Medicaid Resource Book

Colorado Medicaid Benefits and Programs That Support Independence and Employment For Adults with Disabilities

Prepared by the Colorado Department of Health Care Policy and Financing.

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Chapter 1: Introduction

For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or go to the Colorado Department of Health Care Policy & Financing website at **http://www.chcpf.state.co.us**.

Chapter 1: Introduction

The State of Colorado has developed this resource book for adults with disabilities who receive Medicaid services. The book describes Medicaid programs that support independent living. Gaining more independence may enable you to work, if that is your goal. **Phone numbers and websites that you can contact for more information are throughout the book and in Appendix D.** Please keep this book with your important papers. You may need to refer to it often.

Each chapter of this book describes a specific benefit or program available through Colorado Medicaid. Some of the programs have eligibility requirements in addition to the basic requirements for Medicaid.

If you need further information or if you have questions about whether you can participate in a program in this book, you should contact your *case manager*, or call Colorado Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area). You can also visit the website of the Colorado Department of Health Care Policy and Financing at **http://www.chcpf.state.co.us**, where you will find more information and updates to this book.

What is Medicaid?

Medicaid is a medical assistance program that the State of Colorado administers. Medicaid pays for some health care services for certain persons who have low incomes.

This resource book does not include detailed information about who is eligible for Medicaid or how to enroll. Nor does it describe everything that Medicaid will pay for. Instead, it assumes that you already receive Medicaid services and want to know more about the programs and benefits available to assist you in living independently rather than in an institution.

If you need more information regarding eligibility for Medicaid, contact the United States Social Security Administration. Colorado Medicaid uses the same eligibility criteria as the federal Supplemental Security Income (SSI) program. Therefore, if you are eligible for SSI, you will receive Medicaid.

The phone number for the United States Social Security Administration is 1-800-772-1213 or TTY 1-800-325-0778. These lines are staffed from 5:00 A.M. to 5:00 P.M. Mountain Standard Time, Monday through Friday. If you have a touch-tone phone, you can get recorded information on many topics 24-hours a day. Have your Social Security number handy when you call. If you have access to the internet, go to **www.ssa.gov**.

Words in italics are defined at the end of this section.

What is Medicare?

Medicare is the health insurance program for people 65 years of age or older, certain people under age 65 with disabilities and people with end-stage renal disease (ESRD). The federal government administers Medicare.

If you are a person under age 65 with disabilities, you qualify for Medicare if you qualify for Social Security Disability Insurance (SSDI). For more information about SSDI, you can call the United States Social Security Administration at 1-800-772-1213 or TTY 1-800-325-0778, or visit **www.ssa.gov**.

You can also get information on Medicare and Medicaid from the Centers for Medicare and Medicaid Services (CMS) toll free at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048. If you have access to the internet, go to **www.medicare.gov**.

Can I have both Medicaid and Medicare?

Some Medicare beneficiaries are also eligible for Medicaid. Both Medicare and Medicaid pay for certain *acute care* needs. Medicaid can cover *long-term care* that Medicare does not. Medicaid can also cover all or part of your Medicare premiums and/or out-of-pocket costs if your income and resources are low enough. If you have Medicare and Medicaid, Medicare pays your claims first. Medicaid receives the remaining claims for payment.

Words you need to know!

Before you continue reading this resource book, it is important that you know the meaning of several words that often appear. These words are in *italics* whenever they appear, and their definitions are below.

Acute care

Acute care is short-term medical and surgical care that you need because you are sick or recently had an injury. When receiving *acute care*, Medicaid expects you to get better. *Acute care* includes treatment for mental illness. *Acute care* also includes services that can prevent illness or injury, such as immunizations or help to stop smoking. See Chapter 8 for more information.

Appeal

An *appeal* is a legal process that determines if you have received all of the Medicaid benefits you are entitled to. You can request an *appeal* for any program or service that Medicaid denied or limited. When you request an *appeal*, you receive a fair hearing. A fair hearing is a conversation between you, a person representing Medicaid and an Administrative Law Judge. You can file an *appeal* yourself. You do not need a lawyer but you may have a lawyer, or any other person you choose, represent you. See Chapter 9 for more information.

Case manager

A *case manager* is a person who may help you determine what type and amount of *long-term care* services you need. The *case manager* will help you coordinate the services available through Medicaid and other funding sources. *Case managers* are nurses or social workers who know the resources that are available in your community.

Community Centered Boards

Community Centered Boards are non-profit companies that provide services to persons with developmental disabilities and their families. *Community Centered Boards* offer services that support independence and productivity. They provide an alternative to placement in an *institution*. Currently there are twenty *Community Centered Boards*; see Appendix C for a list.

Disposable medical supplies

Disposable medical supplies are supplies that are necessary to treat a medical condition and that you throw away after use. Some examples of *disposable medical supplies* are catheters, dressings, feeding supplies, syringes and diapers. See Chapter 6 for more information.

Durable Medical Equipment (DME)

Durable Medical Equipment is equipment that you use for a medical purpose and that you can use over and over. Some examples of *Durable Medical Equipment* are handrails, respirators, crutches, hospital beds, walkers and wheelchairs. See Chapter 6 for more information.

Home and Community Based Services (HCBS)

Home and Community Based Services are Medicaid programs that enable people who qualify to receive *long-term care* in

(continues on next page)

(Words you need to know, continued)

their own homes rather than in an *institution*. In Colorado, there are several HCBS programs for persons with the following conditions: Brain Injury; Mental Illness; AIDS; Elderly, Blind or Disabled; or Developmental Disability.

See Chapter 2 for more information.

Institution

For Medicaid purposes, *institutions* include hospitals, skilled and intermediate nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR). To be eligible for some Medicaid programs, including *Home and Community Based Services*, you must be "at risk of institutional placement." This means that, if you did not receive care in your home or a community setting, your medical condition or disability would require you to be in a hospital, nursing facility or ICF/MR.

Long-term care

Long-term care is care that a person receives when he or she needs ongoing support for activities of daily living. *Long-term care* includes care in an *institution* and *Home and Community Based Services*.

Medical emergency

A *medical emergency* is a medical crisis that you think may be life threatening or may result in losing a body part such as an arm, leg or eye. Sometimes it is hard to tell if it is an emergency. Some examples of emergencies are severe bleeding, loss of consciousness, severe shortness of breath, chest pain, injury to an eye, broken bones, seizures and severe pain.

Medically necessary

A service or supply is *medically necessary* if it is **all** of the following:

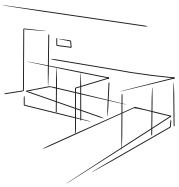
- for the purpose of treating a medical condition
- the most appropriate service or supply, considering potential benefits and harms to the patient
- known to be effective in treating the medical condition, as scientific evidence and medical standards have determined
- furnished in the least costly manner which is safe and effective

Prior authorization

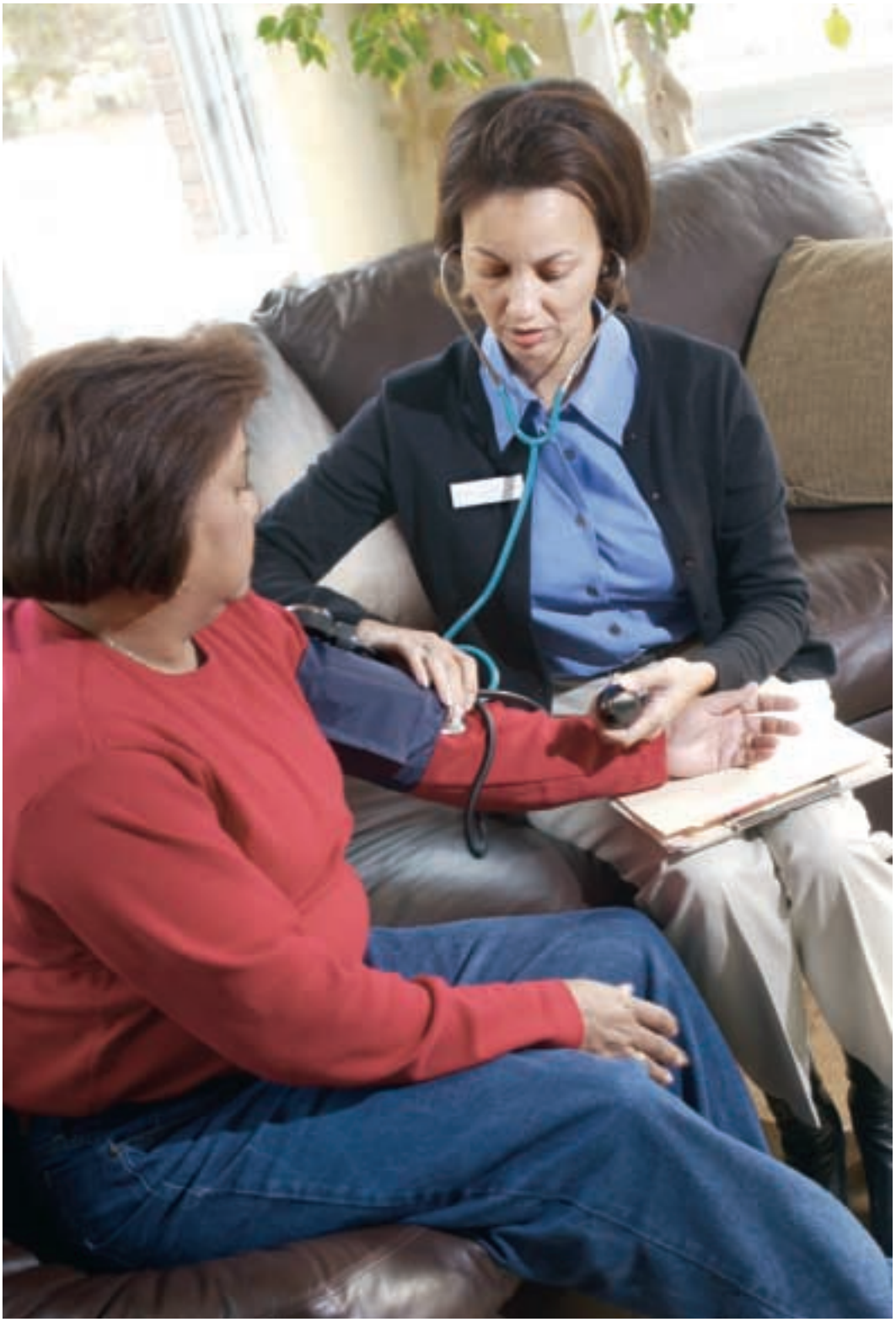
There are some services that Medicaid must approve before you get them. This process is *prior authorization*. The process starts when your doctor or other health care provider completes a form called a *Prior Authorization Request*, or PAR, and sends it to Medicaid. This form gives Medicaid information to decide if the service is *medically necessary*. If Medicaid decides that it is *medically necessary*, Medicaid will pay for that service.

