



**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@consumerdirectcare.com
Please also send FMS Transfer Referral to the new FMS provider. FMS contact information found below.

CLIENT INFORMATION

Name: _____ Waiver: _____
First Last
 Date of Birth: _____ Social Security Number: _____
 Complete Address: _____ Gender: _____
 _____ County: _____
 Medicaid ID Number: _____ ☎ Home: _____
 Email: _____ ☎ Alt: _____

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: _____ Agency: _____
 Email: _____ ☎ Direct Phone: _____
 Comments: _____

 Preferred training language (if different than English): _____

FMS REFERRAL INFORMATION

Previous FMS Provider (FMS Transfer): _____
 FMS Provider: Palco Public Partnerships (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:

| | |
|--------------------------------|----------------------------------|
| Palco | Public Partnerships (PPL) |
| Fax: 501-821-0045 | Fax: 866-947-4813 |
| Email: CO-CDASS@palcofirst.com | Email: cocdassadmin@pcgus.com |

A client whose services exceed \$285.00 per day requires an Over Cost Containment (OCC) review prior to a referral being submitted to CDCO for training.



**CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS)
Service Evaluation Form**

New CDASS Client New HCBS Client

This page is required for initial referrals only. Do not complete for retrainings or AR transfers.

**List all services client is currently receiving or any support client received prior to HCBS enrollment;
Please include frequencies and duration:**

Example: Adult Day Program 3 half days per week, Personal Care 3 days/wk @ 4 hours per visit, RPCP 37 hours/month

List all of the client’s natural supports; Please include frequency and duration for tasks being performed:

Example: Clients Mother providing assistance with bathing 3-4 times per week and dressing 7 days per week as an unpaid natural support.

With transition to CDASS, are the services increasing from current? Decreasing? Please provide explanation.

Example- Natural Supports are no longer able to provide unpaid care and will be paid as a CDASS attendant to ensure the clients health and safety needs are met.

Other pertinent information:

Please send referral form to CDCO: fax 866-924-9072 or infoCDCO@consumerdirectcare.com