

## **█ Case No. █ Appellant's Written Statement**

### **What I am asking the judge to decide**

I ask the judge to set aside the reduction in █ services that began on 2026-09-01 and to order that his services be kept at the prior level pending a lawful decision with proper notice and appeal rights.

### **Summary**

█ is my child and a participant in the CFC program through Developmental Pathways. His authorized services were reduced effective 2026-09-01 without a timely Notice of Action. That cut occurred before the NOA was dated, so it was implemented without the required advance notice and without giving us the ability to appeal. Because the reduction appears to be an individualized decision made without proper procedure, it should be reversed and services reinstated while this appeal proceeds.

### **Services were cut before the notice allowed it**

The agency implemented the service reduction on 2026-09-01, but the Notice of Action is dated 2026-10-26 and lists an effective date of 11/13/2026. This means services were changed 55 days before the notice was issued, so the required advance notice was not provided. The rule requires notice at least 10 days before the date of action, and benefits must be reinstated when they were reduced without advance notice (Exh. A; 42 C.F.R. § 431.211). Under the state rule, benefits should continue pending this appeal and be reinstated to the prior level while this is decided (10 CCR 2505-10 § 8.057).

### **This was an individual decision, and it can be appealed**

We were told the change could not be appealed, but the change was a decision made for █ specifically and was reflected in his individual plan rather than being an automatic, universal change in law or policy. The right to a hearing covers individualized decisions; the exception is limited to automatic changes that affect everyone, which is not the situation here (Exh. B; 42 C.F.R. § 431.220(b)). Because this was set in his individual plan, it is an appealable action and we were wrongly denied that right.

### **The agency has to prove its decision (supporting)**

The agency is the party proposing the reduction of █ services, so it bears the burden to justify that reduction. The record shows the agency initiated the cut (Exh. A). Under the statute, the agency must prove that the proposed order is correct (C.R.S. § 24-4-105(7)).

### **What I am asking for**

1. Set aside the 9/1/2026 reduction.

2. Keep his services at the previous level until a lawful decision is made.
3. Direct the agency to reassess using his current records, with proper written notice and appeal rights for any change.

**Exhibits**

See the attached Exhibit Index and List of Legal Authorities.

█ parent and legal guardian

## Appellant's List of Legal Authorities

Submitted by parent and legal guardian. The rules this appeal relies on, each with where it appears in the record.

| # | Authority                                                      | What it requires                                                                                                                 | Where in the record                                                                                            |
|---|----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| 1 | <b>42 C.F.R. § 431.211</b><br><i>federal regulation</i>        | Notice of a reduction must be mailed at least 10 days before the date of action.                                                 | Services changed 9/1/2026; the notice is dated 10/26/2026 and states an effective date of 11/13/2026. (Exh. A) |
| 2 | <b>10 CCR 2505-10 § 8.057</b><br><i>Colorado Medicaid rule</i> | Benefits continue pending appeal, and are reinstated when they were reduced without advance notice.                              | Services must be reinstated to the level before the cut while this is decided.                                 |
| 3 | <b>42 C.F.R. § 431.210</b><br><i>federal regulation</i>        | A notice must state the action, the reasons for it, and the specific regulations that support it.                                | The notice does not state the hours or services being changed (Exh. A).                                        |
| 4 | <b>C.R.S. § 25.5-4-207(1)(d.5)</b><br><i>Colorado statute</i>  | The judge reviews whether the notice was legally sufficient; an insufficient notice may result in the action being set aside.    | Notice dated 10/26/2026 (Exh. A).                                                                              |
| 5 | <b>42 C.F.R. § 431.220(b)</b><br><i>federal regulation</i>     | The exception to the right to a hearing covers only automatic changes in law that affect everyone, not individualized decisions. | Told it could not be appealed; hours set in his individual plan (Exh. B).                                      |
| 6 | <b>C.R.S. § 24-4-105(7)</b><br><i>Colorado statute</i>         | The party proposing an order (here, the agency that cut services) bears the burden of proof.                                     | The agency proposed the reduction (Exh. A).                                                                    |

### Relief requested

- (1) Set aside the 9/1/2026 reduction.
- (2) Keep his services at the previous level until a lawful decision is made.
- (3) Direct the agency to reassess using his current records, with proper written notice and appeal rights for any change.

## Exhibit Index

| Exh. | What it is                | Document                                                              | Pages |
|------|---------------------------|-----------------------------------------------------------------------|-------|
| A    | The notice being appealed | NOA                                                                   | 1     |
| B    | The new service plan      | Exhibit G Original Annual Service Plan 2026 2027<br>signed 05.27.2026 | 29    |

The exhibits contain confidential medical information about █ and are submitted for this appeal only.

# **EXHIBIT A**

The notice being appealed

*NOA*



08/10/2026

State/Medicaid ID [REDACTED]

### Your Long-Term Care Benefits Status

Dear [REDACTED]

**As of 08/21/2026, your benefits under the Community First Choice (CFC) will be decreased.**

The following services are being impacted: Community First Choice (CFC): Personal Care, Community First Choice (CFC): Homemaker

This decision was made because there has been a reduction in the IHSS service amount based on the services calculator. The state rule that applies to this decision is 10 CCR 2505-10 Section 10 CCR 2505-10 Sections 8.7202.AA.2.d, 8.7001.C.1.i..

You have the right to appeal this decision if you disagree with it. Instructions for how to appeal are on the next page.

If you have questions about this change, please call your case manager from Developmental Pathways at +13033606600.

Sincerely,

Developmental Pathways

Case Manager Signature: [REDACTED]

Supervisor Signature: [REDACTED]

Updated July 2, 2025

# **EXHIBIT B**

The new service plan

*Exhibit G Original Annual Service Plan 2026 2027 signed 05.27.2026*



## Service Plan Signature Page

| <b>Member Information</b> <i>(complete all sections that apply)</i>                                                                                                                                                                                                                                                                                                               |                                  |                                                                               |                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------|-------------------------|
| First Name: [REDACTED]                                                                                                                                                                                                                                                                                                                                                            | Last Name: [REDACTED]            | DOB: [REDACTED]                                                               | Medicaid ID: [REDACTED] |
| Staffing Date: 4/16/26                                                                                                                                                                                                                                                                                                                                                            | Certification Start Date: 7/1/26 | Certification End Date: 6/30/2027                                             |                         |
| Service Plan Type: <input type="checkbox"/> Initial <input checked="" type="checkbox"/> CSR <input type="checkbox"/> Revision                                                                                                                                                                                                                                                     |                                  |                                                                               |                         |
| <b>Statement of Agreement</b>                                                                                                                                                                                                                                                                                                                                                     |                                  |                                                                               |                         |
| <input type="checkbox"/> Member/Guardian indicates that they are in agreement with the information in the Service Plan and agrees to receive services accordingly.<br>OR<br><input type="checkbox"/> Member/Guardian acknowledges that they are choosing not to sign the Service Plan agreement. A Notice of Action will be provided as a result of not signing the Service Plan. |                                  |                                                                               |                         |
| <b>Signatures</b>                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                               |                         |
|                                                                                                                                                                                                                                                                                                                                                                                   |                                  | [REDACTED]                                                                    | 5/27/2026               |
| Member Signature                                                                                                                                                                                                                                                                                                                                                                  | Date                             | Member Signature<br><input type="checkbox"/> Court Appointed Guardian         | Date                    |
| [REDACTED]                                                                                                                                                                                                                                                                                                                                                                        | 5/19/2026                        |                                                                               |                         |
| Legal Guardian Signature                                                                                                                                                                                                                                                                                                                                                          | Date                             | Legal Guardian Signature<br><input type="checkbox"/> Court Appointed Guardian | Date                    |
| <b>Plan Participants</b>                                                                                                                                                                                                                                                                                                                                                          |                                  |                                                                               |                         |
| The following individuals participated in the development of this plan. This plan must be signed by all individuals and providers responsible for its implementation.                                                                                                                                                                                                             |                                  |                                                                               |                         |
| Name                                                                                                                                                                                                                                                                                                                                                                              | Title or Relationship            | Signature                                                                     | Date                    |
| Selemah Griffe                                                                                                                                                                                                                                                                                                                                                                    | Colorado Family Caregivers       | [REDACTED]                                                                    | 5/19/2026               |
|                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                               |                         |
|                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                               |                         |
|                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                               |                         |
|                                                                                                                                                                                                                                                                                                                                                                                   |                                  |                                                                               |                         |