Single Entry Point (SEP) agency

A *Single Entry Point agency*, or Options for Long Term Care agency, is a company or local government entity that has contracted with Medicaid to help people with disabilities and frail older people learn about the many supportive services available through Medicaid and other funding sources. *SEP agencies* employ *case managers* who are responsible for assessing need for *long-term care* services. Currently there are twenty-three *SEP agencies*. See Appendix A for a list.



Chapter 2: Home and Community Based Services



For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or go to the Colorado Department of Health Care Policy & Financing website at **http://www.chcpf.state.co.us**.

Chapter 2: Home and Community Based Services

Home and Community Based Services (HCBS) are for people who need *long-term care* but wish to remain in their own homes, rather than be in an *institution*. Colorado has a long history of promoting home and community-based services for persons with disabilities. In Colorado, there are **six** HCBS programs for adults with special needs including:

- Brain Injury (BI)
- Elderly, Blind or Disabled (EBD)
- Mental Illness (MI)
- Developmentally Disabled (DD)
- AIDS (PLWA)
- Supported Living Services for the Developmentally Disabled (SLS)

Words To Know—See Chapter 1
Long-term care
Institution
Home and Community Based Services
Case manager
Community Centered Boards
Single Entry Point agency

In order to receive HCBS services through Medicaid, you must apply to and be eligible for one of these six programs. You may apply for more than one HCBS program but may receive services through only one program at a time. Certified Medicaid providers must provide the HCBS.

Details of these six HCBS programs are below. In addition, more detail on the types of services that are available through HCBS are at the end of this chapter.

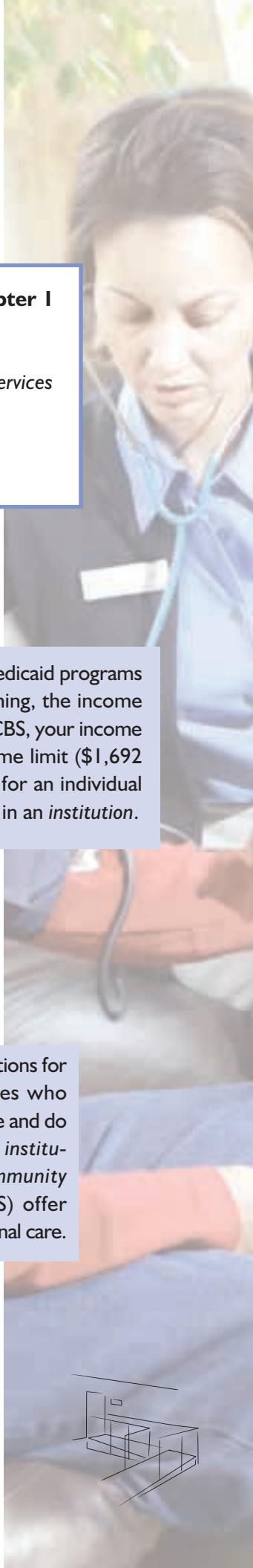
You may qualify for HCBS even if you do not qualify for other Medicaid programs because the eligibility rules for HCBS are different. For one thing, the income level for eligibility under HCBS is higher. In general, to receive HCBS, your income must be less than three times the Supplemental Security Income limit ($1,692 per month in 2004) and your assets must be less than $2,000 for an individual and $3,000 for a couple. You must also be at risk of placement in an *institution*.

Home and Community Based Services for People with Brain Injury(HCBS-BI)

The Brain Injury program provides Medicaid benefits that promote an early discharge from a hospital or inpatient rehabilitation environment. The program is for persons age 16 through 64 with certain types of brain injury.

Enrollment maximum:	300 persons
Is there a waiting list?	Not at the present time
Services available:	Adult Day Services
	Day Treatment
	Supported Living Program
	Transitional Living
	Home Modification
	Assistive Technology
	Counseling
	Behavior Management
	Skills Training for Independent Living
	Respite Care
	Personal Care
	Non-medical Transportation

Colorado has many options for people with disabilities who need medical assistance and do not want to live in an *institution*. *Home and Community Based Services* (HCBS) offer alternatives to institutional care.



Is there Case Management?	Yes, through *Single Entry Point agencies*
Who administers program?	Colorado Department of Health Care Policy and Financing
How to apply?	Through *Single Entry Point agencies* (see Appendix A for a complete list) or through County Departments of Social Services (see Appendix B for a complete list)

Single Entry Point (SEP) agencies are where people with disabilities and the elderly can learn about *Home and Community Based Services* and other supportive services available through Medicaid.

Your *Single Entry Point agency* is responsible for assessing your need for community-based *long-term care* services and for providing case management. The *SEP agency* will assist you in completing the Uniform Long Term Care Form (ULTC 100.2) which Medicaid uses to determine your eligibility for *long-term care* services. Currently there are twenty-three *SEP agencies* serving Colorado's sixty-four counties. See Appendix A.

Home and Community Based Services for the Mentally Ill (HCBS-MI)

This program provides a community alternative to nursing facility care to persons at least 18 years old with major mental illness.

Enrollment maximum:	2,040 persons
Is there a waiting list?	Not at the present time
Services available:	Adult Day Services Alternative Care Facility Electronic Monitoring Home Modification Respite Care Personal Care Homemaker Services Non-medical Transportation
Is there Case Management?	Yes, through *Single Entry Point agencies*
Who administers program?	Colorado Department of Health Care Policy and Financing
How to apply?	Through *Single Entry Point agencies* (see Appendix A for a complete list) or through County Departments of Social Services (see Appendix B for a complete list)

Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA)

This program provides a community alternative to nursing facility or hospital care to persons of any age with HIV/AIDS.

Enrollment maximum:	156 persons
Is there a waiting list?	Not at the present time
Services available:	Adult Day Services Electronic Monitoring Personal Care Homemaker Services Non-medical Transportation

Is there Case Management?	Yes, through *Single Entry Point agencies*
Who administers program?	Colorado Department of Health Care Policy and Financing
How to apply?	Through *Single Entry Point agencies* (see Appendix A for a complete list) or through County Departments of Social Services (see Appendix B for a complete list)

Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD)

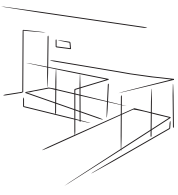
The Elderly, Blind and Disabled HCBS program provides a community alternative to nursing facility care. The program is for frail elderly, blind or disabled persons who are at least 18 years old.

Enrollment maximum:	22,642 persons
Is there a waiting list?	Not at the present time
Services available:	Adult Day Services Alternative Care Facility Electronic Monitoring Home Modification Respite Care Personal Care Homemaker Services Non-medical Transportation In-Home Support Services Community Transition Services
Is there Case Management?	Yes, through *Single Entry Point agencies*
Who administers program?	Colorado Department of Health Care Policy and Financing
How to apply?	Through *Single Entry Point agencies* (see Appendix A for a complete list) or through County Departments of Social Services (see Appendix B for a complete list)

Home and Community Based Services for the Developmentally Disabled (HCBS-DD)

This program provides services and supports which promote community living for persons at least 18 years old with developmental disabilities who need extensive supports to live safely, including access to 24-hour supervision.

Enrollment maximum:	3,200 persons
Is there a waiting list?	Yes
Services available:	Day Habilitation 24-hour Residential Habilitation Non-medical Transportation
Is there Case Management?	Yes, through *Community Centered Boards*
Who administers program?	Colorado Department of Human Services
How to apply?	Through *Community Centered Boards* (see Appendix C for a complete list)



Community Centered Boards are agencies that provide services to persons with developmental disabilities and their families. These agencies offer services that support independence and productivity. They provide an alternative to placement in an *institution*. Currently there are twenty *Community Centered Boards* throughout the state of Colorado. See Appendix C.

Supported Living Services (HCBS-SLS)

The Supported Living Services program provides specialized services in the home or community to persons at least 18 years old with developmental disabilities. You must be able to live independently with limited supports or be receiving extensive supports from other sources such as your family.

Enrollment maximum:	2,800 persons
Is there a waiting list?	Yes
Services available:	Personal Care Home Modification Assistive Technology Counseling and Therapeutic Services Dental Care Vision Services Hearing Services Habilitation Services Supported Living Consultation Non-medical Transportation
Is there Case Management?	Yes, through *Community Centered Boards*
Who administers program?	Colorado Department of Human Services
How to apply?	Through *Community Centered Boards* (see Appendix C for a complete list)

Each HCBS program provides specific services that support independence. Below are descriptions of some of the services that HCBS pays for:

Adult Day Services

An Adult Day Services (ADS) program provides health, mental health, rehabilitation and social services in a day service center. Adult Day programs can be either "Basic" or "Specialized." Specialized programs are limited to people with Alzheimer's, Multiple Sclerosis, Brain Injury, Chronic Mental Illness, Developmental Disability or Stroke, and they provide extensive rehabilitative therapies.

Alternative Care Facility

The Alternative Care Facility (ACF) program is also known as assisted living. An ACF provides a small apartment with meals and offers support services such as personal care, homemaker services, social and recreational activities, medication monitoring and assistance with transportation. While you pay for your room and meals, Medicaid covers the cost of support services that enable you to remain in a community setting.

Assistive Technology

Assistive technology, or assistive devices, is equipment that allows a person with a brain injury or developmental disability to interact with the environment, communicate with other people or improve self-care.

Community Transition Services

Community Transition Services (CTS) provide you with a navigator to help you move out of a nursing facility and into a community-based residence. The navigator will work with you, the nursing facility discharge planner and your case manager to identify and coordinate the Medicaid and non-Medicaid services you need to make the move. CTS may include one-time payments for moving expenses, security deposits and essential household items. There is a $2,000 cap on CTS.

Day Treatment

Day Treatment services take place outside of the home to help you rehabilitate from a brain injury. These include intensive therapies, such as physical, speech and occupational therapy, directed at developing community living skills.

