COLORADO ACCESS CARE MANAGEMENT REFERRAL FORM

REFERRING AGENCY/ORGANIZATION INFORMATION/PERSON REFERRING:

Agency/organization name:	
Name of person referring:	Phone number:
Email address:	Relationship to member:
Would you like care management staff to follow up with updates on case? ☐ Yes ☐ No	

MEMBER INFORMATION:

Member name:	State ID:
Member date of birth:	Member phone number:
Guardian/parent/caregiver name (if applicable):	
Guardian/parent/caregiver phone number (if different from member):	
Custody, guardianship, power of attorney/medical power of attorney (POA/MPOA): ☐ Yes (if yes, please attach custody paperwork to referral) ☐ No	

REFERRAL INFORMATION/MEMBER NEEDS (CHECK ALL THAT APPLY):

☐ Assistance with locating new primary care provider (PCP)	☐ Assistance with locating specialist; if yes, list type:	☐ Complex medical needs
☐ Multiple chronic conditions	☐ Social determinants (food, housing, transportation, etc.)	☐ Behavioral health needs (substance use disorder (SUD), outpatient behavioral therapy, other behavioral health concerns)
☐ Transitions of care (from inpatient or other care transition)	☐ System navigation assistance	☐ Medication/treatment plan concerns
☐ EPSDT	☐ Pregnancy/postpartum support	☐ Other (please list):

To better serve the member, please provide a brief description of the case, member needs, what has already been done and any other important information:

Please submit your referral as well as any important supporting documents (such as the authorization to disclose PHI form, guardianship paperwork, POA paperwork, MDPOA paperwork, and/or custody paperwork) to us at: resource&referral@coaccess.com.

**The authorization to disclose PHI form can be found on our website at coaccess.com/providers/forms.