) to be completed on tasks each day. *Health Maintenance tasks are identified as skilled care tasks that a provider such as a CNA or RN would have traditionally performed outside of CDASS.								
Skin Care								
Nail Care								
Mouth Care								
Dressing								
Feeding								
Exercise								
Transfers								
Bowel Care								
Bladder Care								
Medical Management								
Respiratory Care								
Medication Assistance								
Bathing								
Mobility								
Accompanying								
Positioning								
Total daily Health Maintenance minutes:								**Weekly Total**
Total Daily Minutes:								

Total Weekly Minutes:	**Total Weekly Hours:**

The Case Manager is responsible to review the Member/Authorized Representative identified Homemaker, Personal Care and Health Maintenance Services for appropriateness in comparison with the Member's CDASS Task Worksheet. Any services indicated on the ASMP but not on the Task Worksheet (and vice versa) should be reviewed further by the Member/Authorized Representative and Case Manager. Approval should not move forward until service tasks on the Task Worksheet and ASMP match.

Service frequency and duration identified in this Attendant Support Management Plan for each task are an estimate. The frequency and duration of tasks may vary from day to day based on the Members service needs.

Are there times during the year that your care needs predictably change and you will most likely need to utilize more or less services? Please share this information.

_____

_____

Please inform your Case Manager if your needs change.

PART THREE - Recruiting and Hiring

The steps I am taking to find and hire Attendant(s) are (check all that apply):
Posting Ads:

- ☐ Newspaper
- ☐ Library
- ☐ On-line web sites
- ☐ Medical Facilities
- ☐ Word of Mouth
- ☐ Recruit Current PCP/CNA/Nurse
- ☐ College/University
- ☐ Grocery Store
- ☐ Local Publications
- ☐ Other Bulletin Boards
- ☐ CDASS Attendant Registry
- ☐ Recruit Family/Friends

Other (please specify): _____

PART FOUR – Limitations on Payment to Family - initial one of the following as it pertains to the Client:

_____ I will hire my spouse* or a family member** as an Attendant. I understand that my spouse and live in family caregivers are limited to providing extraordinary care as determined by my SEP Case Manager. I understand that neither my spouse, any family member, nor any guardian will be paid for providing more than 40 hours of care in a 7-day period.

OR

_____ Not applicable: I will not hire a spouse*, a family member**, or guardian.

* Spouse - the Client's husband or wife through legal marriage or common law.

** Family Member - all persons related to the Client through blood, marriage, adoption or common law.

PART FIVE – Emergency Back Up Planning

The steps I plan to take in an emergency and/or during unexpected situations are:
(Please be as specific as possible)

Late / No show Attendant:	
Life or Limb Emergency:	
Unexpected illness or flu:	
Community Wide Disaster (i.e. flood, blizzard, etc.): What would you do if you had to leave your home? What is your plan if you are unable to leave your home and your Attendant is having trouble reaching your home?	
Other (optional):	

PART FIVE ADDENDUM– Safety Plan for Attendant Related Health and Safety Risks

Member Name: Member Medicaid ID:

Authorized Representative Name (if applicable): Today's Date:

You are encouraged to review the educational and support resources related to hiring workers with criminal backgrounds to help you complete this safety plan. They can be found here: ConsumerDirectCO.com/CDASS-Resources. You may request these resources via mail by calling Consumer Direct at 1-844-381-4433. Please be specific and include ways you can monitor your attendants, family and/or friends who can be contacted, community resources that can be used, etc.

If I hire an attendant that creates a health and/or safety risk to the CDASS Member / to me, I will take the following steps to get help:

Please submit this page to Consumer Direct - Colorado via email:
InfoCDCO@ConsumerDirectCare.com

PART SIX – CDASS Monthly Budgeting Worksheet

Monthly Allocation: Total amount available for Attendant support services. Must identify at least two Attendants. Rate of pay and total cost must be listed for all primary Attendants.					=		**1**
Attendant	**Attendant's Hourly Rate**	**Your Cost Per Hour***		**Hours Per Week**		**Total Per Week**	
			X		=		**a.**
			X		=		**b.**
			X		=		**c.**
			X		=		**d.**
			X		=		**e.**
			X		=		**f.**
Attendant Care Wages Per Week Total Add (a) through (f)							**2**
Attendant Care Wages Per Month Total Multiply Weekly Total (Box 2) by 4.3 (average weeks in a month)							**3**

* Refer to the FMS Cost to You table in section 2 of the CDASS manual. Participants in CDASS are the employer of their CDASS Attendants and are required to comply with the Fair Labor Standards Act. This includes paying overtime rates to CDASS Attendants who work more than 40 hours in one week or over 12 hours in a single shift. You may contact your FMS provider about your payroll tax rates. SUTA rates may change over time dependent on your history with Unemployment Claims as an employer. For additional information or training please contact Consumer Direct Colorado. Additional information on overtime is also available through the Colorado Department of Labor.

Managing your CDASS allocation and budgeting is an ongoing task. Your FMS provider will provide a Monthly Member Expenditure Statement (MMES) that will show what you have spent to assist you with keeping on track and within your monthly allocation each month. You also have access to an on-line portal through your FMS provider to help check budget utilization. You will need to work with your individual FMS provider for assistance with completing time-sheets correctly.

PART SEVEN – CDASS Start Date (To be completed by Case Manager)

Preferred CDASS Start Date _____ Alternate Start Date _____

PART EIGHT – Signatures

Member / Authorized Representative Signature _____ Date _____

Case Manager Signature _____ Date _____

Consumer Direct Comments

Consumer Direct of Colorado's Signature _____ Date _____

FOR SINGLE ENTRY POINT CASE MANAGER APPROVAL - PLEASE DO NOT WRITE IN THIS SPACE

Member certification dates:

CDASS Start Date:	
CDASS End Date:	

Case Manager Approval _____ **Date** _____