Electronic Monitor

An electronic monitor is a device that you carry with you that makes it easy to get help in case of an emergency. For example, if you fall and cannot reach the telephone, you can push a button on the monitor that alerts someone that you need assistance. The device may also remind you to go to a medical appointment or take medication. Monitoring must be necessary because you live alone or are alone much of the day.

Habilitation Services

Habilitation services help persons with developmental disabilities to improve skills necessary to live at home or in community-based settings and to work. Therapists teach personal care and work-related skills such as following directions, task completion, problem solving and safety.

Homemaker Services

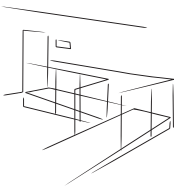
Homemaker services include meal preparation, dishwashing, bed-making, laundry, shopping and routine light housecleaning such as dusting, vacuuming, mopping and cleaning the bathroom and kitchen.

Home Modification

Home modification means making a specific change to your home that will allow you to continue living there and function with greater independence. Some examples of home modification are the installation of ramps or grab-bars, the widening of doorways and the addition of special fixtures in bathrooms. Projects that cost more than $1,000 must receive approval. There is a $10,000 lifetime cap on home modification services.

In-Home Support Services

In-Home Support Services (IHSS) provide attendant support, which includes home health nursing services, home health aide services, personal care and homemaker services. You direct your care, which means that you may choose, train, supervise and schedule your own



attendants. You may select a family member or other authorized representative to direct services for you. An IHSS agency hires the attendants that you choose and handles their hourly wages, payroll, taxes and other employment matters. The agency provides you with IHSS orientation services, cross-disability peer counseling, information and referral services, independent living skills training, individual and systems advocacy and 24-hour back-up services.

IHSS is similar to another consumer direction program, Consumer Directed Attendant Support (CDAS). In CDAS, you have more flexibility and control in directing your care, without the involvement of an agency. See the chapter on CDAS for more information.

Non-medical Transportation

Non-medical transportation is transportation between your home and non-medical community services that you need to prevent admission to an *institution*. This could include transportation to adult day services, shopping, therapeutic swimming, dentist appointments and counseling sessions.

Personal Care

Personal care means daily help with your personal needs such as shaving, bathing, dressing, walking, feeding, care of hair and nails, care of unbroken skin, mouth care, bowel and bladder care, reminding to take medication and accompanying to medical appointments or other basic errands. Personal care can also include insuring safety such as preventing wandering.

Respite Care

Respite care means short-term care that you receive in a nursing facility, alternative care facility or your home, because the person who normally cares for you needs relief. Medicaid limits respite care outside of your home to thirty days in each calendar year.

Supported Living Program

The Supported Living Program helps to maintain your ability to live in the community by providing a 24-hour residential facility or supported living campus. The program is for persons with brain injuries who have maximized their rehabilitative potential but continue to need support and supervision to live in the community.

Transitional Living

Transitional Living services help to improve your ability to live in the community after you leave a hospital or rehabilitation facility. They are 24-hour programs that take place outside of the home. Some program services include medication management, communication skills, social skills, money management and how to maintain a household.

Not all of these services are part of every HCBS program. When you enter an HCBS program, a *case manager* will determine the type and amount of services that you should receive based upon your personal needs.

Also, each program has a limit on the number of people who may enroll. If the program is full, Medicaid will place your name on a waiting list until an opening occurs.

For more information about *Home and Community Based Services*, call your local *Single Entry Point agency* (see Appendix A for a list) or your County Department of Social Services (see Appendix B for a list). You may also call Colorado Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area).

Chapter 3: Home Health Services

For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or go to the Colorado Department of Health Care Policy & Financing website at **http://www.chcpf.state.co.us**.

Chapter 3: Home Health Services

Home health services include skilled services that persons recovering from an illness or injury or persons who are disabled receive at home. The organizations that deliver home health services are **home health agencies**. Medicaid will pay for some home health services when a certified home health agency that has signed a Medicaid provider agreement delivers the services.

Words To Know—See Chapter 1
Prior authorization
Single Entry Point agency
Appeal
Medically necessary
Long-term care

To qualify for home health services under Medicaid, you must:

- be ill, injured, physically disabled or mentally disabled
- need skilled nursing services, Certified Nurse Aide (CNA) services, physical therapy, occupational therapy or speech therapy. See Chapter 2 on *Home and Community Based Services* for unskilled personal care.
- be unable to do the tasks yourself and have no family or caregiver to do them for you
- have a plan of care that your doctor ordered

If you qualify, Medicaid will pay for medically necessary appropriate care, including:

- skilled nursing care
- physical, occupational and speech therapy: After 60 days of continuing care, children 0–17 years old may continue to receive these services. They are not available to adults, after 60 days of continuing care, except as an outpatient benefit.
- unskilled (personal care) services such as help with bathing, dressing or eating

In addition, the home health services must:

- be delivered where you live
- be reasonable in amount, frequency and duration
- not cost more than the daily limit that Medicaid set
- be provided by a Medicaid certified home health agency

Home health services are skilled services that a certified home health agency provides in your home for the treatment of an illness, injury or disability.

What is a "certified" home health agency?

A "certified" home health agency is an agency that Medicaid has approved. The State monitors certified agencies, and they must meet specific standards.

Your health care provider, hospital discharge planner, *Single Entry Point (SEP) agency* or social worker can help you choose a certified home health agency. If you are a member of a Medicaid HMO, the HMO may require you to use certain agencies. Call your HMO's customer service department for more information.

What should I expect from a certified home health agency?

- A certified home health agency should perform criminal background checks on all employees and independent contractors that have contact with patients
- All employees and independent contractors of the agency are guests in your home, and they should treat you and your property with respect
- On the first visit, you should receive a letter explaining your rights and whom to call if you have any complaints
- A registered nurse or therapist should write a care plan to meet your needs. Your doctor must approve your care plan. You have the right to participate in developing the plan and to ask for changes in your plan when necessary
- The agency should tell you about your right to specify how you want medical decisions made if you become unable to make such decisions
- The agency must observe confidentiality regarding your medical information

Skilled services are those services that only a skilled person, such as a nurse, Certified Nurse's Aide (CNA), therapist or other person with extensive training may provide. Some examples of skilled services are: transferring a person from a bed to a wheelchair using a lift, bathing someone with an open wound or sore, performing prescribed range of motion exercises, feeding someone at risk of choking and giving an injection of insulin.

Do I need *prior authorization* for home health services?

For the first 60 calendar days, you do not need prior approval before receiving home health services. Medicaid considers this 60-day period to be *acute* home health. However, if your need for home health care exceeds 60 consecutive calendar days, you move into the *long-term* home health benefit and the services require *prior authorization*. The certified home health agency you select will request approval from your local *SEP agency*. See Appendix A for a list of *SEP agencies*.

Your home health agency will contact the *SEP agency* and will submit a *Prior Authorization Request* (PAR) for approval of long-term home health. A PAR may include home health services for up to one year. If you need services for longer, your home health agency will have to submit a new PAR each year.

Within 10 working days of receipt of the PAR, the *SEP agency* will review your request and perform an assessment for *long-term care*. You and your home health agency will then receive a letter that will say one of three things:

- It will say that you have received approval for the services. You can continue to receive services through the certified home health agency you have chosen
- It will say that approval is pending because Medicaid needs additional information to make a decision. Check with your home health agency **immediately.** If Medicaid does not get the information **within 30 days** they must start the process over
- It will say that Medicaid denied the request. If you think this decision is wrong, you have a right to file an *appeal* **within 15 days** of the date of the letter. See Chapter 9 of this resource book for more information

It is always a good idea to ask your home health agency to provide you with a copy of the *Prior Authorization Request* (PAR) and all attachments that the agency submitted. You should also keep any correspondence you receive directly from Medicaid or the *Single Entry Point agency*. By doing so, you will have a complete record in case you move, or decide later to change to a different home health agency.

What should I do if I have a complaint about the care I receive?

If you have a complaint about your care, you should call the number that the home health agency gave to you on the first visit or you should contact the agency's administrator. If this does not help, you should file a complaint with the Colorado Department of Public Health and Environment by calling 303-692-2800 (Denver Metro Area) or 1-800-842-8826 (outside the Denver Metro Area).

You may also file a complaint in writing. Send it to:

Complaint Program
Colorado Department of Public Health and Environment
HFD-A2
4300 Cherry Creek Drive South
Denver, Colorado 80246

or fax your written complaint to: 303-782-4883.

Provide the following information:

- Dates, times and the names of the people involved
- Your name, address and the best way to contact you (phone, fax, or e-mail)
- If there are witnesses, or other persons who can provide additional information, include their names, addresses and daytime phone numbers

