

Referral to Fort Lyon Supportive Residential Community

Please fax to 719 456 0109 or email to fortlyonreferrals@coloradocoalition.org

ALL QUESTIONS & FORMS MUST BE COMPLETED

Name of Referral Source: _____

Phone: _____ Email Address: _____

How long have you, the referral source, known this individual? _____

Name of referral agency: _____

Today's Date: _____

CLIENT INFORMATION

Client Name: _____

Have you ever been a resident of the Fort Lyon or Sage Ridge Programs?

Yes, FL ____ Yes, SR ____ No ____

How long have you been in Colorado? _____

DOB: _____ Gender: _____

Have you served in the Armed Forces? Yes ____ No ____

Previous Substance Use Treatment? Yes ____ No ____ Where: _____

Substance(s) used in the last six months: _____

Last Use: _____ Type of use: IV SMK SNT ING

Mental Health Diagnosis: Yes ____ No ____ Current Diagnosis? _____

Where receiving treatment? _____

Are you receiving Medication Assisted Treatment?

____ Suboxone ____ Methadone ____ Naltrexone ____ Vivitrol ____ other

Benefits: Medicaid ____ Medicare ____ SSI ____ SSDI ____ AND ____ OAP ____ VA ____

Verification of Benefits? Yes ____ No ____

Any open court or warrants? Yes ____ No ____ **Must be closed before admission!**

Currently on parole or probation? Yes ____ No ____

If yes, please include a release of information for us to speak with the Officer.

Will you need transportation to Fort Lyon? Yes No

Pickup location & Time: 9 **9:15 AM**, 2130 Stout Street, Denver

11:15 AM, 5 W. Las Vegas Street, CO Springs **11:45 AM** 509 E. 13th St. Pueblo

EMERGENCY CONTACT FOR CLIENT:

NAME _____ PHONE: _____



MRN: _____	DOB: _____
CATEGORY: ROI	

Authorization to Request / Release Health Information

Client Name: _____ Client Date of Birth: _____ Last 4 of SSN: _____

I authorize that information may be exchanged between the following:

_____ From <input checked="" type="checkbox"/> To Name: <u>CCH Fort Lyon</u> Address: <u>30999 County Road 15</u> City, State, Zip: <u>Las Animas, CO</u> Phone Number: _____ Fax Number: _____ Email: <u>fortlyonreferrals@coloradocoalition.org</u>	<input checked="" type="checkbox"/> From _____ To _____ (please select) Name or Organization: _____ Relationship to Client: _____ Address: _____ City, State Zip: _____ Phone Number: _____ Fax Number: _____ Email: _____
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Please indicate the purpose of this release (check all that apply):

<input checked="" type="checkbox"/> Continuity of Care	<input type="checkbox"/> Insurance	<input type="checkbox"/> Obtain Benefits
<input type="checkbox"/> Legal	<input type="checkbox"/> Worker's Compensation	<input checked="" type="checkbox"/> Referral
<input checked="" type="checkbox"/> Obtain/Maintain Housing	<input type="checkbox"/> Personal/Other _____	

Information to be released (please check all that apply):

Paper Copy Verbal Exchange Electronic Copy
 Specific Dates of Service: _____

Medical Information:

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Imaging Reports	<input type="checkbox"/> Consultant Reports	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Medication List/History	<input type="checkbox"/> ER Reports
<input type="checkbox"/> AIDS/HIV Information	<input type="checkbox"/> Dental Records	<input type="checkbox"/> Billing Records	<input type="checkbox"/> Eye Care Records
<input type="checkbox"/> Demographic/Face Sheet	<input type="checkbox"/> Diagnoses	<input type="checkbox"/> Hospital Admit/Discharge Summaries	

Mental Health Information:

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Psychiatric Notes	<input type="checkbox"/> Intake/Assessment
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medication List/History
<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> Treatment Status	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Demographic/Face Sheet	<input type="checkbox"/> Diagnoses	<input type="checkbox"/> Hospital Admit/Discharge Summaries

Housing Information:

<input type="checkbox"/> Program Status	<input type="checkbox"/> Case Notes or Housing Advocate Notes
<input type="checkbox"/> Family/Social Composition	<input type="checkbox"/> Voucher/Lease Information
<input type="checkbox"/> Notices/Eviction Information	<input type="checkbox"/> Demographic/Face Sheet

Case Management Information:

