Health First COLORADO
Colorado's Medicaid Program

Options Counseling Referral Information Form

Date Referral Received: ______________________

ADRC Region/ILC Responding to Referral: ______________________

Referral Type: ☐ Self ☐ MDS Section Q ☐ Family/Friend ☐ Ombudsman/Advocate

☐ Other: ______________________

Nursing Facility: ______________________

Contact Name: ______________________ Phone: ______________________

Email: ______________________

Resident Information

Name: ______________________

Nickname: ______________________ Date of Birth: ______________________

Guardian Name (if applicable): ______________________

Guardian Phone: ______________________

Check all that apply: ☐ Elderly ☐ Behavioral Health ☐ Physical Disability ☐ Intellectual Disability

Health First Colorado Eligible: ☐ Yes ☐ No ☐ Pending Health First Colorado ID#: ______________________

If Health First Colorado eligible, Long-Term Care eligible: ☐ Yes ☐ No ☐ Unsure

Nursing Facility admission date: ______________________ Rehab stay: ☐ Yes ☐ No ☐ Unsure

Physician Name: ______________________ Phone: ______________________

Desired Housing Type: ☐ Apartment ☐ House ☐ Group Home ☐ Host Home ☐ Assisted Living Facility

Desired Transition Location: ______________________

Do you have a home to return to? ☐ Yes ☐ No Is accessible housing required? ☐ Yes ☐ No

Do you require affordable housing? ☐ Yes ☐ No ☐ Unsure

Do you require housing subsidy? ☐ Yes ☐ No ☐ Unsure

Do you have family involvement? ☐ Yes ☐ No ☐ Unsure

Do you have caregiver involvement? ☐ Yes ☐ No ☐ Unsure

Do you have a community support network? ☐ Yes ☐ No ☐ Unsure

Which program would you like to use to transition to the community? ☐ CCT-CTS ☐ CTS-EBD

Resident Statement

☐ I will explore options to make the transition to living in the community.

☐ I have decided not to explore options to make the transition to living in the community at this time.

________________ (Resident Initials) I have received information regarding Transition Coordination Agencies and Case Management Agencies that provide community transition services. I have chosen the following agencies:

Resident Provider Preferences

Transition Coordination Agency: ____________________

Contact Name: ____________________

Phone: ____________________

Case Management Agency (for ICM services): ____________________

Contact Name: ____________________

Phone: ____________________

Resident Signature: ____________________

Printed Name: ____________________ Date: ____________

☐ Resident ☐ Legal Guardian ☐ Legal Representative

Options Counselors – Complete and submit a copy of this form to the selected transition coordination agency, case management agency and the Department Teresa.Nguyen@state.co.us

Retain a copy for your records.