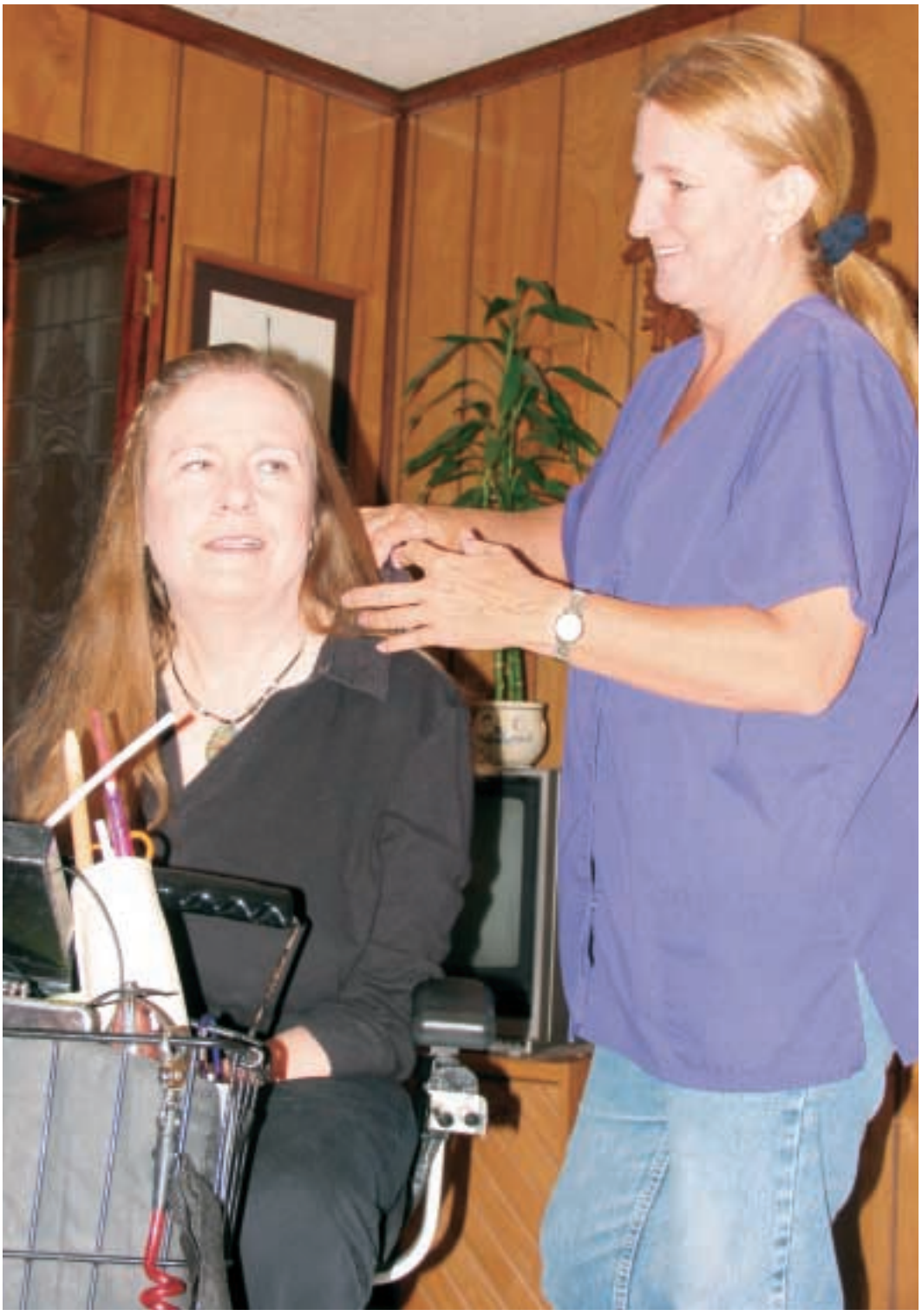
You can file a complaint without giving your name, but you will not receive a report of the investigation and findings.

Where can I get more information?

To find out more about Medicaid's home health benefit, call your local County Department of Social Services (see Appendix B for a list) or Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area).

If you wish to check on the license or certification status of a nurse or nurse aide who is providing care to you, you can call 303-894-7888. This is a 24-hour automated licensure information system. All you need is the person's name or license number.

Chapter 4: Consumer Directed Attendant Support



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Chapter 4: Consumer Directed Attendant Support

Words To Know—See Chapter 1
Case Manager
Appeal

The Consumer Directed Attendant Support (CDAS) program provides in-home services from attendants you select, hire, train and supervise. You direct these services instead of receiving home health services (see Chapter 3) or personal care and homemaker services (see Chapter 2). Under CDAS, you decide what services your attendants will provide and the schedule that best meets your needs. Decisions are up to you, not an agency.

To be eligible for CDAS, you must:

- be enrolled in Medicaid
- have received Medicaid-funded attendant support (home health, personal care or homemaker services) for the past twelve months
- be able to direct your own services
- have a statement from your doctor stating that you are in stable health and that you have the judgment to manage your health and attendant support

To participate in Consumer Directed Attendant Support, YOU must be able to direct your own attendant care.

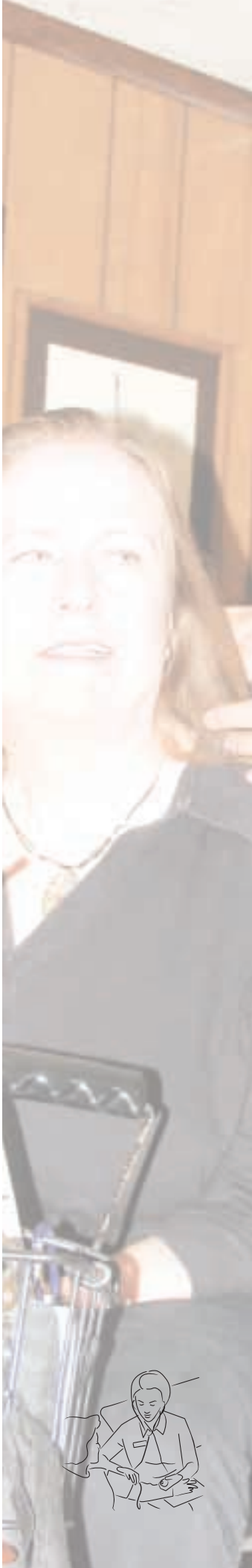
There is a maximum number of people that CDAS can serve. If the program becomes full, CDAS staff will create and maintain a waiting list. Volunteering to be in the program does not affect any other Medicaid benefits you may receive, except that it substitutes for home health, personal care and homemaker services.

Attendant support includes home health nursing services, home health aide services, personal care and homemaker services. Attendant support does not include occupational therapy, physical therapy or speech therapy.

If you decide to participate in CDAS, you must complete the following steps:

- Fill out the initial application and include a doctor's statement
- Complete CDAS training and pass a post-training test
- Develop an Attendant Support Management Plan

The CDAS Training Manual and the training sessions will provide you with the necessary information to develop the Attendant Support Management Plan. The plan describes your attendant support needs and your decisions regarding how your needs will be met. It also includes what you will do in case of an emergency, such as when an attendant does not show up for work.



Participating in CDAS does not change your Medicaid eligibility. You remain a Medicaid client with the same rights as other clients, including the right to request reconsideration or file an *appeal* if you disagree with a Medicaid decision. You may withdraw from CDAS at any time.

Under CDAS, Medicaid calculates a monthly amount that you may spend on attendant services. Medicaid bases the monthly amount, or allocation, on your previous use of home health, personal care and homemaker services. You must budget carefully because you may not spend more than your allocation.

You are responsible for choosing your attendants, deciding on wages and supervising the work the attendant does for you. However, an Intermediary Service Organization (ISO) will help you with paperwork. The ISO performs a criminal background check for each attendant you are considering and provides you with the results. The ISO issues checks to your attendants, calculates and sends payroll taxes to the proper tax authority and issues the required tax forms at the end of the year.

Each month, 12% of your allocation pays for the services that the ISO provides. If there is any unspent money from the monthly allocation, one-half goes into a fund for you to spend on additional services. The remaining half is savings to the State.

Managing your own attendant support means you can:

- Choose the person(s) you want to provide your attendant support
- Decide if you want your attendant(s) to have special knowledge and skills such as nursing aide certification or specific experience
- Train attendants to meet your own needs
- Replace attendants who do not meet your needs
- Request a new assessment if you need more or different services
- Change your Attendant Support Management Plan as needed, if the Program Administrator approves the change

In December and June of each year, you may apply to use the money in your fund to purchase services or equipment that is not otherwise available through Medicaid. These services or equipment must promote your independence and/or improve the condition of your disability. For example, if your doctor directs you to exercise for health improvement, then you may use money in the fund to purchase a membership in a health club or gym.

While you are in CDAS, a *case manager* is available to help you plan and manage your attendant support. The *case manager* will visit you every six months to review your current care needs and ensure that your Attendant Support Management Plan meets those needs. Your *case manager* assists you in coordinating services that are not part of CDAS, if you need them.

Because the CDAS program is new, CDAS staff must evaluate it and will ask you to complete a series of surveys during your participation in the CDAS program. CDAS staff will also conduct random telephone surveys to ensure that your needs are being met.

For more information, or to apply for CDAS, contact the Colorado Department of Health Care Policy and Financing at 303-866-3358 (Denver Metro Area) or 1-800-221-3943 extension #3358 (outside the Denver Metro Area). If you have internet access, visit **www.chcpf.state.co.us/SysChange/cdas/cdasindex.html**.

Chapter 5: Non-emergency Medical Transportation

Photo courtesy of the Regional Transportation District

For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or go to the Colorado Department of Health Care Policy & Financing website at **http://www.chcpf.state.co.us**.

Chapter 5: Non-emergency Medical Transportation

If you need medical services and do not have your own transportation or cannot get a ride with family, friends or a volunteer, Medicaid may pay for your transportation in an ambulance, mobility vehicle, taxi, bus, or wheelchair van, depending on your condition. This may include out-of-state travel, if it is necessary to obtain treatment that is not available closer to your home. Medicaid may consider air travel if the distance to travel is very far.

Words To Know—See Chapter 1
Prior authorization
Medical emergency

Do I need *prior authorization* for non-emergency medical transportation?

Yes. Medicaid requires approval of transportation for medical care when you are not having a *medical emergency*. Medicaid calls this *prior authorization*. If you need medical transportation regularly, you can ask for approval for up to six months. In addition, Medicaid may pay for a family member or friend to travel with you if you cannot travel alone.

For non-emergency medical transportation, contact your County Department of Social Services (see Appendix B for a complete listing). You must make all requests for non-emergency medical transportation to the County Department of Social Services, which must authorize each request. If you qualify for medical transportation, the County's transportation coordinator will make transportation arrangements for you or tell you how to obtain transportation.

What do I do in an emergency?

Remember: If you are having a *medical emergency*, DIAL 911. Medicaid will pay for an ambulance to take you to the hospital.

An emergency is a medical crisis that you think may be life threatening or may result in losing a body part such as an arm, leg or eye. Sometimes it is hard to tell if it is an emergency. If you are not sure, call your doctor or call FirstHelp Nurse Advice at 1-800-283-3221, 24 hours a day, 7 days a week. The nurse can help you decide what you should do.

For more information about medical transportation, call your local County Department of Social Services (see Appendix B for a list) or Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area).

Chapter 6: Durable Medical Equipment

For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or go to the Colorado Department of Health Care Policy & Financing website at **http://www.chcpf.state.co.us**.

