Health First COLORADO
Colorado's Medicaid Program

Reset Form

In-Home Support Services Referral Form

This form is required to enroll a Health First Colorado member in In-Home Support Services (IHSS), and request coaching, an Authorized Representative (AR), or IHSS agency transfer. The member must enroll with an IHSS agency before IHSS may begin. The Training and Support contractor is available to assist with this form and provide more information. Visit the IHSS Resources webpage at hcpf.colorado.gov/participant-directed-programs for the contractor's contact information. **Instructions: Case manager completes this form and sends it with the supporting documents to the member's selected agency. Agency will only accept this form from the case manager. Visit the IHSS Provider List for agency contact information. *Required fields.**

Supporting Referral Documents Checklist

These documents must accompany this referral form for it to be accepted by the IHSS agency.

- ☐ CDASS/IHSS Physician Attestation of Member Capacity
- ☐ Prior Authorization Request (PAR)
- ☐ IHSS Shared Responsibilities Plan
- ☐ Direct Care Services Calculator
- ☐ Professional Medical Information Page/Medication List
- ☐ Health Maintenance Activities Documentation

Referral Information

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

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

Member Information

First Name*: _____ Last Name*: _____

Waiver*: Select Health First CO ID*: _____ SSN*: _____ Date of Birth*: _____

Address*: _____

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 (AR) 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*: _____

IHSS Agency Selection

Agency Name*: _____ Phone #*: _____

Email*: _____ Fax #: _____

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Summary of Member Care Information

Please summarize the member's health condition and status, support needs, and any other important information related to the member's care needs and preferences.*

Member Name (first and last)*: _____ Health First CO #*: _____

AR Name (first and last): _____ Language*: _____