<input type="checkbox"/> Program Status	<input type="checkbox"/> Case Notes/Case Management Notes
<input type="checkbox"/> Family/Social Composition	<input type="checkbox"/> Treatment/Care Plan
<input type="checkbox"/> Intake/Assessment	<input type="checkbox"/> Demographic/Face Sheet
<input type="checkbox"/> Benefit Information	

Substance Treatment Information:

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Assessments	<input type="checkbox"/> Medication List/History
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Discharge Summaries	<input type="checkbox"/> Treatment Status	<input type="checkbox"/> Diagnoses

Authorization

I understand that:

- Due to the integrated care provided by CCH, information released may include a diagnosis or reference to the following condition(s): behavioral health/psychiatric care; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV) or substance use disorders.
- Individuals enrolled in CCH licensed substance treatment (Part 2) programs have their substance-specific records protected by 42 CFR Part 2
- I understand that treatment and payment may not be conditioned on signature of this form.
- I understand that authorizing the disclosure of this information is voluntary.
- I understand that I may revoke this authorization at any time by giving written notice to the Colorado Coalition for the Homeless, except to the extent that CCH has already acted on this request.
- I understand that when information is released, it carries with it the potential for unauthorized redisclosure, and it may no longer be protected by federal confidentiality rules such as HIPAA.
- I understand that I may make a written request for a list of the entities to which my information has been disclosed over a specified period, not to exceed six years preceding the date of my request.
- I understand that if I request to receive records via unsecured email, unencrypted messages (and any attachments) can be read, and potentially copied and forwarded, by anyone.

Expiration

I understand that this release expires on: _____ (not to exceed two years from the date of my signature)

Signature of Client or Personal Representative

Date

Printed Name of Client or Personal Representative

Relationship to Client

NOTICE TO THE RECIPIENT OF THE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (HIPAA and 42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Revocation of Authorization to Release Protected Health Information

I hereby revoke the authorization to release information that I provided to Colorado Coalition for the Homeless allowing CCH to use and disclose my Protected Health Information as outlined on the authorization form, which I signed on _____. I understand that this revocation does not apply to any action Colorado Coalition for the Homeless has taken in reliance on any authorization I signed earlier.

This revocation does not revoke any and all previous authorizations to release information that I have provided to Colorado Coalition for the Homeless.

Client's signature: _____

Date: _____



COLORADO

Bureau of Investigation

Department of Public Safety

BIOMETRIC IDENTIFICATION AND RECORDS UNIT | 690 Kipling Street, Suite 3000 | Denver, CO 80215 |

(303) 239-4208 | cdps.cbi.biru.dis@state.co.us | www.cbi.colorado.gov

Public Request for Criminal History Record Information

Please type or print clearly | Reply will be mailed in 3-5 business days

Please call (303) 239-4208 with any inquiries. Discrepancies must be reported within 30 days.

NAME TO BE CHECKED

Last Name: _____

First Name: _____ Middle Name: _____

Date of Birth (required):

Gender (optional):

Social Security Number:

Male

Female

MM/DD/YYYY

Other: _____

###-##-####

SEND REPLY TO

Colorado Coalition for the Homeless - Fort Lyon

30999 County Road 15, LAS ANIMAS, CO. 81054

PH: (719) 662 - 1162

FAX: (719) 456 - 0109

PURPOSE FOR REQUEST

Public Request/General Inquiry

PLEASE READ AND SIGN BELOW

The record you may receive is for lawful use only and summarizes information sent to the Colorado Bureau of Investigation from fingerprint contributors in the state of Colorado. Unless fingerprints accompany your inquiry, the Colorado Bureau of Investigation cannot guarantee this record relates to the person in whom you have an interest. If the disposition is not shown, or further explanation of an arrest charge or disposition is desired, that information may be obtained from the agency who furnished the arrest information. Only the court of jurisdiction or the respective District Attorney's office wherein the final disposition occurred can provide an official copy to any specific disposition. State law governs access to sealed records. Because additions and deletions to a criminal history record may be made at any given time, a new inquiry should be requested when needed for subsequent use. Any report received from the Colorado Bureau of Investigation as the result of this inquiry shall not be used for the direct solicitation of business for pecuniary (monetary) gain.

