COLORADO
Department of Health Care Policy & Financing

Temporary Sick Time Request
Consumer Direct Attendant Support Services

Member Information:		
Last Name:	First Name:	Medicaid ID#:
Phone:	Email:	
Authorized Representative Information:		
Last Name:	First Name:	EIN:
Phone:	Email:	
Attendant Information:		
Last Name:	First Name:	
Phone:	Email:	
Date of Request:	FMS Vendor:	
Rate of Pay:	Hours Requested:	
Start Date:	End Date:	

Affidavit:

I _____, am requesting sick time for the listed attendant. I agree that I will follow instructions from my FMS Vendor to track sick hours for the attendant. I agree to contact my FMS Vendor in the event of any changes related to this sick time request. I understand that this request is temporary. Attendants will be paid at a standard rate that is already established with the FMS vendor. I understand that sick time authorized will be paid from my CDASS allocation, and that the total hours paid for services must be less than the 129.99% utilization cap. In the event that I have insufficient reserves in my allocation, my request for sick time will be denied.

I attest that the request for sick time is used for one of the following purposes:
(1) to pay a regularly scheduled attendant with flu-like symptoms who is being tested for Coronavirus COVID-19, or
(2) to pay a regularly scheduled attendant who tests positive for Coronavirus COVID-19

Approval of sick time is temporary and limited to the duration of the State of Disaster Emergency declaration or the length of the Department's approved Appendix K waiver per 42 U.S.C. Ch. 7, § 1396n §§ 1915(c).

Member Signature:	Date: