



Referral Form

Options Counseling (OC) Case Management (CM)

Referral Source Information

Minimum required fields indicated by (*)

* Referral Date: _____

* Is the client aware of the referral and provided a program description? Yes No

* Referred by/relationship to the client: self caregiver family professional

*Name: _____ *Agency/organization _____

*Phone number: _____ Email: _____

Client Information

*Client name: _____ *Date of birth (DOB): _____

*Street address: _____

*City and ZIP code: _____ *County: _____

*Phone number: _____ *Preferred language: _____

*Refugee/asylee status: yes no *If yes, date of arrival or date of status: _____

Additional Contact Information (Family/Friends/Power of Attorney/Caregiver[s])

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Insurance Information

Medicare number: _____ Part B/D or Advantage Plan number: _____

Social Security number: _____ Is a veteran? yes no

Medicaid number: _____ 1B case number: _____

Other insurance/discounts: _____

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Case Management (CM)

Safety Concerns (check all that apply) *Must be completed before home visit will be considered.*

- domestic violence hoarding infestations animals in home weapons in home
 substance abuse/use mental health concerns cognitive impairments other concerns

Please elaborate: _____

Reason for referral for services (services needed)

Current living situation alone with others

(please elaborate)

What current services and benefits are established?

Is there a support system in place?

Monthly income (please include source)?

*What needs are the priority?

*Why does the client need services?

Submit completed referral form via one of these options:

- fax to 303-480-6827
- encrypted email to:

AAACaseManagement@drcog.org
for Case Management (CM) or to
boconnor@drcog.org
for Options Counseling (OC)

