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

PART FIVE ADDENDUM II – Safety Plan for Attendant Background Check Exception Request

Member Name: _____ Member Medicaid ID: _____
Authorized Representative Name (if applicable): _____
Attendant Name: _____
Case Manager Name: _____ FMS: _____

You must be specific and answer every question. You may send an additional page if more space is needed to answer any of the listed questions. 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 also request a mailed packet by contacting Consumer Direct at 1-844-381-4433 or InfoCDCO@ConsumerDirectCare.com.

1. What crime/s made this individual initially ineligible for hire?

2. Why do you want to hire this individual?

3. What monitoring will take place by you and/or trusted individuals close to you to ensure your/the member's health and safety is protected and service needs are being met?

4. How will you know if the environment or interaction with this individual becomes unsafe (physical safety, emotional safety, financial safety)?

5. If this individual becomes a health and/or safety risk to me/the member, I will:
    a. Take these steps with the individual:

    b. Contact and/or use these resources:

    c. Report my concerns to these entities:

6. If I need to terminate this individual, I will take the following steps to secure back up care:

7. By signing this document, I agree and confirm that:
    - I will follow this safety plan during the entire time this individual is actively providing my services.
    - My/the member's case manager and FMS will be provided a copy of this safety plan.
    - My/the member's case manager will provide oversight of this safety plan through their quarterly check-ins.
    - The Department will provide oversight of this safety plan through communication with me, my/the member's case manager, FMS, and Consumer Direct, as necessary.
    - I will follow my FMS' attendant termination process if I decide to terminate this individual.

Member / Authorized Representative Signature: Date:

Please submit this page to
the Department of Health Care Policy and Financing
via email:
HCPF_PDP@state.co.us