COLORADO
Department of Health Care Policy & Financing

In-Home Support Services (IHSS) - Shared Responsibilities Plan

Member Name:	Medicaid ID:

Responsibilities of IHSS Agency

Agency Name:	Agency Phone:

These responsibilities **cannot be waived** by the member or Authorized Representative (AR).

- Provide 24-hour back-up service for scheduled visits to clients at any time an Attendant is not available.
- Ensure that adequate staffing is available. Staffing must include backup Attendants to ensure necessary services will be provided in accordance with the Care Plan.
- Counsel Attendants and staff on difficult cases and potentially dangerous situations.
- Verify the Attendant follows all tasks set forth in the Care Plan.
- Administer a skills validation test for Attendants who will perform Health Maintenance Activities.
- Provide in-home supervision for the member as recommended by their Licensed Medical Professional and as agreed upon by the client or their Authorized Representative.
- Legal employer of member's attendants and manages all claims, billing, and payment of attendants
- Provide Independent Living Core Services to the member
- Attendant training, oversight, and supervision by a licensed health care professional.

Participant Directed Services

The following aspects of service may be self-directed by the Member and/or Authorized Representative. The IHSS Agency is required to support and collaborate with a Member and/or Authorized Representative with these tasks as requested or required. **If no boxes are checked, the Agency accepts accountability and responsibility.**

Indicate which aspects of your service delivery you wish to direct:

- ☐ Present or recruit candidates as potential attendants
- ☐ Interview potential attendants
- ☐ Train attendants to meet individual's needs
- ☐ Dismiss attendants who are not meeting the individual's needs
- ☐ Schedule attendants in accordance with the care plan
- ☐ Supervise attendants, ensure service provision is safe, accurate and effective
- ☐ Request a reassessment if level of care or service needs have changed

Care Planning

The following are aspects of care planning for the Member's services under the IHSS program. As part of this Share Responsibilities Plan, identify who will take part in this collaborative process with the IHSS Agency and Case Manager.

IMPORTANT – If the member's treating medical professional has indicated "NO" to Question 2 of Statement of Consumer Capacity on the member's Physician Attestation of Consumer Capacity Form, the **member will require an AR to direct** the following aspects of service delivery.

	Member/Legal Guardian	Authorized Representative
Development of a plan of care that meets all of member's functional and medical needs	☐	☐
Maintain regular communication about member satisfaction with services and updates regarding member health and service needs	☐	☐
Work collaboratively to mediate care plan disputes	☐	☐

Authorized Representative Information and Affidavit		
Refer to the member's Physician Attestation of Consumer Capacity. If the member's Licensed Medical Professional has identified that the member must have an AR, an AR must be identified, and enter contact information in this section.		
Name:	Date of Birth:	Last 4 digits of SSN:
Address:	City:	State/Zip:
Email:	Home Phone:	Cell Phone:
☐ Please contact me via email or text message with updates (standard carrier rates may apply)		
I hereby agree to serve as the Authorized Representative for the aforementioned member and understand my responsibilities and duties. In addition, I certify that: a) I am at least eighteen years of age; b) I have not been convicted of any crime involving exploitation, abuse or assault on another person; and c) I do not have a mental, emotional or physical condition that could result in harm to the member.		
Authorized Representative Signature:		Date:

Member/Legal Guardian Signature		
Person completing this form: ☐ Member ☐ Legal Guardian (If legal guardian, please submit documentation)		
Member/Legal Guardian Signature:		Date:
In case of the member's inability to sign, another person may witness the member's mark above.		
Witness Name:	Witness Signature:	Date:

IHSS Agency Signature	
Agency Name:	
Agency Representative Signature:	Date:

Additional Comments (optional)