In-Home Support Services (IHSS) Member Referral Form

To make a referral, complete and submit this form to the IHSS Agency of the member's choice.
www.colorado.gov/hcpf/in-home-support-services

Referral Process

1. Case Manager must obtain all required forms including the Physician Attestation of Consumer Capacity (PACC) prior to referral.
2. Include all relevant information in the referral packet: PACC, IHSS Care Plan Calculator, previous Shared Responsibilities Plan (if on file), and member demographics.
3. Documentation for skilled tasks, etc.
4. Upon receipt of this referral, the IHSS Agency will contact the member **within five business days**. If the agency accepts the member, the agency will complete an intake assessment and Shared Responsibilities Plan and develop a Care Plan. The Shared Responsibilities Plan and Care Plan will be sent to the Case Manager for review and approval.
5. Care Plans must be reviewed by the Case Manager **within five business days** of receipt. Formal dialogue between Case Manager, IHSS Agency and member will commence if there is a disagreement in the submitted Care Plan.

Member Information

Name: _____ Health First Colorado ID: _____
First *Last*

Address: _____ County: _____

City: _____ ZIP : _____ Waiver: _____

Email: _____ ☎ Phone: _____

Summary of member status & support needs (additional space on page 2): _____

_____

Authorized Representative (AR) Information

Refer to the member's Physician Attestation of Consumer Capacity form; does the member require an Authorized Representative (AR)? ☐ Yes ☐ No

If the Physician Statement doesn't require an Authorized Representative (AR), the member may elect to have one. Does the member voluntarily elect to have an AR? ☐ Yes ☐ No

Case Management

Case Manager Name: _____ Agency: _____

Email: _____ ☎ Direct Phone: _____

Provider Agency

Agency Name:_____ Proposed Start Date: _____

Phone: _____ Fax: _____

Referral Documents Included (Check all that apply):

☐ Care Plan Calculator
☐ Documentation for Health Maintenance Activities (HMA)
☐ Physician Attestation
☐ Prospective PAR
☐ PMIP / Medication List
☐ Shared Responsibilities Plan
☐ Other: _____
_____

Health First COLORADO
Colorado's Medicaid Program

Member Information Continued

Name: _____ Health First Colorado ID: _____
First *Last*

Language: _____ Secondary Contact: _____

Summary of member status & support needs: