COLORADO
Department of Health Care Policy & Financing

Transition Coordination (TC) Referral Form

Referral Information	
Date Options Counseling 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:

Member Information	
Name:	
Nickname:	Date of Birth:
Guardian Name *(if applicable)*:	
Guardian Phone:	
Preferred Language:	
Check all that apply: ☐ Elderly ☐ Behavioral Health ☐ Physical Disability ☐ Intellectual Disability	
Medicaid Eligible: ☐ Yes ☐ No ☐ Pending	Medicaid ID#:
If Medicaid Eligible, Long-Term Care Medicaid: ☐ 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:	
Has home to return to? ☐ Yes ☐ No	Accessible housing required? ☐ Yes ☐ No
Affordable housing required? ☐ Yes ☐ No ☐ Unsure	Housing subsidy required? ☐ Yes ☐ No ☐ Unsure
Family Involvement? ☐ Yes ☐ No ☐ Unsure	Caregiver involvement? ☐ Yes ☐ No ☐ Unsure
Community support network? ☐ Yes ☐ No ☐ Unsure	
Requesting referral to Transition Coordination (TC)? ☐ Yes ☐ No	

COLORADO
Department of Health Care Policy & Financing

Member Statement	
Decide NOT to Pursue Transition	
☐ I have decided not to explore options to make the transition to living in the community at this time. Reason for decision:	
Member Signature:	
Print Name:	Date:
☐ Member declined or was unable to sign	
Decide to Pursue Transition	
☐ I will explore options to make the transition to living in the community. _____ *(Member Initials)* I have been given information regarding Transition Coordination Agencies (TCAs) that provide transition coordination. I am requesting a referral to the agency below.	
Member Provider Preference	
Transition Coordination Agency (TCA):	
Contact Name:	Phone:
Member Signature:	
Printed Name:	Date:
☐ Member ☐ Legal Guardian ☐ Legal Representative	
Member Alternative Preference	
Transition Coordination Agency (TCA):	
Contact Name:	Contact Name:
Member Signature:	
Printed Name:	Printed Name:
☐ Member ☐ Legal Guardian ☐ Legal Representative	

Options Counselors - Complete and submit copies of this form to the Transition Coordination Agency (TCA), and to the Department of Health Care Policy & Financing Community Liaison
Retain a copy for your records.

Colorado Department of Health Care Policy and Financing
1570 Grant Street, Denver, CO 80203-1818
hcpf.colorado.gov

Revised April 2022