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) INFORMATION

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: _____

Full 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 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