Chapter 6: Durable Medical Equipment

***Durable Medical Equipment* (DME) is equipment that:**

- you can use over and over
- is for a medical purpose or to compensate for functional loss due to illness, injury or disability
- is not useful to a person who is not disabled, sick or injured
- is appropriate for use in your home and community

Words To Know—See Chapter 1
Durable Medical Equipment (DME)
Prior authorization
Disposable medical supplies
Medically necessary
Appeal

Medicaid will pay for *Durable Medical Equipment* when:

- your doctor prescribes it for you
- the equipment is primarily for use in your home and community
- you obtain *prior authorization* from Medicaid
- you get the equipment from a Medicaid-certified supplier

Examples of *Durable Medical Equipment* that Medicaid generally covers are:

- adaptive eating utensils
- bath equipment such as handrails, shower chairs and raised toilet seats
- breathing equipment such as oxygen, nebulizers, respirators and ventilators
- crutches and canes
- hospital beds, bed rails and pressure pads
- suctioning equipment
- walkers
- wheelchairs

Durable Medical Equipment does **not** include things that you throw away after use, such as catheters, dressings, feeding supplies, syringes and diapers. These are *disposable medical supplies*. Medicaid may pay for *disposable medical supplies* under certain conditions. For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area).

DME also does not include hearing aids. However, DME does include eyeglasses when they are *medically necessary* for adults who have had eye surgery. Orthotics and prosthetics are a covered benefit. Many of these are available with or without *prior authorization*. For more information on these benefits, see Chapter 7—Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Chapter 8—Acute Care Services.

How do I get *prior authorization* for DME?

Medicaid requires approval of DME before buying or renting it. This process is *prior authorization*. First, your doctor must order DME. You should take the written order to a DME supplier who will work with your doctor to choose the right equipment to meet your needs. The DME supplier will complete a *Prior Authorization Request* (PAR) form and send it to Medicaid. This form should give Medicaid the information it needs to decide if the equipment is *medically necessary*. If Medicaid decides that it is *medically necessary*, Medicaid will pay for buying or renting that item.

Avoid dishonest and fraudulent suppliers!

- Never give out your Medicaid number to anyone who calls you on the telephone or shows up at your door offering you free equipment
- If you suspect a DME supplier has done something wrong, call the **Prior Authorization Hotline** at 303-866-5571 (Denver Metro Area) or 1-800-221-3943 extension #5571 (outside the Denver Metro Area)

Usually within 10 working days of receipt of the PAR, Medicaid will review your request. You will then receive a letter that will tell you one of three things:

- It will say that you have received approval for the equipment that you requested. You can then arrange to buy or rent that equipment
- It will say that approval is pending because Medicaid needs additional information to make a decision. Check with your DME supplier **immediately.** If Medicaid does not get the information **within 30 days** you must start the process over
- It will say that Medicaid denied the request. If you think this decision is wrong, you have a right to reconsideration. You should contact your DME supplier and your doctor to find out if there is any additional information to submit that will support your need for DME. You also have the right to file an *appeal* **within 15 days** of the date of the denial letter. See Chapter 9 of this resource book for more information on reconsideration and *appeal*

A service or supply is *medically necessary* if it is (all of the following):

- for the purpose of treating a health condition
- the most appropriate service or supply, considering potential benefits and harms to the patient
- known to be effective in treating the medical condition, as scientific evidence and medical standards have determined
- furnished in the least costly manner which is safe and effective

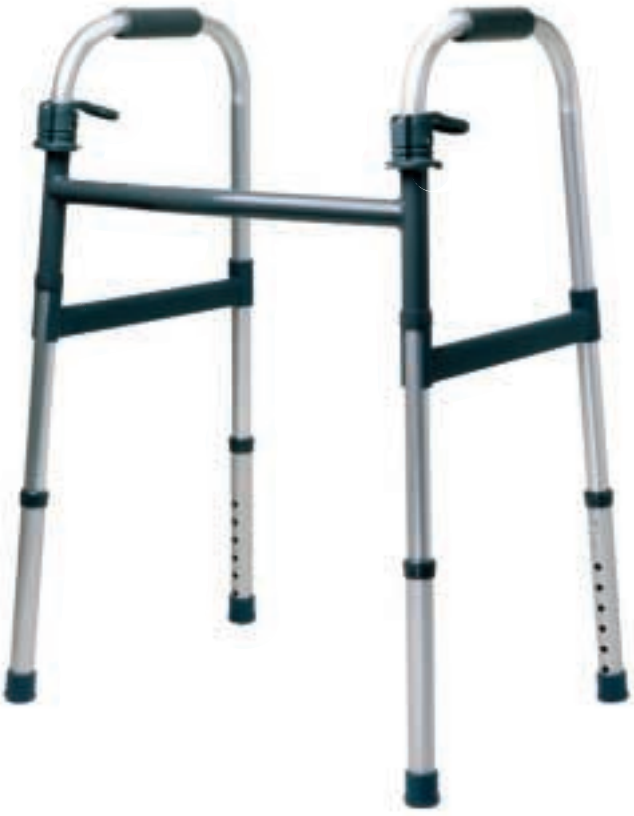
What if I want to add special features to the DME my doctor ordered?

Medicaid allows you to add special features but you will have to pay for them yourself. Medicaid does not pay for upgrades unless they are *medically necessary* and your doctor ordered them.

How do I get equipment repaired?

Repairs do not require the approval of your doctor but may require *prior authorization*. Call your DME supplier (the company you purchased or rented your equipment from) or call the **Prior Authorization Hotline** at 303-866-5571 (Denver Metro Area) or 1-800-221-3943 extension #5571 (outside the Denver Metro Area) to find out if your repair needs approval. If it does, your DME supplier can submit an emergency *Prior Authorization Request*. Your DME supplier may be able to loan you substitute equipment until the repairs are complete. If repair is too costly, Medicaid may approve the purchase or rental of new equipment.

Colorado has a "lemon law" which applies to wheelchairs and assistive technology. Under the law, if a single part of the equipment has to be fixed more than three times, the vendor must either replace the equipment or refund the original cost of the equipment to Medicaid.



Chapter 7: Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or go to the Colorado Department of Health Care Policy & Financing website at **http://www.chcpf.state.co.us**.

Chapter 7: Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit is available to children and teens through age 20. **If you are 21 years old or older, this program does not apply to you.**

Words To Know—See Chapter 1
Prior authorization
Medically necessary
Appeal
Disposable medical supplies
Durable Medical Equipment (DME)

EPSDT helps children and teens get early identification and treatment of medical, dental, vision, mental health and development problems. EPSDT pays for screening exams, sometimes called well-child check-ups, which include a detailed health and developmental history, a "head to toe" physical exam, age-appropriate immunizations, laboratory tests and health education.

A diagnosis is the identification of any problem or illness. If a doctor diagnoses a problem or illness during a screening exam, you are entitled to further evaluation and treatment for this condition. The doctor will write your diagnosis and additional care needs, including the reasons for them, in your medical record.

Every screening exam should end with a treatment plan. A treatment plan may list additional tests or services, referrals to other doctors or specialists and prescriptions for medications. The treatment plan should include needs you have for additional health education. It should also include a date for your next appointment.

Medicaid requires approval of some EPSDT services and equipment before you get them. Medicaid calls this process *prior authorization*. The process starts when your doctor completes a *Prior Authorization Request* (PAR) form and sends it to Affiliated Computer Services (ACS). This form should give ACS the information it needs to decide if the service or equipment is *medically necessary*. If ACS decides that it is *medically necessary*, Medicaid will pay for that service or item.

Usually within 10 working days of receipt of the PAR, ACS will review your request. You will then receive a letter that will tell you one of three things:

- It will say that you have received approval for the service. You can then arrange to receive that service
- It will say that approval is pending because ACS needs additional information to make a decision. Check with your doctor **immediately.** If ACS does not get the information **within 30 days,** you must start the process over
- It will say that Medicaid denied the request. If you think this decision is wrong, you have a right to request reconsideration or to file an *appeal* **within 15 days** of the date of the letter. See Chapter 9 of this resource book for more information on reconsideration and *appeal*

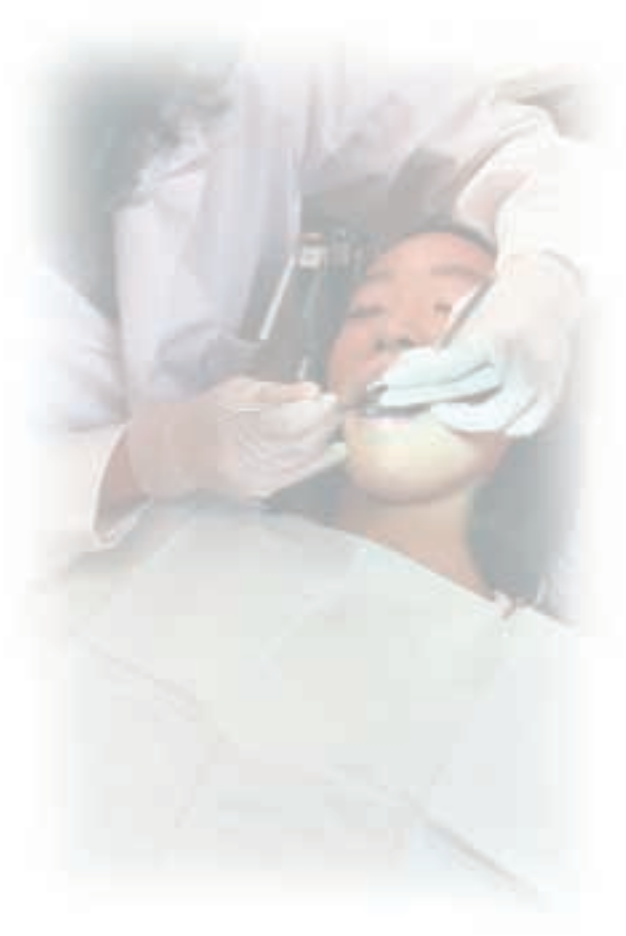
Some of the services and items EPSDT may pay for are:

- assistive technology
- augmentative communication equipment
- bath equipment such as rails, shower chair or bench
- braces for the teeth for severe conditions such as cleft palate
- chiropractic treatments
- dental care including fillings
- *disposable medical supplies* such as diapers (after the age of 3), syringes and catheters
- *Durable Medical Equipment* such as walkers, wheel chairs and special car seats
- extended care facilities
- feeding supplies such as G-tubes, J-tubes and NG-tubes
- hearing tests and treatments including hearing aids
- hospital beds, bed rails, mattresses and pressure pads
- orthotics such as braces and splints
- oxygen and oxygen equipment such as nebulizers, respirators or ventilators
- prosthetics such as glass eyes and artificial limbs
- rehabilitation facility care
- skilled nursing services and therapies
- suctioning equipment
- surgeries
- therapies such as Occupational (OT), Physical (PT) and Speech (ST)

An EPSDT screen includes:

- history of how the patient has developed and grown
- developmental evaluation
- behavior assessment
- "head to toe" physical exam
- vision and hearing testing
- immunizations
- laboratory tests
- check of the mouth and teeth and a reminder to visit the dentist every six months
- information on what the patient might need in the coming months

- tracheotomy and laryngectomy equipment and supplies
- transportation to and from medical and dental care if you meet transportation program requirements (see Chapter 5)
- vision exams and treatment including eyeglasses
- wheelchairs, accessories and repairs

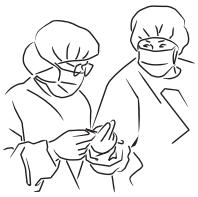


This list does not include everything that EPSDT might cover if it is *medically necessary*.

