COLORADO
Department of Health Care Policy & Financing

Consumer-Directed Attendant Support Services
Emergency Situation Request Form

Consumer-Directed Attendant Support Services (CDASS) members or their Authorized Representatives (ARs) use this form to request an Emergency Situation to exceed Weekly Caregiver or daily hour limits. Your Financial Management Services (FMS) contractor will review the information provided and approve or deny the request. If required information is missing, or the form is submitted by someone other than the member or their AR, the request will be denied and must be properly resubmitted.

Instructions: CDASS member, or their AR, complete all sections that apply. Submit it to your FMS contractor. See page 3 for FMS contact information. *Required fields.

1. Member and Request Information

Member name*: _____ **Member Medicaid ID*:** _____

Person completing this form*: _____

I am the*: ☐ Member ☐ Authorized Representative

Email address*: _____ **Phone number (optional):** _____

2. Requested Emergency Period

Requested start date*: _____

Note: The total duration of the emergency situation request cannot exceed 21 calendar days. Work weeks span from Sunday at 12 a.m. to Saturday 11:59 p.m.

3. Emergency Situation Information

Date form submitted to FMS*: _____

Date emergency began*: _____ **Date emergency ended (if known):** _____

Nature of emergency event (at least one response required, check all that apply)*:

- ☐ Caregiver scheduling problem/unexpected staffing shortage*
- ☐ Caregiver quit with short notice/no notice
- ☐ Sudden caregiver illness or injury
- ☐ Hospitalization of caregiver
- ☐ Family emergency affecting caregiver
- ☐ Natural disaster/weather emergency
- ☐ Transportation issue

**Caregiver scheduling problem/unexpected staffing shortage cannot exceed 2 times in a 2-month period)*

***Describe what happened. Include when the event occurred and why it was unexpected.**

If you select either of the following reasons, you must complete the questions in **section A. Unavailable Caregiver and Staffing Efforts.**

- Caregiver scheduling problem/unexpected staffing shortage
- Caregiver quit with short notice/no notice

A. Unavailable Caregiver and Staffing Efforts

Name(s) of unavailable caregiver(s):

_____

What scheduled care was affected? Include the date(s) and time(s), if known.

What alternative staffing efforts did you attempt? Include who you contacted and the result, if known.

Did you contact or attempt to contact another caregiver who could provide the affected scheduled care?

☐ Yes ☐ No

Provide any additional details that will help explain the emergency.

B. Emergency Circumstances and Response

*Answer each question for the emergency period you listed in section 3.

1. Was this emergency **unexpected**, or was there **no reasonable way** for you to know it might happen?
   ☐ Yes ☐ No
2. Did the event cause a scheduled caregiver to suddenly become unavailable?
   ☐ Yes ☐ No
3. Was there a risk to the member's health, safety, or ability to remain in their home without these services?
   ☐ Yes ☐ No
4. Did you try to implement your emergency plan as outlined in your Attendant Support Management Plan (ASMP)?
   ☐ Yes ☐ No

   If you answered "No" to question 4, briefly describe why you did **not** try to implement your emergency plan outlined in your ASMP.

5. If supporting documentation about this emergency situation is requested from your FMS or the Colorado Department of Health Care Policy and Financing, are you able to provide it? Supporting documentation can include: emails, text messages, medical appointment records, etc.
   ☐ Yes ☐ No

4. Member/Authorized Representative Attestation

By signing below, I confirm that I have read this form and that:

- I am the CDASS member or their Authorized Representative,
- I am requesting an exception based on an emergency situation that occurred during the timeframe I listed in section 3,
- I have provided complete and accurate information about the emergency situation,
- I understand that the requested period cannot exceed 21 calendar days,

- I understand that my FMS will review the request following CDASS rule (10 CCR 2505-10 8.7000) and provide me an approval or denial of the request, and
- I understand that if I give false information on this form, to my FMS, or to the State of Colorado that I may be subject to administrative and/or legal penalties.

Printed name*: _____

Signature*: _____

Date*: _____

Preferred way to be contacted if follow-up is needed: _____

CDASS Financial Management Services (FMS) Contact Information

Return the completed form and any required supporting documentation to your FMS using the submission method provided by your FMS.

Public Partnerships LLC. (PPL)
Phone: 1-888-752-8250
Email: cocdasscasemanagement@pplfirst.com
Fax: 866-947-4813

Palco, Inc.
Phone: 1-866-710-0456
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