**Member and Provider must receive a copy of this completed signature page and a copy retained in case management agency files.**

|                        |                       |                 |                         |
|------------------------|-----------------------|-----------------|-------------------------|
| First Name: [REDACTED] | Last Name: [REDACTED] | DOB: [REDACTED] | Medicaid ID: [REDACTED] |
|------------------------|-----------------------|-----------------|-------------------------|

| Service                                 | Provider                   | Total Units | Certification Start and End Dates | Service Frequency, Scope, and Duration                        | HCBS Service Goal                                                    |
|-----------------------------------------|----------------------------|-------------|-----------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------|
| S5130 - Homemaker Svc U2                | Colorado Family Caregivers | 261         | 7/1/26-6/30/27                    | 1.25 hours per week for 52 weeks for homemaker services.      | [REDACTED] goal is to work on appropriate communication with others. |
| T1019 - Personal Care Svc Per 15 Min U2 | Colorado Family Caregivers | 4,745       | 7/1/26-6/30/27                    | 22.75 hours per week for 52 weeks for personal care services. | [REDACTED] goal is to work on appropriate communication with others. |
|                                         |                            |             |                                   |                                                               |                                                                      |

**Member and Provider must receive a copy of this completed signature page and a copy retained in case management agency files.**



**Developmental Pathways**  
Dedicated to Individuals with Disabilities

## Developmental Pathways Disclosures and Acknowledgements

| Name of individual in services: [REDACTED]            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of birth: [REDACTED]                             | SSN: [REDACTED] and/or Medicaid ID [REDACTED]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Name of person initialing/signing document [REDACTED] |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Relationship to individual in services: <b>Mother</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Initials                                              | Agreement Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| [REDACTED]                                            | <p><b>Notice of Privacy Practices for Protected Health Information:</b> Developmental Pathways (DP) safeguards your Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulations. This notice explains how DP uses and discloses your PHI and how you can exercise your rights under HIPAA. By Initialing the box to the left, you are acknowledging that you have received DP's Notice of Privacy Practices for Protected Health Information.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| [REDACTED]                                            | <p><b>Encryption Opt-Out:</b> To safeguard your PHI and ensure confidentiality, DP encrypts external electronic communication which contains your confidential information. This practice is designed to provide an extra level of security and requires the recipient to use a password to access the message. In order to opt-out of this requirement, DP must receive written notification. This written notification is completed by marking the appropriate option and initialing the box.</p> <p><b>Please check one!</b></p> <p><input type="checkbox"/> I would like DP to continue to send electronic communication <b>encrypted</b>.</p> <p><input checked="" type="checkbox"/> I hereby grant DP permission to send electronic communication <b>unencrypted</b>. This permission applies to me and my legal guardian as appropriate.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| [REDACTED]                                            | <p><b>Exercising Your Rights:</b> You have the same human and civil rights as every other U.S. citizen. These rights should be limited or changed only to the extent necessary to be helpful to you, and then only with "due process". Due process includes your Individualized Plan (Service Plan), the Packet Review Committee, the Human Rights Committee, and/or legal process. If you would like assistance in exercising your rights, you can select a friend, a family member, a staff person, a Case Manager, the ARC or any other person to support you. By initialing the box, you are acknowledging that you understand these rights.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| [REDACTED]                                            | <p><b>Right to Choice of Service Provider:</b> DP and our Case Managers will ensure that individuals and families:</p> <ul style="list-style-type: none"> <li>• Have choice of available long-term care programs and services</li> <li>• Have availability to resources outlining qualified providers</li> <li>• Have the right to select among qualified providers</li> <li>• Have the right to change providers at any time</li> <li>• Have access to DP's complaint and/or grievance processes</li> <li>• Have the option of case management agencies</li> <li>• Understand providers have the right to accept or deny the request for services</li> </ul> <p>By initialing the box, you are acknowledging the you have received DP's written notice of potential conflict of interest.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| [REDACTED]                                            | <p><b>Authorization for Release and Exchange of Information:</b> The following organizations/providers are hereby authorized to release, exchange, and share oral and written PHI with each other regarding the Individual named above:</p> <ul style="list-style-type: none"> <li>• <b>DP and:</b> Physicians involved in my care, HCBS Providers involved in my care, Home Health providers involved in my care, therapists involved in my care, and hospitals and related facilities involved in my care</li> <li>• <b>Information to be released, exchanged, and shared:</b> Health information including but not limited to diagnosis, treatment, history, master file records, billing records, treatment notes, service and related plans, and information pertaining to home and community-based services and supports</li> <li>• <b>Purpose or need for which the information is to be used and disclosed:</b> coordination/continuity of care, case management, assessment, benefits coordination/acquisition, disability determination, and program compliance</li> </ul> <p>By initialing the box, you acknowledge you have received the release of information agreement, understanding you can revoke it at any time and that it will expire 1 year from date of signing. By initialing you are also releasing DP from all liability for disclosing the requested information.</p> |
| [REDACTED]                                            | <p><b>Complaint Process:</b> In any system, there will be disagreements and complaints. Each person has a right to have such disagreements taken seriously and dealt with in a consistent, fair, and timely manner. By initialing the box, you are acknowledging that you have received a written summary of the Complaint Process.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| [REDACTED]                                            | <p><b>*For HCBS-SLS, State SLS, CHRP 18+ and HCBS-DD Only*</b> <b>Authorized Representative Information:</b> An Authorized Representative (as defined in Section 25.5-10-202 (1.3) C.R.S.) is a person you choose, or your guardian chooses, to help you to access or direct services or supports available through your CMA, Developmental Pathways.</p> <ul style="list-style-type: none"> <li>• <b>Benefits of appointing an Authorized Representative:</b> can help you communicate with your IDT; can help you make decisions regarding services and supports; can help you communicate and advocate for your best interests.</li> <li>• <b>Authorized Representatives can be:</b> (1) A non-guardian family member; (2) Friend; (3) Arc Advocate</li> </ul> <p>By initialing the box, you acknowledge you have received information about and understand Authorized Representatives. If you are interested in having an Authorized Representative, please fill out and sign the additional form with your Case Manager.</p>                                                                                                                                                                                                                                                                                                                                                                |