A service or supply is *medically necessary* if it is all of the following:

- for the purpose of treating a medical condition
- the most appropriate service or supply, considering potential benefits and harms to the patient
- known to be effective in treating the medical condition, as scientific evidence and medical standards have determined
- furnished in the least costly manner which is safe and effective

If you have questions, call your local EPSDT Outreach Coordinator. The Outreach Coordinator can help you understand what Medicaid covers, how to get appropriate care and even help find a doctor or other provider. He or she can also tell you about other sources of help, such as housing and food banks. To find out who the EPSDT Outreach Coordinator is in your area, call the EPSDT Liaison at (303) 866-6010 (Denver Metro Area) or 1-800-221-3943, extension #6010 (outside the Denver Metro Area).



Chapter 8: Acute Care Services

For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or go to the Colorado Department of Health Care Policy & Financing website at **http://www.chcpf.state.co.us**.

Chapter 8: Acute Care Services

Acute care is medical and surgical care that you need because you are sick or recently injured. Highly trained personnel, such as doctors, paramedics, nurses and psychologists, provide *acute care*. When receiving *acute care*, Medicaid expects that your condition will improve.

Acute care includes mental health services such as counseling. *Acute care* also includes services that can prevent illness or injury such as immunizations or smoking cessation classes.

Words To Know—See Chapter 1
Acute Care
Prior authorization
Medically necessary
Appeal
Durable Medical Equipment (DME)
Disposable medical supplies

How do I get acute medical care under Medicaid?

When you enroll in Medicaid, you choose the way you wish to receive your health care. The choices are:

- an HMO (Health Maintenance Organization)
- the Primary Care Physician Program (PCP Program)
- basic Medicaid

If you need help understanding these options, call Health*Colorado* at 303-839-2120 (Denver Metro Area) or 1-888-367-6557 (outside the Denver Metro Area).

Once you choose a program, you need to follow that program's rules about using health care services. For example, if you are a member of an HMO or the PCP Program, you select a Primary Care Physician (PCP) who will provide you with a "medical home" and will coordinate all the medical care that you need. The PCP will provide a referral when you need to see a specialist or other provider. However, except in an emergency or to receive family planning services, if you receive services without a referral, you will have to pay for them.

How do I get mental health care under Medicaid?

When you become eligible for Medicaid, you automatically enroll in a Mental Health Assessment and Services Agency (MHASA). If you need mental health services, call the MHASA. The MHASA will provide or make arrangements for all necessary mental health services including assessment, development of a treatment plan, inpatient or outpatient treatment, case management and coordination of any other mental health services that you need.

If you do not know which MHASA to contact, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area).

If you feel that you cannot get the type of mental health services that you need through your MHASA, contact the Medicaid Ombudsman at 303-813-1173 (Denver Metro Area) or 1-877-317-9900 (outside the Denver Metro Area).

What is *prior authorization*?

Medicaid requires approval of some *acute care* services (see list below) before you get them. Medicaid calls this process *prior authorization*. The process starts when your doctor or other health services provider completes a *Prior Authorization Request* (PAR) form and sends it to Medicaid. This form should give Medicaid the information it needs to decide if the service is *medically necessary*. If Medicaid decides that it is *medically necessary*, Medicaid will pay for that service.

Usually within 10 working days of receipt of the PAR, Medicaid will review your request. You will then receive a letter that will tell you one of three things:

- It will say that you have received approval for the service. You can then arrange to receive that service
- It will say that approval is pending because Medicaid needs additional information to make a decision. Check with your doctor or the appropriate provider **immediately.** If Medicaid does not get the information **within 30 days** you must start the process over
- It will say that Medicaid denied the request. If you think this decision is wrong, you have a right to request reconsideration or to file an *appeal* **within 15 days** of the date of the letter. See Chapter 9 of this resource book for more information on reconsideration and *appeal*

What is an emergency?

An emergency is a medical crisis that you think may be life threatening or may result in losing a body part such as an arm, leg or eye. Some examples of emergencies are:

- severe bleeding
- loss of consciousness
- severe burns
- severe shortness of breath
- chest pain
- injury to an eye
- broken bones
- seizures
- severe pain

If you have an emergency, you should call 911 or, if appropriate, ask someone to drive you to the emergency room of a hospital. Sometimes it is hard to tell if it is an emergency. If you are not sure, call your doctor or call FirstHelp Nurse Advice at 1-800-283-3221, 24 hours a day, 7 days a week. The nurse can help you decide what you should do.

Will I have to pay anything when I receive acute medical care?

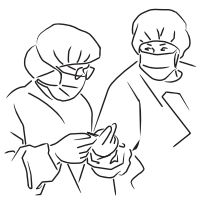
Yes, you have to pay a *co-payment* unless you are:

- a child under age 19
- a pregnant woman
- living in a nursing facility
- a member of an HMO who has waived the co-payments

Co-payments are your share of the cost for your health care. Providers will usually ask you to pay the co-payment at the time you receive services. However, some providers, especially hospitals, may choose to send you a bill. The co-payment amount changes often so you should check with your provider when you receive services. At the time of printing this book, co-payments are:

Service	Your Co-payment*
For each doctor office visit	$2.00
For each inpatient hospital day	$10.00
For each outpatient hospital service	$3.00
For each prescription drug	
generic	$1.00
brand name	$3.00
For *Durable Medical Equipment* or *disposable medical supplies*	$1.00 per date of delivery or repair
For lab services	$1.00
For X-rays	$1.00

*as of October 2004



What *acute care* services does Medicaid cover?

Medicaid covers services that are *medically necessary* when your health care provider orders them. A partial list of covered services is below.

Ambulance

Emergency ground and air transport are covered services.

Contact Lenses

Medicaid covers contact lenses with *prior authorization* if you are under age 21. If you are age 21 or older and have had eye surgery, contact lenses may be covered services.

Dental Services

Diagnostic, preventative and correctional procedures are covered services if you are under age 21. If you are age 21 or older, only emergency procedures with *prior authorization* are covered services.

Doctor Office Visits, Lab Tests and X-ray Services

Visits to your primary care provider are covered services. Visits to a specialist or other provider require a referral from your primary care provider if you are a member of a Health Maintenance Organization (HMO) or Medicaid's Primary Care Physician (PCP) Program.

Drugs

Medicaid does not cover over-the-counter drugs, or drugs that you can buy without a prescription, except for aspirin, insulin and prenatal vitamins. Prenatal vitamins are for women that are pregnant or have delivered a baby within the past 90 days.

Medicaid covers prescription drugs except for drugs to treat infertility and obesity. Cosmetics are not covered drugs. Medicaid does not cover cough and cold remedies if you are age 21 or older. Some drugs need *prior authorization*.

Durable Medical Equipment

Medicaid requires *prior authorization* for Durable Medical Equipment. See Chapter 6 of this resource book for more information.

Emergency Services

Medicaid covers emergency services when you go to an emergency room for a true emergency. However, if you go to the emergency room when it is not an emergency, you may have to pay for the visit.

Eye Exams

Eye exams are covered services if you are under age 21. If you are age 21 or older, eye exams are covered services only if you have a medical complaint such as headaches or blurred vision.

Eyeglasses

Medicaid covers eyeglasses if you are under age 21. If you are age 21 or older and have had eye surgery, Medicaid may not cover eyeglasses.

Family Planning Services

You have a right to receive family planning services from any Medicaid provider **without** *prior authorization* or a referral.

Hearing Implants

Medicaid requires *prior authorization* for hearing implants if you are age 21 or older.

Hospital

Both inpatient and outpatient services are covered services.

Mental Health Assessment and Treatment

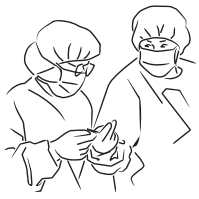
Medicaid covers mental health services when your assigned Mental Health Assessment and Services Agency (MHASA) provides them.

Out-of-State Services

Medicaid covers out-of-state emergency services if the provider has obtained a Colorado Medicaid Provider Number. Out-of-state non-emergency services must have *prior authorization* and must be unavailable in Colorado.

Physical and Occupational Therapy

Physical and occupational therapy need *Prior authorization*.



Smoking Cessation

Medicaid will cover services that help you stop smoking one time with *prior authorization*.

Sterilization

Medicaid requires *prior authorization* for sterilization.

Transplants

Medicaid requires *prior authorization* for transplants.

This list does not include everything that Medicaid might cover. If you have questions about your benefits, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area).

If you wish to complain about services that you have received from an HMO, call the Medicaid Ombudsman at 303-830-3560 (Denver Metro Area) or 1-877-435-7123 (outside the Denver Metro Area).

Chapter 9:
Reconsideration and Appeal

For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or go to the Colorado Department of Health Care Policy & Financing website at **http://www.chcpf.state.co.us**.

Chapter 9: Reconsideration and Appeal

After you apply to participate in a Medicaid program or to receive a specific Medicaid service, you will receive a letter explaining what the Medicaid office has decided regarding your request. If you do not agree with the decision that Medicaid stated in the letter, you have a right to reconsideration or *appeal*.

What is reconsideration?

Reconsideration means that you ask the Medicaid office to look at your case again. You or your doctor may send more information about why you need the services that Medicaid denied. You may ask your doctor to explain in more detail the medical reason why you need the services. This might make it possible for Medicaid to change its action. You or your doctor should send the additional information to:

Medicaid PARS
P.O. Box 30
Denver, Colorado 80201

If you or your doctor sends further information about why you need the services, Medicaid will send you another letter telling you what the Medicaid office has decided.

