COLORADO CHOICE TRANSITIONS
YOUR PATH TO INDEPENDENCE

HOME & COMMUNITY BASED SERVICES HCBS | ELDERLY, BLIND AND DISABLED EBD

Options Counseling/Community Transition Referral Information Form

Options Counseling Agency _____

Transition Coordination Agency _____

Transition Coordinator _____

Print Client Name _____

Print Client Nickname _____ DOB _____

Disability Type: Elderly ☐ Mental Illness ☐ Physical ☐ Intellectual Disability ☐

Referral Type: Self ☐ MDS Section Q ☐ Other ☐ _____

Nursing Facility _____

Nursing Facility Contact Name _____

Phone Number _____ E-Mail _____

Phone Number for Client _____

Guardian Name (if applicable) _____

Contact Information _____

Medicaid Eligible ☐ Yes ☐ No ☐ Pending Medicaid # _____

If Medicaid Eligible: Long Term Care Medicaid ☐ Yes ☐ No

Nursing facility admission date _____

Copy of doctor's admitting orders received_____

Physician name _____

Contact information _____

Availability of the following information:

Driver's License ☐Yes ☐No Proof of Income ☐Yes ☐No ID ☐Yes ☐No

Birth Certificate ☐Yes ☐No Social Security Card ☐Yes ☐No

Housing subsidy needed: ☐ Yes ☐ No

Date/Time Initial Visit Scheduled _____

Resident Statement:

☐ I will explore opportunities to make the transition to living in the community.

☐ I have decided not to move into the community at this time.

Signature: _____ Date: _____

Printed Name: _____

☐ Resident ☐ Legal Guardian ☐ Legal Representative