|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                   |                                                                                   |  |                               |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--|-------------------------------|
| <input type="checkbox"/>                                                          | <p><b>*For Medicaid Recipients Only* Medicaid Appeal Rights:</b> An individual may have the right to a Medicaid Appeal Rights (also known as the right to a Medicaid Fair Hearing) before a State Administrative Law Judge. By initialing the box, you are acknowledging you have received a written summary of the process for requesting a Medicaid Appeal.</p> |                                                                                   |  |                               |
| <input type="checkbox"/>                                                          | <p><b>*For STATE SLS and FSSP Only* Dispute Resolution:</b> If you are dissatisfied with a decision or action taken by DP, there are steps to dispute that decision or action. By initialing the box, you are acknowledging that you have received an oral and written summary of the Dispute Resolution Process and of the mediation option.</p>                 |                                                                                   |  |                               |
| <input type="checkbox"/>                                                          | <p><b><i>Regular business office hours of operation follow a Monday through Friday 8:30a to 5:00p schedule except for federal, state, or local holidays and unplanned closures due to inclement weather or other emergencies. Information about unplanned closures will be posted on our website and across social media platforms.</i></b></p>                   |                                                                                   |  |                               |
| <p><b>SIGNATURE:</b></p>                                                          | <table border="1"> <tr> <td data-bbox="228 495 435 579">  </td> <td data-bbox="435 495 1008 579"></td> <td data-bbox="1008 495 1546 579"> <p><b>DATE:</b> 5/27/2026</p> </td> </tr> </table>                                                                                     |  |  | <p><b>DATE:</b> 5/27/2026</p> |
|  |                                                                                                                                                                                                                                                                                                                                                                   | <p><b>DATE:</b> 5/27/2026</p>                                                     |  |                               |



**Request for an Authorized Representative**  
(As defined in Section 25.5-10-102(1), C.R.S.)

I authorize (Name): \_\_\_\_\_ to act as my representative in matters pertaining to services and supports provided to me through Developmental Pathways, Inc. I understand that I may revoke this authorization at any time either verbally or in writing. This authorization is limited to one year from the date of signatures below. Items initialed and circled below are included in this authorization:

█ Invitation to: *(please circle)*: (1) Annual SP Staffing; (2) IDT Meetings Held on My Behalf During the Year; (3) Invited to IDT Meetings Only Upon My Request

█ Copies of documents: *(please circle)*: (1) SP; (2) ISSPs; (3) IDT Meeting Summaries

█ Copies of Notices of major changes in my services and supports or SP goals

█ Copies of Incident Reports (specify): █ █

█ Communication between my Authorized Representative and: *(circle one or more choices)* My Case Manager: My support coordinator: My nurse: My program supervisor: related to any of the above.

*(No third party documents may be copied. Only the originator of the document has authority to release those documents. Developmental Pathways will provide information on how to obtain third party documents.)*

I would like my Authorized Representative to keep what I say, and everything they learn about me confidential and not share the information with anyone unless I give permission. I understand that while the above named person(s) has (have) been designated as my Authorized Representative, this does not change my role or rights regarding my input and choices in planning my services and supports and changes in these to the extent that it is possible for me to participate.

█  
\_\_\_\_\_  
Individual/Guardian/Parent of a minor  
  
5/27/2026  
\_\_\_\_\_  
Date

█ █  
\_\_\_\_\_  
Name (printed) \_\_\_\_\_ Date  
  
█  
\_\_\_\_\_  
Witness: (Case Manager or Designee) & Date

\*\* \* \*\* \* \*\* \* \*\* \* \*\* \* \*\* \* \*\* \*

**Acceptance of Authorized Representative Appointment**

I accept the designation to act as Authorized Representative in the manner described above for one year. I understand this authorization may be revoked at any time, verbally or in writing, by the person requesting I be his/her Authorized Representative.

█  
\_\_\_\_\_  
Signature of Authorized Representative  
  
5/19/2026  
\_\_\_\_\_  
Date of Acceptance Signature

█ █  
\_\_\_\_\_  
Name (printed) \_\_\_\_\_  
  
█  
\_\_\_\_\_  
Signature of Witness: (Case Manager or Designee) & Date

Distribution: Authorized Representative, Individual, Case Manager, Service Agency(ies)

# Signature Page

**10 CCR 2505 – 10 8.503.80.A. Client responsibilities:** The parent or legal guardian of a client is responsible to assist in the enrollment of the client and cooperate in the provision of services. Failure to do so shall result in the client's termination from the HCBS-CES waiver. The parent or legal guardian shall:

1. Provide accurate information regarding the client's ability to complete activities of daily and nightly routines and medical and behavioral conditions.

## Signatures

Select one: ☐ Parent ☐ Legal Guardian

I certify, to the best of my knowledge, all information on this application is true and complete.

Signature:

Print Name:

Date:

Case Manager/ Resource Coordinator

I certify, to the best of my knowledge, all information on this application is true and complete.

Signature

Print Name: Sadie Dicus

Date: 5/19/2026

[Operational Memo 18-020](#) provides instruction for submitting this CES application to EQ Health Solutions.

Please visit [www.ColoradoPAR.com](http://www.ColoradoPAR.com) for additional support.

Client's Name: \_\_\_\_\_ Today's Date: 5/24/2026

initial to indicate that your CES Case Manager has reviewed with you the following safeguards:

1. I have received 10 day prior notice describing the date, time, and location of our CES planning meeting, or I have waived notice in order to arrange a more timely meeting.
2. I understand that I have the right to change this plan at any time. I will contact my Case Manager to request any change, and understand an Inter-Disciplinary Team (IDT) meeting will need to occur by phone or in person. Services provided must be prioritized needs on the Service Plan or Addendum, and are to be medically necessary to reasonably assist my family member to achieve or maintain maximum functional capacity in performing daily living skills.
3. I have been provided the information necessary to request a change to my plan, and am aware it may take up to 30 days to conduct the IDT meeting and implement the request. Examples of a change include: add/decrease services, increased supervision due to caregiver health emergency, new support due to injury of client in services, previously unknown need for behavior supports, etc. Services must be allowable within the program and not billable to School, Medicaid, or third party insurance.
4. I understand that my CES Case Manager is Sadie Dicus. I understand the role of the Case Manager and what I can expect from him/her.
5. I understand that no services will be funded without prior written authorization in the form of a Service Plan revision. (No substitution or switching of one service for another service can occur without a revised Service Plan, and no rollover of unused units/hours from month to month can occur without being described in the SP). Items/services purchased personally cannot be reimbursed.
6. I understand that Federal Guidelines require my CES Case Manager to contact me at least quarterly each year, and conduct four face to face visits. I understand that I can contact my CES Case Manager as needed.
7. I understand that supporting diagnostic information from my medical provider and/or the completion of various functioning/skill assessments may be required. Due to HIPAA regulations, I or my guardian/parent may be requested to furnish this information.
8. I understand that enrollment in a Medicaid waiver program requires that I receive a waiver service every calendar month in order to remain enrolled.
9. I understand that it is my responsibility to provide requested information within specific timelines in order to maintain my eligibility for the waiver services received, (e.g. County Department of Human Services documents/ Medicaid required paperwork, Long Term Care Professional Medical Information Page, proof of citizenship, etc.)
10. My CES Case Manager has reviewed with me my rights as outlined on the Children's Extensive Services Basic Rights, as well as the Dispute Resolution, Medicaid Appeal Rights and Complaint Process. I have received a copy of these documents.
11. I understand the criteria for rec \_\_\_\_\_ rvices as outlined in the CES Waiver guidelines.

