**Case Manager Client Direction Checklist**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | Has assessment visit and assessment (100.2) been completed? | **YES** | **NO** | **DATE** |
|  | * *If yes, proceed to #2* |  |  |  |
|  | * *If no, schedule assessment visit and complete assessment* |
| 2 | Is client Financially Medicaid approved for LTC Medicaid Waiver Program? | **YES** | **NO** | **DATE** |
|  | * *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 participant (Traditional agency based, IHSS or CDASS) to determine what they would like, their goals and what they are comfortable with? | **YES** | **NO** | **DATE** |
|  | * *If yes, proceed to #4* |  |  |  |
|  | * *If no, schedule assessment visit and complete assessment* |
|  | ***Note:*** *Refer to the “What Fits” chart to assist the client with this discussion.* |  |  |  |
| 4 | For CDASS: Have all the following forms been completed and filed appropriately? | **YES** | **NO** | **DATE** |
|  | 1. Physician’s Attestation of Consumer Capacity (Client must be in stable health to participate in CDASS.) |  |  |  |
|  | 1. Authorized Representative Screening and Questionnaire (if applicable) |  |  |  |
|  | 1. Authorized Representative Designation and Affidavit (if applicable) |  |  |  |
|  | 1. Client Responsibilities |  |  |  |
|  | * *Are all forms complete? If yes, proceed to #5* |  |  |  |
|  | * *If no, request client obtain forms* |
| 5 | For CDASS: Has an allocation been determined? | **YES** | **NO** | **DATE** |
|  | * *If yes, proceed to #6* |  |  |  |
|  | * *If no, complete the CDASS task worksheet with the client and if applicable the CDASS authorized representative.* |
| 6 | Has a referral for services been made and documented in Client File? | **YES** | **NO** | **DATE** |
|  | 1. IHSS is the best fit and chosen by the participant. Send a referral to the IHSS Agency. |  |  |  |
|  | 1. CDASS is the best fit and chosen by the participant. Send CDASS referral form to Consumer Direct of Colorado (CDCO). |  |  |  |
|  | * *If no, complete appropriate referral and send* |  |  |  |

**Case Manager CDASS Specific Checklist**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | Have you provided a copy of the Task Worksheet and CDASS Allocation to the participant? | **YES** | **NO** | **DATE** |
|  | * *If yes, proceed to #2* |  |  |  |
|  | * *If no, send information to participant* |
|  |  |  |  |  |
| 2 | Has Consumer Direct of Colorado (CDCO) confirmed receipt of the referral within 1 business day of sending? | **YES** | **NO** | **DATE** |
|  | * *If yes, proceed to #3* |  |  |  |
|  | * *If no, contact CDCO to confirm it was received* |
|  |  |  |  |  |
| 3 | Has a reviewed ASMP been received from CDCO? | **YES** | **NO** | **DATE** |
|  | * *If yes, proceed to #4* |  |  |  |
|  | * *If no, contact CDCO for status* |
|  | **Note:** |  |  |  |
|  | 1. CDCO has 45 days to train a client or authorized representative |  |  |  |
|  | 1. The client or authorized representative must complete and return the ASMP to CDCO for review |  |  |  |
|  | 1. 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.** |  |  |  |
|  |  |  |  |  |
| 4 | Has the ASMP been approved? | **YES** | **NO** | **DATE** |
|  | * *If yes, send a copy of the approved ASMP to CDCO and proceed to #5* |  |  |  |
|  | * *If no, and you have concerns regarding the ASMP, contact the client or authorized representative directly to make any adjustments* |
|  |  |  |  |  |
| 5 | Has the referral form been sent to the chosen FMS provider? | **YES** | **NO** | **DATE** |
|  | * *If yes, proceed to #6* |  |  |  |
|  | * *If no, complete referral form* |
|  | **Note:** The following forms should be sent to the FMS provider: |  |  |  |
|  | 1. Referral Form - use the referral form previously completed and sent to CDCO |  |  |  |
|  | 1. Physician’s Attestation of Consumer Capacity |  |  |  |
|  | 1. Authorized Representative Designation and Affidavit (if applicable) |  |  |  |
|  | 1. Authorized Representative Screening Questionnaire |  |  |  |
|  | 1. Client Responsibilities |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 6 | 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 #7* |  |  |  |
|  | * *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. | | | |
|  |  |  |  |  |
| 7 | Has the PAR been completed and sent to the Fiscal Agent for approval? | **YES** | **NO** | **DATE** |
|  | * *If yes, proceed to #8* |  |  |  |
|  | * *If no, complete PAR and sent to Fiscal Agent for approval* |
|  |  |  |  |  |
| 8 | Has the approved PAR been received from the Fiscal Agent 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.* |

**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.* |