X

Signature of Requesting Party (required per State law)

Drug Abuse Screening Test (DAST-10)

General Instructions

“Drug use” refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Date of Assessment: _____

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. **Have you used drugs other than those required for medical reasons?**

No Yes

2. **Do you use more than one drug at a time?**

No Yes

3. **Are you always able to stop using drugs when you want to?**

No Yes

4. **Have you had “blackouts” or “flashbacks” as a result of drug use?**

No Yes

5. **Do you ever feel bad or guilty about your drug use?**

No Yes

6. **Does your spouse (or parents) ever complain about your involvement with drugs?**

No Yes

7. **Have you neglected your family because of your use of drugs?**

No Yes

8. **Have you engaged in illegal activities in order to obtain drugs?**

No Yes

9. **Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?**

No Yes

10. **Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?**

No Yes

Comments: _____

Scoring

Score 1 point for each question answered “Yes”, except for question 3 for which a “No” receives 1 point.

DAST Score: _____

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?

(0) Never {Skip to Qs 9-10}
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

3. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

4. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Skip to Questions 9 and 10 if Total Score of Questions 2 and 3 =0

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

9. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Record total score here: _____

Fort Lyon Residential Community

BIOPSYCHOSOCIAL ASSESSMENT

Patient Name:

Date of Birth:

Today's Date:

Please complete this form in its entirety.

Presenting Problem

1. Please describe what brings you in today?
2. How long have you been experiencing this problem?
3. Rate the intensity of this problem (1 being mild and 5 being most severe)
4. How is the problem interfering with your daily functioning?
5. What are your current goals for therapy / treatment?

6. If treatment was successful, how would your life be different?

Current Symptoms

7. Are you currently experiencing any of the following symptoms now or in the last 30 days? (Please check all that apply)

- | | | | |
|--|---|--|--------------------------|
| <input type="checkbox"/> <i>Angry / Irritable</i> | <input type="checkbox"/> <i>Have Special Powers</i> | <input type="checkbox"/> <i>Reoccurring Nightmares</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Anxiety</i> | <input type="checkbox"/> <i>Hearing Things</i> | <input type="checkbox"/> <i>Sadness</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Avoidance</i> | <input type="checkbox"/> <i>Helpless</i> | <input type="checkbox"/> <i>Seeinig Things</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Can't Be in Crowds</i> | <input type="checkbox"/> <i>Hopeless</i> | <input type="checkbox"/> <i>Self-Esteem Problems</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Can't Concentrate</i> | <input type="checkbox"/> <i>Impulsive</i> | <input type="checkbox"/> <i>Self-Harm</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Depression</i> | <input type="checkbox"/> <i>No Motivation</i> | <input type="checkbox"/> <i>Sleep Changes</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Easily Startled</i> | <input type="checkbox"/> <i>Not Hungry</i> | <input type="checkbox"/> <i>Sleep Too Little</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Fatigue / No Energy</i> | <input type="checkbox"/> <i>No Need for Sleep</i> | <input type="checkbox"/> <i>Sleep Too Much</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Feeling Nervous</i> | <input type="checkbox"/> <i>Panic Attacks</i> | <input type="checkbox"/> <i>Stress</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Feeling Worthless</i> | <input type="checkbox"/> <i>People Out to Get Me</i> | <input type="checkbox"/> <i>Substance Use</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Fearful</i> | <input type="checkbox"/> <i>People Watching Me</i> | <input type="checkbox"/> <i>Suicidal Thoughts</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Food or Eating Changes</i> | <input type="checkbox"/> <i>Poor Memory</i> | <input type="checkbox"/> <i>Suspicious</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Grief and Loss</i> | <input type="checkbox"/> <i>Prefer Being Alone</i> | <input type="checkbox"/> <i>Talk Too Fast</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Guilt</i> | <input type="checkbox"/> <i>Relationship Problems</i> | <input type="checkbox"/> <i>Thoughts of Dying</i> | <input type="checkbox"/> |
| <input type="checkbox"/> <i>Lack of Interest</i> | <input type="checkbox"/> <i>Restless</i> | <input type="checkbox"/> <i>Too Much</i> | <input type="checkbox"/> |

8. Do you now or have you ever contemplated committing suicide? Yes No N/A

9. Are you a survivor of trauma? Yes No N/A

10. Are you pregnant now? Yes No N/A
11. If yes, when are you expecting?
12. Are you at risk for HIV/AIDS/Sexually Transmitted Diseases? (Unsafe Sex / Using Needles?) Yes No N/A
13. Please list all of your allergies to foods or medications

14. Has your physical health prevented you from participating in activities? Yes No N/A

Substance Use

15. Have you ever used any form of tobacco, such as cigarettes, snuff, chewing tobacco, etc.) Yes No N/A
16. Are you a former tobacco user? Yes No N/A