 Parent/Guardian Signature: \_\_\_\_\_ Date: 5/27/2026

 CES Case Manager Signature: \_\_\_\_\_ Date: 5/19/2026



## NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

### Introduction:

Developmental Pathways ("DP") safeguards your protected health information (PHI) as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state law and regulations. This Notice explains how DP uses and discloses your PHI and how you can exercise your rights under HIPAA.

### DP's Duties:

1. **Notify You of DP's Privacy Policies.** Federal law requires that DP notify you of its legal duties and privacy policies and procedures with respect to your PHI. This Notice is intended to satisfy that requirement.
2. **Use And Disclose Your PHI Only As Described In This Notice.** DP will abide by the terms of this Notice as long as it remains in effect. DP will use and disclose your PHI without first obtaining your written authorization only as described in this Notice. If DP obtains your written authorization for a use or disclosure not described in this Notice, you may revoke or modify that authorization at any time by submitting the appropriate form to the Privacy Officer designated on below. The Privacy Officer will provide you with a copy of the form upon request.

### How DP Might Use or Disclose Your PHI Without Your Authorization For Treatment, Payment, or Health Care Operations

1. **Uses and Disclosures for Treatment, Services, and Supports.** DP may use your PHI to provide you with medical treatment, services or supports. We may disclose your PHI to physicians, psychologists, service providers and staff and other persons providing treatment, services or supports to you.
2. **Use for Payment Purposes:** DP may use your PHI to prepare bills for services that it has provided to you and to collect payment for those services.
3. **Uses and Disclosures for Health Care Operations.** DP may use your PHI for agency operations. These uses are necessary to manage DP's operation and to monitor the quality of your care. DP may disclose your PHI to qualified personnel of authorized external agencies whose responsibility it is to license, to accredit to monitor, to approve, or to conduct other functions as appropriate.

### How DP Might Otherwise Use or Disclose Your PHI Without Your Authorization

1. **Appointment Reminders:** We may use your PHI to contact you about an upcoming appointment or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. **Disclosures to Family Members Or Authorized Representatives.** DP may disclose your PHI to your parent if you are a minor, to your guardian, or to an individual designated by you, or designated by your parent, if you are a minor, or by your guardian, if appropriate, to assist you in acquiring or utilizing services or supports from DP to the extent access to confidential is within the scope of the designated person's authority.



## NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

3. **Disclosures to Business Associates.** DP has contracted with one or more third parties (referred to as a business associate) to use and disclose your PHI to perform services for DP. DP will obtain each business associate's written agreement to safeguard your PHI.
4. **Uses and Disclosures for Health Oversight Activities.** DP may disclose your PHI to qualified professional personnel of community centered boards, regional centers and other service agencies, including boards of directors and Human Rights Committee members to the extent necessary for the acquisition, provision, oversight or referral of services and supports. DP may disclose your PHI to the Colorado Departments of Health Care Policy and Financing ("HCPF") or Human Services ("DHS") or their designees as deemed necessary. DP may disclose your PHI to The Legal Center for People with Disabilities and Older Persons (the "Legal Center"), 455 Sherman St., Suite 130, Denver, CO 80203, as long as that organization serves as the protection and advocacy system for Colorado, when (a) the Legal Center has received a complaint has from you or on your behalf, or (b) if you do not have a legal guardian or if the State of Colorado or the State's designee is your legal guardian.
5. **Uses and Disclosures For Judicial And Administrative Proceedings.** DP may use or disclose your PHI in connection with court proceedings, such as disclosures of your PHI to a court or to persons authorized by an order of the court, issued after a hearing, notice of which was given to you or your personal representative, where appropriate, and to the custodian of the information.
6. **Uses or Disclosures Required By Law.** DP may use or disclose your PHI as required by any statute, regulation, court order or other mandate enforceable in a court of law.
7. **Disclosures to HHS.** DP may disclose your PHI to the United States Department of Health and Human Services ("HHS"), the government agency responsible for overseeing DP's compliance with federal privacy law and regulations regulating the privacy of PHI.
8. **Disaster Relief.** DP may use or share PHI about you to a public or private entity authorized by law or charter to assist in disaster relief efforts. This will be done to coordinate those efforts with those entities in notifying a parent/guardian, personal representative, family member, other relative, close personal friend, or other person identified by you of your location, general condition or death.
9. **Mistreatment, Abuse, Neglect or Exploitation.** DP may share PHI about you to a government and/or regulatory authority authorized by law to receive reports of mistreatment, abuse, neglect or exploitation if we believe you are a victim, perpetrator or witness. This will occur to the extent the disclosure is: (a) required by law; (b) agreed to by or your authorized representative; or (c) authorized by law and necessary to prevent serious harm to you or potential victims and we are informed by law enforcement or public officials that immediate enforcement activity requires disclosure of PHI.
10. **To Avert Serious Threat to Health and Safety.** DP may disclose PHI about you to prevent a serious threat to your health and safety or the health and safety of another or the public.
11. **Correctional Institutions.** DP may share PHI about you to a correctional institution or law enforcement having custody of you. The disclosure will be made if necessary: (a) to provide health care to you; (b) for the health and safety of others; or (c) for the safety, and security of the correctional institution.
12. **Fundraising.** DP may use or share PHI about you to raise funds for DP or its foundation, the SUN Foundation. We may also use your information to contact you to volunteer or provide in-kind contributions. We will only use demographic information such as your name, address and phone number and will not release this information to any outside entity. IF YOU DO NOT WANT DP OR ITS FOUNDATION TO CONTACT YOU FOR FUNDRAISING please notify the SUN Foundation Director at 303 858-2004 or SUN Foundation, 14280 E. Jewell Avenue, Suite A, Aurora, CO 80012.



## NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

13. **Marketing.** DP may use PHI to inform you about services and supports available to you and give you information about providers of those services and supports. We may communicate this information to you face to face, in phone conversations, by fax or e-mail. We will only use demographic information such as your name, address and phone number and will not release this information to any outside entity. DP does not sell PHI to any entity.

### Your Privacy Rights As A Participant In One Or More Of DP's Programs

You may exercise the rights described below by contacting DP's Privacy Officer at the mailing address or telephone number listed below and requesting a copy of the appropriate form.

