

**CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS)  
ATTENDANT SUPPORT MANAGEMENT PLAN (ASMP)  
Supported Living Services Waiver (SLS)**

Client Information					
Client Name:		Medicaid ID #:			
Address:		City:		Zip:	
Phone:		E-mail:			
Authorized Representative's (AR) Contact Information (optional)					
Rep Name:		Relationship to client:			
Address:		City:		Zip:	
Phone:		E-mail:			
Community Center Board (CCB) Case Manager Contact Information					
CCB Case Manager Name:		CCB Agency Name:			
Phone:		E-mail:			
Financial Management Services Agency Selection					
FMS Agency (please check one): <input type="checkbox"/> Acumen <input type="checkbox"/> Palco <input type="checkbox"/> Public Partnerships (PPL)					

<p><b><u>PART ONE - CARE NEEDS</u></b></p> <p>Information about me, my supports and my needs:</p>          <p>Information about any support or accomodation I need for communication:</p>   
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**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
<b>Homemaker Services: please list estimated time (in minutes) to be completed on tasks each day.</b>								
Floor Care								
Bathroom Cleaning								
Kitchen Cleaning								
Trash Removal								
Meal Preparation								
Dishwashing								
Bed Making								
Laundry								
Dusting								
<b>Total daily Homemaker minutes:</b>								<b>Weekly Total</b>
<b>Enhanced Homemaker Services: please list estimated time (in minutes) to be completed on tasks each day.</b>								
Habilitation								
Extraordinary Cleaning								
<b>Total daily Enhanced Homemaker minutes:</b>								<b>Weekly Total</b>
<b>Personal Care Services: please list estimated time (in minutes) to be completed on tasks each day.</b>								
Eating								
Respiratory Assistance								
Skin Care Maintenance								
Bladder/bowel care								
Hygiene								
Dressing								
Transfers								
Mobility								
Positioning								
Medical Equipment								
Money Management								
Menu Planning & Grocery Shopping								
Accompanying								
Bathing								
Medication Reminders								
<b>Total daily Personal Care minutes:</b>								<b>Weekly Total</b>

TASKS	SUN	MON	TUES	WED	THUR	FRI	SAT	Weekly Minutes
<b>Health Maintenance Services: please list estimated time (in minutes) to be completed on tasks each day.</b> *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								
Prescribed Exercise/ROM								
Transfers								
Positioning								
Accompanying								
Mobility								
Bowel Care								
Bladder Care								
Medical Management								
Respiratory Care								
Medication Assistance								
Bathing								
<b>Total daily Health Maintenance minutes:</b>								<b>Weekly Total</b>
<b>Total Daily Minutes:</b>								
<b>Total Weekly Minutes:</b>			<b>Total Weekly Hours:</b>					
<p><b>The Case Manager is responsible to review the client/authorized representative identified homemaker, enhanced homemaker, personal care and health maintenance services for appropriateness in comparison with the client'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 client/authorized representative and the case manager. Approval should not move forward until service tasks on the task worksheet and ASMP match.</b></p> <p><b>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 client service needs.</b></p> <p>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.</p> <p>_____</p> <p>_____</p> <p>Please inform your case manager if your needs change.</p>								

### **PART THREE - Recruiting and Hiring**

**The steps I am taking to find and hire attendant(s) are (check all that apply):**

**Posting Ads:**

- |  |   |
|--|---|
| <input type="checkbox"/> Newspaper                     | <input type="checkbox"/> College/University       |
| <input type="checkbox"/> Library                       | <input type="checkbox"/> Grocery Store            |
| <input type="checkbox"/> On-line web sites             | <input type="checkbox"/> Local Publications       |
| <input type="checkbox"/> Medical Facilities            | <input type="checkbox"/> Other Bulletin Boards    |
| <input type="checkbox"/> Word of Mouth                 | <input type="checkbox"/> CDASS Attendant Registry |
| <input type="checkbox"/> Recruit Current PCP/CNA/Nurse | <input type="checkbox"/> 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 CCB 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 SIX – CDASS Monthly Budgeting Worksheet (1 of 2)**

### **Monthly Allocation for Homemaker, Personal Care, Enhanced Homemaker (if applicable):**

Must identify at least two attendants. Rate of pay and total cost must be listed for all primary attendants.

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**1**

<b>Attendant</b>	<b>Attendant's Hourly Rate</b>	<b>Your Cost Per Hour*</b>		<b>Hours Per Week</b>		<b>Total Per Week</b>	
			<b>X</b>		=		<b>a.</b>
			<b>X</b>		=		<b>b.</b>
			<b>X</b>		=		<b>c.</b>
			<b>X</b>		=		<b>d.</b>
			<b>X</b>		=		<b>e.</b>
			<b>X</b>		=		<b>f.</b>
<b>Attendant Care Wages Per Week Total</b> Add (a) through (f)							<b>2</b>
<b>Attendant Care Wages Per Month Total</b> Multiply Weekly Total (Box 2) by 4.3 (average weeks in a month)							<b>3</b>

\* Refer to the FMS "Cost to You" table in section 5 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.

**The same attendants can be listed for both budgets (page 6 and page 7). If applicable, combined hours for all services are subject to Fair Labor Standards Act guidelines, referenced above. Family members are not permitted over 40 hours per week.**

**PART SIX – CDASS Monthly Budgeting Worksheet (2 of 2)****Monthly Allocation for Health Maintenance:**

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.
<b>Attendant Care Wages Per Week Total</b> Add (a) through (f)							<b>2</b>
<b>Attendant Care Wages Per Month Total for Health Maintenance</b> Multiply Weekly Total (Box 2) by 4.3 (average weeks in a month)							<b>3</b>
<b>Total Attendant Care Wages Per Month for ALL Services</b> Add Attendant Care Wage Totals from Page 6 and Page 7 (Box 3)							<b>4</b>

\* Refer to the FMS "Cost to You" table in section 5 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 Client Expenditure Statement (MCES) that will show what you have spent and assist you to stay on track and within your monthly allocation. You also have access to an online portal through your FMS provider to help check budget utilization. You will need to work with your individual FMS provider for assistance with completing timesheets correctly.**

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

\_\_\_\_\_  
Preferred CDASS Start Date

\_\_\_\_\_  
Alternate Start Date

**PART EIGHT – Signatures**

\_\_\_\_\_  
Client / Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Case Manager Signature

\_\_\_\_\_  
Date

**Consumer Direct Comments**

\_\_\_\_\_  
Reviewer's Signature

\_\_\_\_\_  
Date

**FOR COMMUNITY CENTER BOARD CASE MANAGER APPROVAL  
PLEASE DO NOT WRITE IN THIS SPACE**

**Does Client have Enhanced Homemaker  
(check one): YES ☐ or NO ☐**

**Habilitative ☐ and/or Extraordinary Cleaning ☐**

**Date goal was developed: \_\_\_\_\_**  
(Updated Goal **required** before Start Date if Habilitative checked)

**Client Certification Dates:**

**CDASS Start Date: \_\_\_\_\_**

**CDASS End Date: \_\_\_\_\_**

\_\_\_\_\_  
Case Manager Approval

\_\_\_\_\_  
Date