

PASA Contact Information Form

Please fill out this form entirely and return to the Provider Team: by email
providers@dpcolo.org or fax 303.341.0382

General Information

PASA Name							
Mailing Address						Suite/Unit	
City				State		Zip	
Phone		Fax		Website			
Physical Address (if different)						Suite/Unit	
City				State		Zip	

Points of Contact

Please designate a single contact for each type of communication below. The same person may be the contact for multiple types of communication, but each type of communication can only have one contact.

Director: This individual will receive high-level and general information, HCPF directives, and PASA meeting details.							
Name				Title			
Email					Phone		
Service Plans: This individual will receive invitations to service plan meetings, assessment reminders, and SP documents.							
Name				Title			
Email					Phone		
Requests for Proposal: This individual will receive emails identifying clients who are seeking placement with an agency. PASAs are requested to respond stating whether or not they would like to work with the client.							
Name				Title			
Email					Phone		
HRC: This individual will be the point of contact for our Human Rights Committee, to discuss and prepare packets for rights restrictions, rights suspensions, and mistreatment allegations.							
Name				Title			
Email					Phone		
Billing: This individual will be contacted when we have questions about billing and payment for services rendered.							
Name				Title			
Email					Phone		

Miscellaneous Information

Do you bill Medicaid directly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you work with adults?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you work with children?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will you provide services in a family caregiver setting?	<input type="checkbox"/> Yes, please list services below <input type="checkbox"/> No Family Caregiver Service(s):				