1. **Right to Access Your PHI.** You may request a review or photocopies of your PHI on file with DP by submitting the appropriate form to the Privacy Officer. DP will provide access, or will mail the photocopies to you, within 30 days of your request unless the PHI is not available on-site, in which case DP will provide access or mail the photocopies within 60 days of your request. DP may extend the deadline for access or mailing by up to 30 days. DP will provide you with a written explanation of any denial of your request for access or photocopies. DP may charge you a reasonable, cost-based fee for photocopies or for mailing. If there will be a charge, the Privacy Officer will first contact you to determine whether you wish to modify or withdraw your request.
2. **Right to Amend Your PHI.** You may amend your PHI on file with DP by submitting the appropriate request form to the Privacy Officer. DP will respond to your request within 60 days. DP may extend the deadline by up to an additional 30 days. If DP denies your request to amend, DP will provide a written explanation of the denial. You would then have 30 days to submit a written statement explaining your disagreement with the denial. Your statement of disagreement would be included with any future disclosure of the disputed PHI.
3. **Right to an Accounting Of Disclosures Of Your PHI.** You may request an accounting of DP's disclosures of your PHI by submitting the appropriate form to the Privacy Officer. DP will provide the accounting within 60 days of your request. DP may extend the deadline by up to an additional 30 days. The accounting will exclude the following disclosures: (a) disclosures for "treatment," "payment," or "health care operations," (b) disclosures to you or pursuant to your authorization, (c) disclosures to family members or close friends involved in your care or in payment for your care, (d) disclosures as part of a data use agreement, and (e) incidental disclosures. DP will provide the first accounting during any 12-month period without charge. DP may charge a reasonable, cost based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Officer will first contact you to determine whether you wish to modify or withdraw your request.
4. **Right to Request Additional Restrictions On The Use Or Disclosure Of Your PHI.** You may request that DP place restrictions on the use or disclosure of your PHI for "treatment," "payment," or for "health care operations" in addition to the restrictions required by federal law by submitting the appropriate request form to the Privacy Officer. DP will notify you in writing within 30 days of your request whether it will agree to the requested restriction. DP is not required to agree to your request.
5. **Right to Request Communications By Alternative Means Or To An Alternative Location.** DP will honor your reasonable request to receive PHI by alternative means including electronic means, or at an alternative location, if you submit the appropriate request form to the Privacy Officer.
6. **Right to A Paper Copy Of This Notice.** You may request at any time that the Privacy Officer provide you with a paper copy of this Notice.



## NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

### Other Uses of Protected Health Information

Other uses and disclosures of PHI not covered by this notice or the laws that apply to DP will be made only with your written permission. If you provide us written permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke permission, thereafter, we will no longer use or disclose PHI about you for the reasons set forth in the prior authorization.

### A Note about Personal/Authorized Representatives

All of the rights described above may be exercised by your personal representative after the personal representative has provided proof of his or her authority to act on your behalf. Proof of authority may be established by (a) designation of an authorized representative; (b) a power of attorney for health care purposes, notarized by a notary public; (b) a court order for appointment as guardian, or (c) any other document which the Privacy Officer, in his or her sole discretion, deems appropriate.

### Your Right To File A Complaint

If you believe that your privacy rights have been violated because DP has used or disclosed your PHI in a manner inconsistent with this Notice, because DP has not honored your rights as described in this Notice, or for any other reason, you may file a complaint in one, or both, of the following ways:

1. **Internal Complaint:** Within 180 days of the date you learned of the conduct, you can submit a complaint using the appropriate complaint form to the Privacy Officer, Developmental Pathways, Inc., 14280 E Jewell Avenue, Suite A, Aurora, CO 80012, or call (303) 360-6600 and ask for the Privacy Officer. You can obtain a complaint form from the Privacy Officer.
2. **Complaint To HHS:** Within 180 days of the date you learned of the conduct, you may submit a complaint by mail to the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C. 20201.

### DP's Anti-Retaliation Policy

DP will not retaliate against you for submitting an internal complaint, a complaint to HHS, or for exercising your other rights as described in this Notice or under applicable law.

### Whom to Contact For More Information about DP's Privacy Policies and Procedures

If you have any questions about this Notice, or about how to exercise any of the rights described in this Notice, you should contact DP's Privacy Officer by mail c/o Developmental Pathways, 14280 E. Jewell Avenue, Suite A, Aurora, CO 80012, or call (303) 360-6600 and ask for the Privacy Officer.

### Revisions to the Privacy Policy and To The Notice

DP reserves the right to change this Notice or DP's privacy policies and procedures at any time. New notice or policies and procedures will be effective for all PHI we maintain including PHI created or received by us prior to the effective date of the new notice. Current notices will be posted on our website [www.developmentalpathways.org](http://www.developmentalpathways.org) and posted in our facilities.

**Effective Date of This Notice: April 2003 (Rev. July 2022)**

## C.R.S. 25.5-10 delineates the following specific legal rights in sections 218-231:

|                                                                                                                                                                                                                     |                                                                                                                                                                                                     |                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  <p>Legal rights and responsibilities guaranteed to all other persons<br/>C.R.S. 25.5-10-218</p>                                   |  <p>Have an Individualized Plan; participate in making your plan; choose your providers<br/>C.R.S. 25.5-10-219</p> |  <p>Medical services and treatment<br/>C.R.S. 25.5-10-220</p>                                                                                       |
|  <p>Be treated humanely; not to be abused; complain if you get hurt; complain if you don't get services<br/>C.R.S. 25.5-10-221</p> |  <p>Religious belief, practice, and worship<br/>C.R.S. 25.5-10-222</p>                                             |  <p>Communications and visits including: private conversations; friends &amp; visitors; send &amp; receive personal mail<br/>C.R.S. 25.5-10-223</p> |
|  <p>Fair employment practices (such as fair pay for work)<br/>C.R.S. 25.5-10-224</p>                                               |  <p>Register and vote<br/>C.R.S. 25.5-10-225</p>                                                                   |  <p>Review your records; expect confidentiality<br/>C.R.S. 25.5-10-226</p>                                                                          |
|  <p>Personal property (and a place to put your things)<br/>C.R.S. 25.5-10-227</p>                                                |  <p>Influence policy: participate in conversations about rules &amp; services<br/>C.R.S. 25.5-10-228</p>         |  <p>Notification: be given notice if a right is suspended<br/>C.R.S. 25.5-10-229</p>                                                              |
|  <p>Be free from discrimination<br/>C.R.S. 25.5-10-230</p>                                                                       |  <p>Sterilization: choose what happens to your body<br/>C.R.C. 25.5-10-231</p>                                   |  <p>Oral interpretation or language assistance (including sign language)</p>                                                                      |

**HOW TO EXERCISE YOUR RIGHTS:** You have the same human and civil rights as every other U.S. citizen. These rights should be limited or changed only to the extent necessary to be helpful to you, and then only with “due process”. Due process includes your Individualized Plan (Service Plan), the Packet Review Committee, the Human Rights Committee, and/or legal process. If you would like assistance in exercising your rights, you can select a friend, a family member, a staff person, a Case Manager, the Arc, or any other person to support you.



## **Right to Choice of Service Provider**

Developmental Pathways, Inc. (DP) is a Community Centered Board (CCB). We are a private non-profit organization designated in Colorado statute as a Case Management Agency (CMA) in the long-term service and support system for persons with intellectual and developmental disabilities residing in Arapahoe, Douglas, and Elbert counties and the city of Aurora.

As a CCB, DP is responsible for case management services for both State-funded and Medicaid Waiver-funded programs. Case Management duties include intake, eligibility determination, waitlist management, service plan development, monitoring, investigations of allegations of mistreatment, and many other functions. These functions are carried out by the Case Management Department. Your Case Manager (CM) is the person who provides many of these services to you

As your Case Manager, I am responsible for providing you with options regarding your choice of providers. Effective July 1, 2022 DP has separated from its prior relationships that maintained a shared executive team with Continuum of Colorado, a Medicaid provider agency. This separation completes DP's efforts to come into full compliance with the federal and state laws related to conflict free case management.

In our catchment areas, individuals and families have the choice of over 400 providers approved for various Home and Community Based Services (HCBS). Your CM will work with you and your family to make certain you have a choice of qualified providers.

In summary, our Case Managers (CMs) will ensure that individuals and families:

- Have choice of available long-term care programs and services.
- Have availability to resources outlining qualified providers.
- Have the right to select among qualified providers.
- Have the right to change providers at any time.
- Have access to DP's complaint and/or grievance processes.

Please note: Providers have the right to accept or deny requests for services.



