Health First COLORADO
Colorado's Medicaid Program

# In-Home Support Services (IHSS) Client Referral Form

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

**Referral Process**

1. Case Manager must obtain all required forms including the Physician's Attestation prior to referral.
2. Include all relevant information in the referral packet: Physician's Attestation, Authorized Representative forms (if applicable), IHSS Care Plan Calculator, client demographics,
3. documentation for skilled tasks, etc.
4. Upon receipt of this referral, the IHSS Agency will contact the client **within five business days**. If the agency accepts the client, the agency will complete an intake assessment and develop a Care Plan. The 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 client will commence if there is a disagreement in the submitted care plan.

## CLIENT INFORMATION

Name: Smith _____ Medicaid ID: _____
*First* *Last*

Address: _____ County: _____

City: _____ ZIP : _____ Waiver: _____

Email: _____ ☎ Phone: _____

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

_____

## AUTHORIZED REPRESENTATIVE (AR) INFORMATION

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

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

*(If the answer to either of the above questions is YES, please include the appropriate AR forms)*

## 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
☐ Physician Attestation
☐ PMIP / Medication List
☐ Documentation for Health Maintenance Activities (HMA)
☐ Dummy PAR
☐ AR Designation form
☐ Client & Provider Agency Responsibilities form
☐ Other: _____
_____

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## CLIENT INFORMATION CONTINUED

Name: Smith _____ Medicaid ID: _____
*First* *Last*

Language: _____ Secondary Contact: _____

Summary of client status & support needs: