



CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) TRAINING & FMS MEMBER REFERRAL FORM

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

□ Initial Training □ Retraining □ Supplemental Training □ AR Transfer □ FMS Transfer **Date:** _

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.

MEMBER INFORMATION	
Name:	Waiver:
First	Last
Date of Birth:	Social Security Number:
Complete Address:	Gender:
	County:
Medicaid ID Number:	🖀 Home:
Email:	🖀 Alt:
AUTHORIZED REPRESENTATIVE (AR) I	NFORMATION
Refer to the member's Physician Statement of Consumer Capabilities form to answer the questions below. Does the member require an Authorized Representative? □ Yes □ No If an AR is not required, the member can opt to have one. Does the member 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 Member:
Complete Address:	SSN:
	The second secon
Email:	🖀 Alt:
If the AR is optional, what areas of CDASS is the AR authorized to manage (i.e. budget, training)?:	
CASE MANAGEMENT	
	Agency:
Email:	Errect 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 MEMBER'S ASMP, ALLOCATION WORKSHEET, AND AR AFFIDAVIT SHOULD BE SENT WITH THIS FORM TO THE MEMBER'S CHOSEN FMS.	
FMS Providers:	
Palco Fax: 501-821-0045 Email: CO-CDASS@palcofirst.com	Public Partnerships (PPL) Fax: 866-947-4813 Email: cocdassadmin@pplfirst.com

A Member 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 Member

□ New HCBS Member

This page is required for initial referrals only. Do not complete for re-trainings or AR transfers.

List all services member is currently receiving or any support member 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 member's natural supports; Please include frequency and duration for tasks being performed:

Example: Member's 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 member's health and safety needs are met.

Other pertinent information:

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