## Critical Incident Reporting Criteria and Process

**What is a critical incident?** A critical incident is an actual or alleged event that creates the risk of serious harm to the mental and/or physical health or welfare of an individual receiving waiver services.

### How to report a Critical Incident or Mistreatment allegation/incident to Developmental Pathways

To report a critical incident, please call the Developmental Pathways reporting line: **303-858-2170**

\*\*\*Families of individuals in services or individuals in services can contact their Case Manager to have the CM assist in calling the reporting line if they choose \*\*\*

### Critical Incident Types and Definitions

1. **Injury/Illness to a Member:** Resulting in treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb serious burn, skin wounds, etc. or admission into a hospital.
2. **Missing Person:** Person is not immediately found; their safety is at serious risk or there a risk to public safety. Also consider supervision levels, alone time, and the contingency plan (team agreed upon allotted time to report an individual missing).
3. **Damage to Member's Property/Theft:** Deliberate damage, destruction, theft or use of a member's belongings or money.
4. **Medication Error/Management Issues:** Issues with medication dosage, scheduling, timing, set-up, compliance and administration which results in harm or an adverse effect which necessitates medical care.
5. **Death:** Expected or unexpected.
6. **Criminal Activity:** Any illegal activity that is allegedly committed by the waiver participant in which there is law enforcement involvement;
  - a. Violation of probation or parole that potentially will result in the revocation of probation/parole.
  - b. Any criminal offense that is committed by a waiver participant that results in immediate incarceration.
  - c. A criminal offense where a ticket or summons was given to the waiver participant
7. **Unsafe Housing/Displacement:** Individual is residing in an unsafe living conditions due to a natural event (such a fire or flood) or environmental hazard (such as infestation), and is at risk of eviction or homelessness
8. **Mistreatment (Abuse, Neglect and Exploitation):** See below for more information on Mistreatment definitions and the investigative process.
9. **Other High-Risk Issues:**
  - a. Substance abuse which results in hospitalization or rehabilitation
  - b. Victim of a crime
  - c. Suicide ideation
  - d. Suicide Attempts

### What happens once a critical incident is reported to Developmental Pathways?

1. Please report all critical incidents within 24 hours of when they occur or when you became aware of the incident.
2. Once a critical incident is reported, the agency or the DP Case Manager will fill out a critical incident report template with the details of what happened.
3. The incident then gets reported to the Colorado Department of Health Care Policy and Financing (HCPF) through an online reporting system.
4. Developmental Pathways and/or the agency will complete follow up steps for each Critical Incident. Those follow up steps will be different depending on the type of critical incident.
5. Once the report is complete and follow up actions take place the incident is closed out.



### **Mistreatment Allegations or Incidents**

If you have any concerns about a situation that has occurred or a situation that was reported to you that may meet the definition of mistreatment (abuse, neglect or exploitation), please report that incident to Developmental Pathways.

### **Definitions**

**Mistreatment is defined as:**

- a) Abuse;
- b) Caretaker neglect;
- c) Exploitation;
- d) An act or omission that threatens the health, safety, or welfare of a person with an intellectual and developmental disability; or
- e) An act or omission that exposes a person with an intellectual and developmental disability to a situation or condition that poses an imminent risk of bodily injury to the person with an intellectual and developmental disability.

**1. Abuse is defined as** any of the following acts or omissions committed against a person with an intellectual and developmental disability:

- a) The nonaccidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;
- b) Confinement or restraint that is unreasonable under generally accepted caretaking standards; or
- c) Subjection to sexual conduct or contact classified as a crime under the "Colorado Criminal Code", title 18, C.R.S.
- d) **Sexual Abuse**
  - a. "Sexual contact" means the knowing touching of the victim's intimate parts by the actor, or of the actor's intimate parts by the victim, or the knowing touching of the clothing covering the immediate area of the victim's or actor's intimate parts if that sexual contact is for the purposes of sexual arousal, gratification, or abuse.
  - b. "Sexual intrusion" means any intrusion, however slight, by any object or any part of a person's body, except the mouth, tongue, or penis, into the genital or anal opening of another person's body if that sexual intrusion can reasonably be construed as being for the purposes of sexual arousal, gratification, or abuse.
  - c. "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, analingus, or anal intercourse. Emission need not be proved as an element of any sexual penetration. Any penetration, however slight, is sufficient to complete the crime.

**2. Caretaker neglect is defined as:**

- a) neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health and safety of a person with an intellectual and developmental disability is not secured for a person with an intellectual and developmental disability or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for an at-risk adult with an intellectual and developmental disability.
- b) Notwithstanding the provisions of paragraph (a) of this subsection (1.8), the withholding, withdrawing, or refusing of any medication, any medical procedure or device, or any treatment, including but not limited to resuscitation, cardiac pacing, mechanical ventilation, dialysis, artificial nutrition and hydration, any medication or medical procedure or device, in accordance with any valid medical directive or order, or as described in a palliative plan of care, shall not be deemed caretaker neglect.



- c) As used in this subsection (1.8), "medical directive or order" includes a medical durable power of attorney, a declaration as to medical treatment executed pursuant to [section 15-18-104, C.R.S.](#), a medical order for scope of treatment form executed pursuant to article 18.7 of title 15, C.R.S., and a CPR directive executed pursuant to article 18.6 of title 15, C.R.S.

**3. Exploitation is defined as:** means an act or omission committed by a person who:

- a) Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person with an intellectual and developmental disability of the use, benefit, or possession of anything of value;
- b) Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person with an intellectual and developmental disability;
- c) Forces, compels, coerces, or entices a person with an intellectual and developmental disability to perform services for the profit or advantage of the person or another person against the will of the person with an intellectual and developmental disability; or
- d) Misuses the property of a person with an intellectual and developmental disability in a manner that adversely affects the person with an intellectual and developmental disability's ability to receive health care or health care benefits or to pay bills for basic needs or obligations.

**Developmental Pathways Investigative Process**

1. Per the Mandatory Reporting Law, for all at risk adults, incidents of suspected mistreatment must be reported to police within 24 hours. Police will pass this report to Adult Protective Services (APS) or the reported can also call APS make a secondary report. For children, please report to Child Protective Services or police if necessary.
2. Police/APS/CPS may conduct the investigations, if they do not then the CCB or agency will conduct an investigation.
3. Once a report is received and it meets the definition of Mistreatment, a trained investigator will open an investigation.
4. Witness interviews are completed with the individual in services, guardians, peers, and staff members involved in the incident.
5. The investigator will collect information and documents from the agencies that may assist with the investigation.
6. Once all evidence is collected the investigator will determine a conclusion to the investigation and report this conclusion to the agency director and the guardian or authorized representatives.
7. The investigator will make recommendations to the agency, but it is ultimately up to that agency to determine follow up actions to the investigation.

