A&I avenues
Reimagining Case Management

Intake Information

Applicant's Information		
Last Name:	First Name:	M.I.:
Medicaid ID#:	Date of Birth:	
Mailing Address:		

Referral Information (if different than applicant)	
First Name:	Last Name:
What is your relationship to the individual seeking supports? ☐ Spouse ☐ Child or Child-in-law ☐ Parent/Guardian ☐ Guardian (Non-Parental) ☐ Partner/Significant Other ☐ Other Relative: ☐ Friend ☐ Neighbor ☐ Advocate ☐ Service/Provider Agency: ☐ Other:	
Cell Phone Number:	Home Phone Number:
Work Phone Number:	Email:
Preferred method of contact: ☐ Phone ☐ Email	

Reason for Contact
Is the individual currently enrolled in an LTSS Program and had an LTSS assessment? ☐ Yes, enrolled in an LTSS Program and had an LTSS Assessment ☐ Yes, had an LTSS Program and had an LTSS assessment but not currently enrolled in an HCBS Program ☐ No ☐ Unknown
Is the individual/guardian seeking services aware that the referral has been made? ☐ Yes ☐ No
Do you have the individual's permission or legal authority or the guardian's permission to talk with the agency? ☐ Yes ☐ No

Eligibility Screen ADLs

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Does the individual have any difficulty with any of the following Activities of Daily Living (ADLs)? ☐ Bathing ☐ Dressing ☐ Eating ☐ Toileting ☐ Transferring ☐ Mobility ☐ None
Does the individual display/have any of the following? ☐ Memory or Cognitive Impairments ☐ Mental Health Concerns ☐ Uncertain
If yes or uncertain, describe:
Does the individual potentially have Intellectual and/or developmental disability (The definition of a developmental disability for the purposes of receiving DD services in Colorado is, "IQ of 70 or below OR Adaptive Behavior of 70 or below with a neurological condition that manifested prior to the individual's 22nd birthday.") ☐ No ☐ Yes

Financial Information

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Does the individual have Health First Colorado (Medicaid)? ☐ No ☐ Yes ☐ Unknown If not, has the individual begun the Health First Colorado (Medicaid) application process? ☐ No ☐ Yes ☐ Unknown
Date application submitted:

Additional Demographic Information

Additional Demographic Information	
Date of Birth:	Assigned Sex at Birth:
Does the member have a Social Security Number? ☐ No ☐ Yes	
Social Security Number:	

Primary language of the individual: ☐ English ☐ Spanish ☐ French ☐ Japanese ☐ Korean ☐ Chinese (Mandarin) ☐ Chinese (Cantonese) ☐ ASL (American Sign Language) ☐ Russian ☐ Other
Does the individual have a Primary Care Provider? ☐ No ☐ Yes
Physician Name:
Physician Telephone:
Physician Fax: