Health First COLORADO
Colorado's Medicaid Program

Reset Form

Consumer-Directed Attendant Support Services Referral Form

This form is required to enroll a Health First Colorado member in the Consumer-Directed Attendant Support Services (CDASS) program, request coaching, assign an Authorized Representative (AR), and change Financial Management Services (FMS) contractors. The member/AR must complete orientation with the Training and Support contractor and enroll with an FMS before CDASS may begin. The contractor is available to help with the enrollment process. Visit the CDASS Resources webpage at hcpf.colorado.gov/participant-directed-programs for the contractor's contact information. **Instructions: Case manager sends referral with supporting documents to Consumer Direct for Colorado (CDCO) by fax to 866-924-9072 or email infoCDCO@consumerdirectcare.com. CDCO will only accept referrals from the case manager.**

Referral Documents Checklist

☐ Member Responsibilities Form
☐ CDASS/IHSS Physician Attestation of Member Capacity Form
☐ Authorized Representative Questionnaire and Designation Form (if applicable)
☐ Monthly Allocation
☐ Direct Care Services Calculator

Referral Information

Date: _____ Type (check one): ◯ Orientation ◯ Coaching ◯ AR Transfer ◯ FMS Transfer

If Coaching is selected, specify type: ◯ Required ◯ Supplemental (see *CDCO's website* for examples)

Orientation must be completed within 45 days from the referral date. Does this member's orientation need to be extended or expedited? ◯ No, not necessary ◯ Yes, expedite ◯ Yes, extend

Member Information

First Name: _____ Last Name: _____

Waiver: Select Health First CO #: _____ Social Security #: _____ Date of Birth: _____

Phone #: _____ Alternate Phone #: _____ Email: _____

Date services should begin: _____ Are reasonable accommodations needed? ◯ Yes ◯ No

Authorized Representative Information

Refer to the member's Physician Attestation of Member Capacity Form. If the member is required to have an Authorized Representative or chooses to assign one, complete this section.

First Name: _____ Last Name: _____

Relationship to Member: Select Social Security #: _____ Date of Birth: _____

Phone #: _____ Alternate Phone #: _____ Email: _____

Case Manager Information

Case Manager Name: _____ Agency Name: Select

Email: _____ Direct Phone Number: _____

Financial Management Services Contractor Selection—Complete only for FMS Transfer

◯ Palco
Email: enrollment@palcofirst.com
Fax: 877-859-8757

◯ Public Partnerships (PPL)
Email: cocdassadmin@pplfirst.com
Fax: 866-947-4813

Transfer Date: _____