If at any time during the reporting process you have questions or concerns, please feel free to contact your Case Manager at Developmental Pathways or contact:

Dani McCann  
 Program Manager of Investigations and Critical Incidents  
 720-412-7231 cell  
[d.mccann@dpcolo.org](mailto:d.mccann@dpcolo.org)



## Authorization for Release and Exchange of Information

The following organizations/providers are hereby authorized to release, exchange, and share oral and written protected health information (PHI) with each other regarding the Individual named above:

Developmental Pathways, Inc. and:

- Physicians involved in my care.
- HCBS Providers involved in my care.
- Home Health Providers involved in my care.
- Therapists involved in my care.
- Hospitals and related facilities involved in my care.
- Regional Accountable Entity (RAE) (as listed here):
- School District (as listed here):
- Others (as listed here):

Information to be released, exchanged, and shared:

- Health information including but not limited to diagnosis, treatment, history, master file records, billing records; treatment notes; service and related plans, and information pertaining to home and community-based services (HCBS) and supports
- Other (as described here):

Purpose(s) or need for which the information is to be used and disclosed:

- Coordination/Continuity of Care
- Case Management
- Assessment
- Benefits Coordination/Acquisition
- Disability Determination
- Program Compliance
- Other (as listed here):



I understand that HIV/AIDS related information and/or records, psychotherapy notes, genetic testing information or notes, sickle cell anemia related information and/or records and drug/alcohol diagnosis, and treatment and referral information will not be released without a separate release specifically authorizing such release signed by you.

I understand that I make revoke this Authorization at any time by giving written notice to Developmental Pathways, except to the extent that Developmental Pathways has already taken action on this request. This Authorization will expire on \_\_\_\_\_ (MM/DD/YYYY), or, if left blank, one year from the date of my signature (whichever event comes first). I release Developmental Pathways from all liability for disclosing the requested information.

Authorization: I understand that authorizing the disclosure of this information is voluntary. This Authorization may be used and re-used to obtain information learned and records prepared after the date this release was signed as long as this Authorization remains valid. I understand that when information is released, it carries with it the potential for unauthorized re-disclosure, and it may no longer be protected by federal confidentiality rules such as HIPAA.

## PURPOSE / OVERVIEW

The purpose of this process is to affirm our commitment to addressing complaints and grievances. In any service system, there will be disagreements and complaints and we support each person's right to have their complaints and grievances taken seriously and to receive consistent, timely, and fair attention in addressing the concerns. We invite feedback and encourage clients and their families to let us know when something has gone wrong or is not to their satisfaction. We also welcome positive feedback.

You will not be forced to do anything, be intimidated, or be threatened, and no one will retaliate, or 'get back at you' if you use this Complaint Procedure. Disagreeing or complaining will not negatively affect your services.

## HOW TO USE THE COMPLAINT PROCESS

If you disagree with certain things Developmental Pathways, Inc., does or does not do, or treats you in a way you don't like, please let us know by sharing your complaint with us. Developmental Pathways will work with you to try to solve the problem. The steps to take are listed below.

If your complaint is about Early Intervention, direct service providers such as Program Approved Service Agencies (PASAs), or other organizations, you will follow their complaint process rather than this one.

If you would like to appeal a decision related to your authorized services through a State General-funded program such as Family Support or State Supported Living Services or through a home and community-based services Medicaid Waiver such as CES, CHRP, DD, or SLS, please use the Dispute or Appeal processes for those services.

## STEPS TO TAKE

### Step 1:

Tell the person who is part of the complaint what is wrong. You can tell them in person, on the phone, in writing (letter, fax, or email) or you or someone else can write it down and give it to them. You can do this yourself, or you can ask for help from your legal guardian or authorized representative. The person should acknowledge and try to address the problem within 3 working days, if they can.

### Step 2:

If you are still not satisfied, submit your complaint in writing to your Case Manager or Service Coordinator, or, if the complaint is about your Case Manager/Coordinator, submit your complaint in writing to the supervisor. You can write it down or have someone write it for you. The Case Manager/Coordinator or supervisor should acknowledge and try to address the problem within 3 working days, if they can.

- If the complaint is not resolved within 10 working days, a meeting can be scheduled to address the concern. You will then have a meeting with the person who is part of your complaint and the Manager or his/her designee.



## Complaint and Grievance Procedure

- At this meeting, you may have someone with you, including your authorized representative or others, to assist you in presenting your complaint.
- What is discussed and decided at the meeting will be put in writing, and you will get a written decision within 10 working days of your meeting.

### Step 3:

If you are not satisfied with that decision, you can submit your complaint in writing to the Chief Executive Officer of Developmental Pathways, Inc. within 7 calendar days after receipt of the written decision.

Address: Developmental Pathways: Attention CEO  
14280 E. Jewell Avenue, Suite A, Aurora, CO, 80012

The Chief Executive Officer, or designee, will review the problem within 10 working days and schedule a meeting with you and the other people involved.

The Chief Executive Officer or designee will make a final decision and will send it to you in writing within 10 working days of the meeting. This is the last step of the complaint process and the decision becomes final.

### RELATED POLICIES

Grievance, Complaint, and Dispute Policy

Confidentiality Policy

Conflict-Free Case Management Policy

MANE Reporting and Investigation Policy

Nondiscrimination Policy

Person-Centered Policy



## Medicaid Appeal Rights

### POLICY

An individual may have the right to a Medicaid Appeal Rights (also known as the right to a Medicaid Fair Hearing) before a State Administrative Law Judge. The following procedures will be used to comply with sections 8.057 and 8.7202 of the Medicaid Rules.

### MEDICAID APPEAL RIGHTS

When you have the right to a Medicaid Appeal Rights, you should receive a notice entitled, "Long-Term Care Application Status Letter" or the "Long-Term Care Benefits Status Letter." These letters will give you information regarding the action that has been proposed or has been taken, how to request a hearing before an administrative law judge, timeframes for making your appeal, and a form for making a written request for such a hearing. In addition, you have the right to request Medicaid Appeal Rights under the following circumstances:

### WHEN YOU MAY BE ABLE TO REQUEST A MEDICAID APPEAL HEARING

#### 1. You may request a Medicaid Appeal Hearing if:

- a. You are found financially ineligible for HCBS or Long-Term Services and Supports (LTSS) Benefits
- b. Functionally ineligible for HCBS waiver and Long-Term Services and Supports Programs or nursing facility admissions
- c. Do not meet program eligibility requirements.

#### AND

#### **The action that has been or will be taken is one of the following:**

- d. The individual or applicant is determined to not have a Developmental Disability
- e. The individual or applicant is found ineligible for LTSS
- f. The individual or applicant is determined eligible or ineligible for placement on a waiting list for LTSS
- g. An adverse action occurs that affects the individual's or applicant's waiver enrollment status

The individual or applicant voluntarily withdraws.

#### 2. You may request a Medicaid Appeal Rights if you are applying for any of the following developmental disabilities services or are on the wait list for developmental disabilities services:

- a. Developmental Disabilities Home and Community Based Services Medicaid Waiver ("DD Medicaid waiver")
- b. Supported Living Services Home and Community Based Services Medicaid Waiver ("SLS Medicaid waiver")
- c. Children's Extensive Support Home and Community Based Services Medicaid Waiver ("CES Medicaid waiver")
- d. Family Support Services Program ("FSSP")



## Medicaid Appeal Rights

### **AND**

**The action that has been or will be taken is one of the following:**

- e. An application for services is denied or is not acted upon with reasonable promptness
- f. The recipient requesting the hearing believes the action is erroneous, including the loss of coverage without notice
- g. The resident of a nursing facility believes the facility has erroneously determined that the individual must be discharged
- h. The individual believes the determination regarding the preadmission and annual resident review requirements is erroneous

At the hearing, you will have the right to bring evidence and present witness testimony. You can represent yourself at the hearing, or have an attorney, relative, friend, or other spokesperson represent you.



