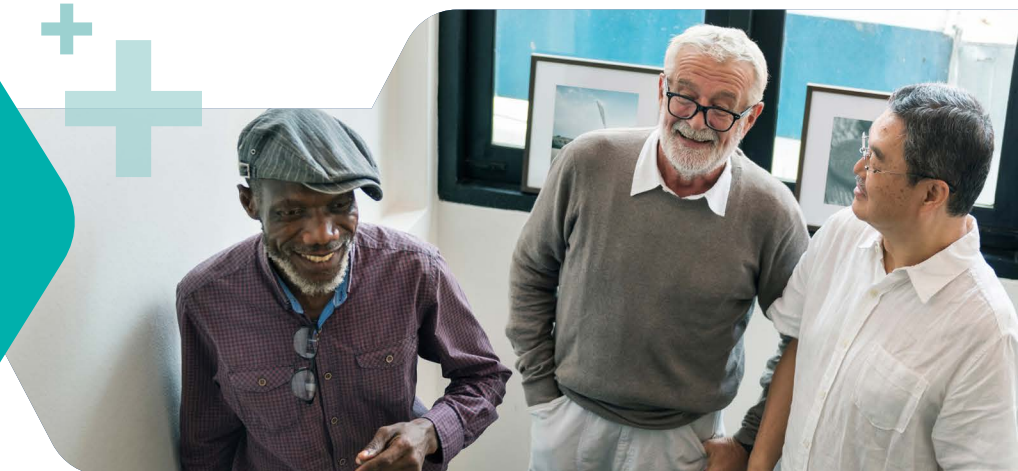# Referral form
Options Counseling
Case Management

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:

*Role: *Agency:

*Phone Number: Email:

Client Information

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

*Street Address:

*City and ZIP code: *County:

*Phone number(s):   *Preferred Language:

*Refugee/Asylee Status: yes   no *If yes, date of arrival or date of status: A-number:

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:

If you are unsure if a referral is appropriate, please call 303-480-6700 or email ADRCreferrals@drcog.org to discuss the situation.

DRCOG area agency on
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Aging and Disability
Resources for Colorado

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:

Current living situation: alone   with others

Reason for referral for services (services needed): Please be as specific as possible in these sections. Give details about the individual's needs. For example, if an individual requires in-home care, state whether they need house cleaning, personal care or skilled nursing assistance such as medication management.

What current services and benefits are established? (For example: Medicare, Medicaid, food stamps, Supplemental Security Income, home and community-based services, housing placement services, case management.)

Is there a support system in place? (For example: service providers, family or friends.)

Monthly income (please include source)?

What service needs are the priority?

* How would services benefit this individual?

If you need digital accessibility assistance, submit a request at drcog.org/access or call 303-455-1000. Please expect a response within 72 hours (three business days).

Submit completed referral form by encrypted email to ADRCreferrals@drcog.org