If you do not have more information, if you do not want to send more information or if you disagree with the reconsideration decision, you can request an *appeal*.

What is an *appeal*?

You can request an *appeal* for any program or service that Medicaid denied or limited. When you request an *appeal*, you receive a "fair hearing." A fair hearing is a conversation between you, Medicaid and an Administrative Law Judge where you can explain why you think you should have the service that Medicaid denied.

If you want a fair hearing, you must make your request in writing within **15 calendar days** from the date that you received your letter denying a service. If you cannot ask for a hearing within the required 15 days, you may ask the Administrative Law Judge, in writing, for an extension of up to 90 days.

If you want to *appeal* a decision regarding services that Medicaid denied, you can ask anyone you wish to help you.

To request a fair hearing, you must write a letter stating why you wish to *appeal*, **OR** you must complete a Request for Fair Hearing form (end of this section), and mail it to:

Administrative Hearings Division
Colorado Department of Personnel and Administration
1120 Lincoln Street, Suite 1400
Denver, Colorado 80203

After you request a hearing, you will receive a notice telling you the date, time and place of your hearing. If you are unable to go to your hearing at that time, and it is for a good reason, you may receive an extension. If you need an extension, call the Administrative Hearings Division at 303-764-1400. If you do not attend the hearing at the scheduled time, and if you have not requested an extension prior to that time, the Administrative Law Judge will dismiss your hearing and Medicaid will take the action that it stated on your original letter.

You have a right to:

- attend the hearing and look at the papers that Medicaid used to make the decision
- bring a lawyer, or any other person you choose, to represent you
- have an impartial Administrative Law Judge hear your case

The Administrative Law Judge will give you a written decision after the hearing.

If you believe that you have been discriminated against because of your race, color, sex, religion, handicap, national origin, age or political beliefs, you have the right to file a complaint with:

Civil Rights Division
Colorado Department of Regulatory Agencies
1560 Broadway, Suite 1050
Denver, Colorado 80202
303-894-2997

You may also file a complaint with the Office of Civil Rights in the U.S. Department of Health and Human Services. For more information call (303) 844-2024 or (303) 844-3439 (TDD) or go to **http://www.hhs.gov/ocr/**.

REQUEST FOR FAIR HEARING

Please complete this form and mail it to:

Administrative Hearings Division
Colorado Department of Personnel and Administration
1120 Lincoln Street, Suite 1400
Denver, Colorado 80203

Name (Please Print): _____

Home Address: _____

City & Zip Code _____

Home Phone:_____ Household or ID Number: _____

Social Security Number: _____

I request a fair hearing before an Administrative Law Judge.
At the hearing, I will appeal adverse action(s) taken by (check one):

☐ Colorado Department of Health Care Policy and Financing

☐ Single Entry Point Agency
If you submitted a Prior Authorization Request (PAR) and received a denial, please provide the PAR number found on the denial letter _____

☐ County Department of Social Services
Which county? _____
Who has been working with you at the county? _____
What is their phone number? _____

Was a conference held? (circle one) Yes No Other _____
Please list the types of assistance or services you have been receiving _____
_____
What type of assistance or service was affected? _____
_____

What happened to your assistance or services? (circle one of five choices below)

Terminated Amount Changed Application was Denied

Recovery of Overpayment Other

Please attach a copy of the notice that you received.

If my home address or phone number changes, I will immediately notify the Administrative Hearings Division at the above address or at telephone number (303) 764-1400. I understand that my appeal can be dismissed if the Division is unaware of my current address or if my appeal is not submitted in a timely manner.

Date:_____ Signature: _____

Appendices

For more information, call Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or go to the Colorado Department of Health Care Policy & Financing website at **http://www.chcpf.state.co.us**.

Appendix A: Single Entry Point Agencies

Note: At the time of printing, the addresses and telephone numbers below were correct. However, agencies sometimes move or change phone numbers. To get the most up-to-date information, call Colorado Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area).

In some cases, one office serves several counties, so your county may not be in alphabetical order.

ADAMS, ARAPAHOE, DENVER, DOUGLAS, ELBERT
Longterm Care Options, LLC
4500 Cherry Creek Drive South, Suite 500
Denver, CO 80246
720-974-0032

ALAMOSA, SAGUACHE
Alamosa County Nursing Service
8900 Independence Way
Alamosa, CO 81101
719-589-6639

BENT, KIOWA
Bent County Nursing Service
701 Park Avenue
Las Animas, CO 81054
719-456-0517

BOULDER, GILPIN, CLEAR CREEK, BROOMFIELD
Adult Care Management, Inc.
1455 Dixon Avenue, Suite 320
Lafayette, CO 80026
303-439-7011

CONEJOS, COSTILLA
Conejos County Nursing Service
19023 State Highway 285 South
La Jara, CO 81140
719-274-4307

DELTA, GUNNISON, HINSDALE
Delta County Department of Social Services
Courthouse Annex
560 Dodge Street
Delta, CO 81416
970-874-2048

EL PASO, TELLER
Rocky Mountain OLTC
2812 E. Bijou
Colorado Springs, CO 80909
719-457-0660

FREMONT, PARK, CHAFFEE, LAKE, CUSTER
Central Mountain OLTC
172 Justice Center Road
Canon City, CO 81212
719-275-2318

GARFIELD, GRAND, JACKSON, SUMMIT, MOFFAT, RIO BLANCO, ROUTT, EAGLE, PITKIN
Garfield County Department of Social Services
108 Eighth Street, Suite 300
Glenwood Springs, CO 81602
970-945-9191

JEFFERSON
Jefferson County Department of Human Services
900 Jefferson County Parkway
Golden, CO 80401
303-271-4216

KIT CARSON, LINCOLN, CHEYENNE
Kit Carson County Public Health
252 S. 14th Street
Burlington, CO 80807
719-346-7158

LARIMER
Larimer County Department of Human Services
1501 Blue Spruce Drive
Fort Collins, CO 80524
970-498-6364

LAS ANIMAS, HUERFANO
Las Animas County Department of Social Services
204 South Chestnut
Trinidad, CO 81082
719-846-2276

MESA
Mesa County Department of Human Services
2952 North Avenue
Grand Junction, CO 81501
970-248-2888

MONTEZUMA, DOLORES
Montezuma County Health Department
County Annex Building
106 West North St
Cortez, CO 81321-3189
970-565-3056

MONTROSE, SAN MIGUEL, OURAY
Montrose County Department of Health and Human Services
1845 S. Townsend Avenue
Montrose, CO 81401
970-252-5092

MORGAN, LOGAN, SEDGWICK, PHILLIPS, YUMA, WASHINGTON
Northeastern Colorado Area Agency on Aging
231 Main Street, Suite 211
Fort Morgan, CO 80701
970-867-9409

OTERO, CROWLEY
Otero County Department of Human Services
Courthouse
13 W. Third
La Junta, CO 81050
719-383-3167

PROWERS, BACA
Prowers County Public Health Nursing Service
1001 S. Main Street
Lamar, CO 81052
719-336-8721

PUEBLO
Pueblo County Department of Social Services
212 W. 12th Street
Pueblo, CO 81003
719-583-6845

RIO GRANDE, MINERAL
Rio Grand County Department of Social Services
1015 6th Street
Del Norte, CO 81132
719-657-2138

SAN JUAN, LA PLATA, ARCHULETA
San Juan Basin Health Department
281 Sawyer Drive
Durango, CO 81301
970-247-5702

WELD
Weld County Area Agency on Aging
1551 North 17th Avenue
Greeley, CO 80632
970-353-3800

Appendix B: County Departments of Social Services

Note: At the time of printing, the addresses and telephone numbers below were correct. However, agencies sometimes move or change phone numbers. To get the most up-to-date information, call Colorado Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or visit the Colorado Department of Human Services website at: **http://www.cdhs.state.co.us/edo/org/hs_counties.html**

Adams County Department of Social Services
7190 Colorado Blvd.
Commerce City, CO 80022
(303) 287-8831

Alamosa County Department of Social Services
610 State Street
Alamosa, CO 81101
(719) 589-2581

Arapahoe County Department of Human Services
14980 E. Alameda Drive
Aurora, CO 80012
(303) 636-1130

Archuleta County Department of Social Services
449 San Juan
Pagosa Springs, CO 81147
(970) 264-2182

Baca County Department of Social Services
772 Colorado Street
Springfield, CO 81073
(719) 523-4131

Bent County Department of Social Services
215 2nd Street
Las Animas, CO 81054
(719) 456-2620

Boulder County Department of Social Services
3400 Broadway
Boulder, CO 80304
(303) 441-1000

Broomfield County Department of Health and Human Services
#6 Garden Center
Broomfield, CO 80020
(720) 887-2200

Chaffee County Department of Social Services
641 West 3rd Street
Salida, CO 81201
(719) 539-6627

Cheyenne County Department of Social Services
51 South 1st
Cheyenne Wells, CO 80810
(719) 767-5629

Clear Creek County Department of Human Services
Courthouse
Georgetown, CO 80444
(303) 679-2365

Conejos County Department of Social Services
Courthouse
Conejos, CO 81129
(719) 376-5455

Costilla County Department of Social Services
123 Gasper St.
San Luis, CO 81152
(719) 672-4131

Crowley County Department of Social Services
601 Main
Ordway, CO 81063
(719) 267-3546

Custer County Department of Human Services
205 South 6th Street
Westcliffe, CO 81252
(719) 783-2371

Delta County Department of Social Services
Courthouse Annex
560 Dodge
Delta, CO 81416
(970) 874-2030

Denver County Department of Human Services
1200 Federal Blvd.
Denver, CO 80204-3221
(720) 944-3666

Dolores County Department of Social Services
420 North Main, Courthouse
Dove Creek, CO 81324
(970) 677-2250

Douglas County Department of Health & Human Services
101 Third Street
Castle Rock, CO 80104
(303) 688-4825

Eagle County Department of Health & Human Services
500 Broadway Street
Eagle, CO 81631
(970) 328-8840 or 1-800-225-6136

Elbert County Department of Social Services
325 Pueblo Ave.
Simla, CO 80835
(719) 541-2369

El Paso County Department of Human Services
105 North Spruce
Colorado Springs, CO 80905
(719) 636-0000

Fremont County Department of Social Services
172 Justice Center Road
Canon City, CO 81212
(719) 275-2318

