COLORADO
Office of Economic Security
Division of Employment & Benefits

Home Care Allowance Care Plan Summary

Name:_____

SSN: _____

Services	Frequency	Duration

Client and/or Family Designated Respite Plan? Yes ☐ No ☐

If yes, the plan is:

The services/frequency/duration listed above are based on the information discussed between myself and my case manager during the assessment/care planning process. This is a tentative plan and the case manager will be in contact with me once eligibility has been determined (functional/financial) so that the care plan can be finalized.

I have been informed of the choice of providers available and understand I may change providers at any time. I will notify my case manager when I change providers. I have reviewed the services contained in this preliminary care plan and choose to accept these services in the community.

Other available program and or service options to include but not limited to Medicaid waiver options were discussed with me and or my representative to ensure all of my needs are being addressed.

_____ _____ _____ _____

Signature of Client Date Signature of Case Manager Date

6 Month Review

_____ _____

Signature of Case Manager Date