



Transition Coordination (TC) Referral Form

Referral Information	
Date Options Counseling Referral Received:	
ADRC Region/ILC Responding to Referral:	
Referral Type: <input type="checkbox"/> Self <input type="checkbox"/> MDS Section Q <input type="checkbox"/> Family/Friend <input type="checkbox"/> Ombudsman/Advocate <input type="checkbox"/> Other	
Nursing Facility:	
Contact Name:	
Phone:	Email:
Member Information	
Name:	
Nickname:	Date of Birth:
Guardian Name <i>(if applicable)</i> :	
Guardian Phone:	
Preferred Language:	
Check all that apply: <input type="checkbox"/> Elderly <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Physical Disability <input type="checkbox"/> Intellectual Disability	
Medicaid Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	Medicaid ID#:
If Medicaid Eligible, Long-Term Care Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
Nursing Facility Admission Date:	Rehab Stay: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Physician Name:	Phone:
Desired Housing Type: <input type="checkbox"/> Apartment <input type="checkbox"/> House <input type="checkbox"/> Group Home <input type="checkbox"/> Host Home <input type="checkbox"/> Assisted Living Facility	
Desired Transition Location:	
Has home to return to? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accessible housing required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Affordable housing required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Housing subsidy required? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Family Involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	Caregiver involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Community support network? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
Requesting referral to Transition Coordination (TC)? <input type="checkbox"/> Yes <input type="checkbox"/> No	





Member Statement	
Decide NOT to Pursue Transition	
<input type="checkbox"/> I have decided not to explore options to make the transition to living in the community at this time. Reason for decision:	
Member Signature:	
Print Name:	Date:
<input type="checkbox"/> Member declined or was unable to sign	
Decide to Pursue Transition	
<input type="checkbox"/> I will explore options to make the transition to living in the community. _____ (<i>Member Initials</i>) I have been given information regarding Transition Coordination Agencies (TCAs) that provide transition coordination. I am requesting a referral to the agency below.	
Member Provider Preference	
Transition Coordination Agency (TCA):	
Contact Name:	Phone:
Member Signature:	
Printed Name:	Date:
<input type="checkbox"/> Member <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Legal Representative	
Member Alternative Preference	
Transition Coordination Agency (TCA):	
Contact Name:	Contact Name:
Member Signature:	
Printed Name:	Printed Name:
<input type="checkbox"/> Member <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Legal Representative	

Options Counselors - Complete and submit copies of this form to the Transition Coordination Agency (TCA), and to the Department of Health Care Policy & Financing Community Liaison
Retain a copy for your records.

Colorado Department of Health Care Policy and Financing
1570 Grant Street, Denver, CO 80203-1818
hcpf.colorado.gov

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