## Nondiscrimination Policy

### POLICY

As a recipient of federal financial assistance, Developmental Pathways, Inc. does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, national origin, disability, age, sex, veteran status, sexual identity, genetic information, religion, or creed in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, and in staff and employee assignments to individuals, whether carried out by Developmental Pathways directly, through a contractor, or through any other entity with which Developmental Pathways arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (nondiscrimination on the basis of race, color, national origin), Section 504 of the Rehabilitation Act of 1973 (nondiscrimination on the basis of disability), the Age Discrimination Act of 1975 (nondiscrimination on the basis of age), regulations of the U.S. Department of Health and Human Services issued pursuant to these three statutes at Title 45 Code of Federal Regulations (Parts 80, 84, and 91), and all applicable federal and state laws, rules, or regulations.

Additionally, in accordance with Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, Developmental Pathways does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of sex (including gender identity) in admission to, participation in, or receipt of the services and benefits under any of its health programs and activities, and in staff and employee assignments, whether carried out by Developmental Pathways directly, through a contractor, or through any other entity with which Developmental Pathways arranges to carry out its programs and activities.

In case of questions, please contact:

Provider Name: Developmental Pathways, Inc.  
Contact Person/Section 504 Coordinator: Erica Kitzman  
Telephone number: (303) 858-2306

### AUTHORITY

Title VI of the Civil Rights Act of 1964  
Section 504 of the Rehabilitation Act of 1973  
Age Discrimination Act of 1975  
Title 45 Code of Federal Regulations (Parts 80, 84, and 91)  
Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116

## CREDO FOR



# MUTUAL RESPECT

## Background

At Developmental Pathways, Inc., we value **kindness, collaboration, and competency** and are committed to person-and-family-centeredness. We strive to create and support an environment of inclusion and belonging for individuals and their families, our internal team members, and external community partners.

While we maintain formal policies to support grievances, complaints, disputes, and formal person-centeredness and individual rights, these guiding principles are intended to frame mutual accountability in our day-to-day work.



Case managers will return calls and emails within two business days. If you do not hear from your case manager within that time frame, please contact their supervisor.

## Guiding Principles for Connection

Our teams are committed to the following to support the most collaborative and successful working relationships:



Having a caring attitude



Honoring & respecting differences



Supporting mutual accountability & respect



Actively listening to individuals, families, & community members

DP staff members are committed to nonpartisan professionalism, which means no matter the subject matter, we pledge to:



Engage respectfully with one another & our community



Employ thoughtful delineation between our professional roles & personal roles in the community



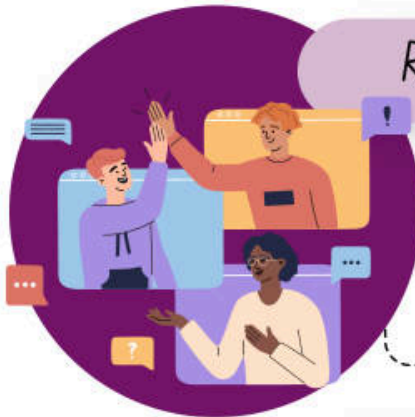
Demonstrate our commitment to nonpartisanship while at work to support safe, comfortable spaces for everyone



## Credo for Mutual Respect

### Individual, Family, and Community Partner Guidelines

Our expectation is that you reciprocate these relational touchstones.



#### *Respectful & Courteous Communication*

Name-calling, abusive, and/or attacking language will not be tolerated. Our staff may ask to reschedule the meeting or call to allow team members to regroup and collect their thoughts.

#### *Respect & Courtesy of Health & Safety Protocols*

We work with thousands of individuals and families and have a diverse workforce—many of whom have compromised immune systems and/or live with others who do. Our team members may need to occasionally reschedule meetings to ensure the health and safety of everyone.



#### *Please Share Feedback*



Our teams work with an open-door policy, and we encourage the individuals and families we serve to share feedback as early as possible. The sooner we hear from you, the faster we can address it.

## CREDO PARA



# RESPECTO MUTUO

## Fondo

En Developmental Pathways, Inc., valoramos la amabilidad, la colaboración y la competencia y estamos comprometidos con centrarnos en la persona y la familia. Nos esforzamos por crear y apoyar un entorno de inclusión y pertenencia para las personas y sus familias, los miembros de nuestro equipo interno y los socios comunitarios externos.

Si bien mantenemos políticas formales para respaldar quejas, disputas y un enfoque formal en la persona y los derechos individuales, estos principios rectores tienen como objetivo enmarcar la responsabilidad mutua en nuestro trabajo diario.



Los administradores de casos devolverán las llamadas y los correos electrónicos dentro de dos días hábiles.

Si no recibe noticias de su administrador de casos dentro de ese plazo, comuníquese con su supervisor.

## Principios rectores para la conexión

Nuestros equipos están comprometidos con lo siguiente para respaldar las relaciones laborales más colaborativas y exitosas:



**Tener una actitud solidaria**



**Honar y respetar las diferencias**



**Apoyar la responsabilidad y el respeto mutuos**



**Escuchar activamente a individuos, familias y miembros de la comunidad.**

Los miembros del personal del DP están comprometidos con el profesionalismo no partidista, lo que significa que, sin importar el tema, nos comprometemos a:



*Interactuar respetuosamente entre nosotros y con nuestra comunidad.*



*Delimitar cuidadosamente nuestras funciones profesionales y personales en la comunidad.*



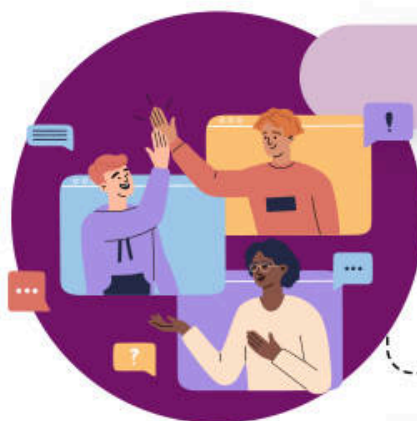
*Demostrar nuestro compromiso con el no partidismo en el trabajo para apoyar espacios seguros y cómodos para todos.*



## Credo para el respeto mutuo

### Directrices para particulares, familias y socios comunitarios

Nuestra expectativa es que usted corresponda con estos pilares relacionales.



#### *Comunicación respetuosa y cortes*

Nuestro personal puede pedir que se re programe la reunión o la llamada para que los miembros del equipo puedan reagruparse y ordenar sus pensamientos.

#### *Respeto y cortesía de los protocolos de salud y seguridad*

Trabajamos con miles de personas y familias y contamos con una fuerza laboral diversa, muchos de los que tienen sistemas inmunológicos comprometidos y/o viven con otras personas que lo tienen. Es posible que los miembros de nuestro equipo necesiten reprogramar reuniones ocasionalmente para garantizar la salud y la seguridad de todos.



#### *Por favor comparta sus comentarios*

Nuestros equipos trabajan con una política de puertas abiertas y alentamos a las personas y familias a las que servimos a compartir sus comentarios lo antes posible. En cuanto lo sepamos, más rápido podremos solucionarlo.

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support@coloradofamilycaregivers.com

Provider Agency

Colorado Family Caregivers

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### Status

### Timestamp

### Agent Delivery Events

### Status

### Timestamp

### Intermediary Delivery Events

### Status

### Timestamp

| Certified Delivery Events | Status           | Timestamp             |
|---------------------------|------------------|-----------------------|
| Carbon Copy Events        | Status           | Timestamp             |
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