COLORADO
Department of Health Care Policy & Financing

CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS)

TRAINING & FMS CLIENT REFERRAL FORM

This form will only be accepted by the Medicaid client's case management agency

☐ Initial Training Referral (Date: _____) ☐ Retraining Referral (Date: _____) ☐ FMS Transfer ☐ AR Transfer

PLEASE SEND REFERRAL FORM TO CDCO: fax 866/924-9072 or infoCDCO@consumerdirectonline.net

CLIENT INFORMATION

Name: _____ Waiver: _____
First *Last*

Date of Birth: _____ Social Security Number: _____

Complete Address: _____ Gender: _____

_____ ☎ Home: _____

Medicaid ID Number: _____ ☎ Alt: _____

Email: _____

AUTHORIZED REPRESENTATIVE (AR) INFORMATION

Refer to the client's Physician Statement of Consumer Capabilities form; does the client require an Authorized Representative? ☐ Yes ☐ No

If the Physician Statement doesn't require an AR, the client can opt to have one. Does the client voluntarily opt to have an AR? ☐ Yes ☐ No

*(If the answer to **either** question above is **YES**, complete the information below. Otherwise, indicate N/A.)*

Name: _____ Relationship to Client: _____

Complete Address: _____ SSN: _____

_____ ☎ Phone: _____

Email: _____ ☎ Alt: _____

If the AR is optional, what areas of CDASS is the AR authorized to manage (i.e. budget, training)?: _____

_____

CASE MANAGEMENT

Case Manager Name: _____ SEP Agency: _____

Email: _____ ☎ Direct Phone: _____

Comments: _____

_____

FMS REFERRAL INFORMATION

Program Type: (Choose One) ☐ AwC ☐ FEA FMS Provider: ☐ ACES$ ☐ Morning Star ☐ PPL

FMS Provider Referral Date: _____ CDASS Desired Start Date: _____

THE CLIENT'S ASMP, ALLOCATION WORKSHEET, AND AR AFFIDAVIT SHOULD BE SENT WITH THIS FORM TO THE CLIENT'S CHOSEN FMS.

FMS PROVIDERS:

ACES$	Morning Star	PPL
Fax: (303) 242-8864	Fax: 1-844-450-3343	Fax: 1-866-947-4813
Email: cosecure@mycil.org	Email: MS-COtransition@morningstarfs.com	Email: cocdassadmin@pcgus.com