Garfield County Department of Social Services
2014 Blake Ave.
Glenwood Springs, CO 81602
(970) 945-9191

Gilpin County Department of Human Services
2960 Dory Hill Rd., Suite 100
Black Hawk, CO 80403-8780
(303) 582-5444

Grand County Department of Social Services
620 Hemlock
Hot Sulphur Springs, CO 80451
(970) 725-3331 or (303) 572-3821

Gunnison County Department of Social Services
225 N. Pine Street, Suite A
Gunnison, CO 81230
(970) 641-3244

Hinsdale County Department of Social Services
225 N. Pine St, Suite A
Gunnison 81230
(970) 641-3244

Huerfano County Department of Social Services
121 W. 6th Street
Walsenburg, CO 81089
(719) 738-2810

Jackson County Department of Social Services
P.O. Box 338
Walden, CO 80480
(970) 723-4750

Jefferson County Division of Human Services
900 Jefferson County Parkway
Golden, CO 80401-6010
(303) 271-1388

Kiowa County Department of Social Services
Courthouse, 1305 Goff Street
Eads, CO 81036
(719) 438-5541

Kit Carson County Health & Human Services
252 S. 14th St.
Burlington, CO 80807
(719) 346-8732

Lake County Department of Human Services
112 W. 5th Street
Leadville, CO 80461
(719) 486-2088

La Plata County Department of Social Services
1060 E. Second Avenue
Durango, CO 81301
(970) 382-6150

Larimer County Department of Human Services
1501 Blue Spruce Dr.
Fort Collins, CO 80524-2000
(970) 498-6300

Las Animas County Department of Human Services
204 S. Chestnut Street
Trinidad, CO 81082
(719) 846-2276

Lincoln County Department of Social Services
(719) 743-2404
Courthouse, 103 3rd Ave.
Hugo, CO 80821

Logan County Department of Social Services
508 South 10th Ave., Suite 2
Sterling, CO 80751
(970) 522-2194

Mesa County Department of Human Services
2952 North Avenue
Grand Junction, CO 81502
(970) 241-8480

Mineral County Department of Social Services
1015 6th Street
Del Norte, CO 81132
(719) 657-3381

Moffat County Department of Social Services
595 Breeze Street
Craig, CO 81625
(970) 824-8282

Montezuma County Department of Social Services
109 W. Main, Room 203
Cortez, CO 81321
(970) 565-3769

Montrose County Department of Health and Human Services
1845 South Townsend
Montrose, CO 81401
(970) 252-5000

Morgan County Department of Human Services
800 East Beaver Avenue
Fort Morgan, CO 80701
(970) 542-3530

Otero County Department of Social Services
Courthouse, 3rd & Colorado
La Junta, CO 81050
(719) 383-3100 (Adult Protection)
(719) 383-3165 (Child Welfare)

Ouray County Department of Social Services
541 4th Street
Ouray, CO 81427
(970) 325-4437

Park County Department of Social Services
PO Box 1193
Bailey, CO 80421
(719) 836-4139 or (303) 980-1836

Phillips County Department of Social Services
127 East Denver, Suite A
Holyoke, CO 80734
970-854-2280

Pitkin County Department of Social Services
100 Elk Run Drive, suite 122
Basalt, CO 81621
970-927-1611

Prowers County Department of Social Services
1001 South Main
Lamar, CO 81052
(719) 336-7486

Pueblo County Department of Social Services
212 W. 12th Street
Pueblo, CO 81003
(719) 583-6160

Rio Blanco County Department of Social Services
345 Market Street,
Meeker, CO 81641-3421
(970) 878-5011

Rio Grande County Department of Social Services
1015 6th Street
Del Norte, CO 81132
(719) 657-3381

Routt County Department of Social Services
136 6th Street
Steamboat Springs, CO 80477
(970) 879-1540

Saguache County Department of Social Services
605 Christy Ave.
Saguache, CO 81149
(719) 655-2537

San Juan County Department of Social Services
1557 Greene Street
Silverton, CO 81433
(970) 387-5631

San Miguel County Department of Social Services
333 West Colorado Ave.
Telluride, CO 81435
(970) 728-4411

Sedgwick County Department of Human Services
118 West 3rd
Julesburg, CO 80737
(970) 474-3397, ext.13 or (303) 573-5887

Summit County Department of Social Services
37 County Road 1005
Frisco, CO 80443
(970) 668-4100

Teller County Department of Social Services
740 Highway 24
Woodland Park, CO 80866-9033
(719) 687-3335

Washington County Department of Human Services
875 E. 1st St.
Akron, CO 80720-0395
(970) 345-2238 or (888) 844-2238 (toll free)

Weld County Department of Social Services
315 North 11th Ave.
Greeley, CO 80631
(970) 352-1551 or 1-800-927-1551

Yuma County Department of Social Services
340 South Birch Street
Wray, CO 80758-1814
(970) 332-4877

Appendix C: Community Centered Boards

Note: At the time of printing, the addresses and telephone numbers below were correct. However, agencies sometimes move or change phone numbers. To get the most up-to-date information, call Colorado Medicaid Customer Service at 303-866-3513 (Denver Metro Area) or 1-800-221-3943 (outside the Denver Metro Area) or visit the Colorado Association of Community Centered Boards website at **www.caccb.org/res.html**

ADAMS
North Metro Community Services, Inc.
1001 West 124th Avenue
Westminster, CO 80234
303-457-1001

ALAMOSA, CONEJOS, COSTILLA, MINERAL, RIO GRANDE, & SAGUACHE
Blue Peaks Developmental Services, Inc.
703 Fourth Street
Alamosa, CO 81101
719-587-5135

ARAPAHOE & DOUGLAS COUNTIES & THE CITY OF AURORA
Developmental Pathways, Inc.
11111 E. Mississippi Avenue
Aurora, CO 80012
303-360-6600

ARCHULETA, DOLORES, LA PLATA, MONTEZUMA & SAN JUAN
Community Connections, Inc.
281 Sawyer Drive, Suite 200
Durango, CO 81303
970-259-2464

BACA, EASTERN BENT, KIOWA & PROWERS
Southeastern Developmental Services, Inc.
P.O. Box 328
Lamar, CO 81052
719-336-3244

BOULDER & BROOMFIELD
Imagine!
1400 Dixon Avenue
Lafayette, CO 80026
303-665-7789

CHAFFEE, CUSTER, & FREMONT
Developmental Opportunities, Inc.
P.O. Box 2080
Canon City, CO 81215
719-275-1616

CHEYENNE, ELBERT, KIT CARSON, LINCOLN, LOGAN, MORGAN, PHILLIPS, SEDGWICK, WASHINGTON & YUMA
Eastern Colorado Services for the Developmentally Disabled, Inc.
P.O. Box 1682
Sterling, CO
970-522-7121

CLEAR CREEK, GILPIN, JEFFERSON, & SUMMIT
Developmental Disabilities Resource Center, Inc.
11177 W. 8th Avenue
Lakewood, CO 80215
303-233-3363

CROWLEY, OTERO, AND WESTERN BENT
Arkansas Valley Community Center
P.O. Box 1130
La Junta, CO 80150
719-384-8741

DELTA, GUNNISON, HINSDALE, MONTROSE, OURAY, & SAN MIGUEL
Community Options, Inc.
P.O. Box 31
Montrose, CO 81402
970-249-1412

DENVER
Denver Options, Inc.
9900 E. Iliff Avenue
Denver, CO 80231
303-636-5600

EAGLE, GARFIELD, LAKE & PITKIN
Mountain Valley Developmental Services, Inc.
P.O. Box 338
Glenwood Springs, CO 81602
970-945-2306

EL PASO, PARK & TELLER
The Resource Exchange
418 S. Weber
Colorado Springs, CO 80903
719-380-1100

GRAND, JACKSON, MOFFAT, RIO BLANCO, & ROUTT
Horizons Specialized Services, Inc.
P.O. Box 774867
Steamboat Springs, CO 80477
970-879-4466

HUERFANO & LAS ANIMAS
Southern Colorado Developmental Disabilities, Inc.
P.O. Box 781
Trinidad, CO 81082
719-846-4409

LARIMER
Foothills Gateway, Inc.
301 Skyway Drive
Fort Collins, CO 80525
970-226-2345

MESA
Mesa Developmental Services, Inc.
950 Grand Avenue
Grand Junction, CO 81501
970-243-3702

PUEBLO
Colorado Bluesky Enterprises. Inc.
115 W. 2nd Street
Pueblo, CO 81003
719-546-0572

WELD
Centennial Developmental Services, Inc.
P.O. Box 69
Evans, CO 80621
970-339-5360

Appendix D: For More Information Please Call …

Federal Government

United States Social Security Administration
1-800-772-1213
1-800-325-0778 (TTY)
www.ssa.gov

Centers for Medicare and Medicaid Services
1-800-633-4227
1-877-486-2048 (TTY)
www.medicare.gov

United States Department of Health and Human Services
Office of Civil Rights
303-844-2024
303-844-3439 (TDD)
www.hhs.gov/ocr/

State of Colorado

Colorado Department of Health Care Policy and Financing

Colorado Medicaid Customer Service
303-866-3513 (Denver Metro Area)
1-800-221-3943 (Outside the Denver Metro Area)

Prior Authorization Hotline
303-866-5571 (Denver Metro Area)
1-800-221-3943 extension #5571 (Outside the Denver Metro Area)

Consumer Directed Attendant Support Program
303-866-3358 (Denver Metro Area)
1-800-221-3943 extension #3358 (Outside the Denver Metro Area)
www.chcpf.state.co.us/SysChange/cdas/cdasindex.html

EPSDT Liaison
303-866-6010 (Denver Metro Area)
1-800-221-3943 extension #6010 (Outside the Denver Metro Area)

Colorado Department of Public Health and Environment

Complaint Program
303-692-2800 (Denver Metro Area)
1-800-886-7689 (Outside the Denver Metro Area)

Colorado Department of Regulatory Agencies

Civil Rights Division
303-894-2997

Colorado Department of Personnel and Administration

Administrative Hearings Division
303-764-1400

Other Agencies

FirstHelp Nurse Advice
1-800-283-3221 (Available 24 hours a day, 7 days a week)

HealthColorado
303-839-2120 (Denver Metro Area)
1-888-367-6557 (Outside the Denver Metro Area)