If yes, what form(s) of tobacco have you used in the past? (Please check all that apply)

- Cigarettes Pipes Cigars Chewing Tobacco
- Snuff Other

17. Have you been in a program to help you quit using tobacco in the last 30 days? Yes No N/A

Substance Use / Addiction Present

18. Would you or someone you know say you are having a problem with alcohol use / addiction? Yes No N/A
19. Would you or someone you know say you are having a problem with pills or illegal drugs? Yes No N/A
20. Would you or someone you know say you are having problems with other addictions, like gambling, pornography, or shopping? Yes No N/A
21. Have you ever been to a self-help group? Yes No N/A

Substance Use / Addiction Past

22. Would you or someone you know say you had a problem with alcohol use or addiction? Yes No N/A
23. Would you or someone you know say you had a problem with pills or illegal drugs? Yes No N/A
24. Would you or someone you know say you had problems with other addictions, like gambling, pornography, or shopping? Yes No N/A
25. Is there a history in your family of addiction Yes No N/A
26. If yes, please describe in more detail:

Personal, Family, and Relationships

27. Have you ever been arrested? Yes No N/A

28. If yes, did you serve time in prison or a corrections facility? Yes No N/A

29. Please list out your family members (parents, children, brothers, sisters, etc.)

30. Does anyone in your family have a history of mental health disorders? Please describe: Yes No N/A

31. Has a significant person or family member entered into your life or left your life in the last 90 days? Yes No N/A

32. How are the relationships with your family members? Please describe:

33. How are the relationships in your support circle (friends, extended family, etc.)? Please describe:

34. Have there been any problems with your family in the past (abuse, conflicts, stress, loss, etc.)? Please describe:

35. Are there any problems with your family now (abuse, conflicts, stress, loss, etc.)? Please describe:

36. Have there been any problems with your support circle in the past? Please describe:

37. Are there any problems with your support circle now? Please describe:

38. What is your marital status now? (Please check all that apply)

Single Married In a Relationship Widowed

Divorced

39. Have you ever had problems in your marriage or relationships? Yes No N/A

40. If yes, please check a reason why:

Abuse Conflict Loss Divorce/Seperated

Trust Issues Infidelity/Cheating Other

41. Do you have any close friends? Yes No N/A

42. Do you have problems being in friendships? Yes No N/A

43. Do you get along well with others (neighbors, co-workers, people around you, etc.)? Yes No N/A

44. What do you like to do for fun / in your spare time? Please explain:

Education

45. Please check the highest level you completed in school:

- No Education* *K - 5th* *6th - 8th* *9th - 12th*
 GED *College Degree* *Masters Degree* *Advanced Degree*

46. Would you describe your schooling experience as a positive? Yes No N/A

47. Are you currently in school or in a training program? Yes No N/A

Work

48. What is your work history like?

- Good* *Poor* *Sporadic* *Other*

49. How long do you usually stay in your job?

- Weeks* *Months* *About a Year* *Longer than 1 year*

50. Are you retired from working? Yes No N/A

51. If yes, what kind of work did you do before you retired?

52. Do you feel financially secure? Yes No N/A

53. Have you ever served in the military? Yes No N/A

54. If yes, what is your status?

- Active* *Reserves* *Retired* *Other*

Medical

55. Who is your current Primary Care Physician?

Phone Number:

56. Past Medical/Surgical Problems:

57. Are you experiencing any medical problems now? Please explain: Yes No N/A

58. Past Medications and Dosages:

59. Are you taking any medications currently and what are the dosages for each? Yes No N/A

60. Have you ever been to a mental health professional before? Yes No N/A

61. If yes, Who: When: Reason for Changing:

62. Current APRN/Psychiatrist, if applicable:

63. Is there anything else you'd like to share with me?

Medical Approval Information

Patient Name: _____ DOB: _____ Date Of Clearance Evaluation: _____

Allergies. Please include any food allergies/ restrictions	Current Medication List:
Current Medical/Psychiatric Problem List:	
Please fill out or attach current treatment information. Treatment Plan:	Medication Directions:

By signing below, I acknowledge the patient is currently medically approved to enter the Fort Lyon Residential Supportive Community and information provided above is correct.

Print Name & Medical Credential: _____

Signature: _____ Date: _____

In addition to this Medical Clearance Form, please fax a copy of your most recent Tuberculosis (TB) test results (ideally done within 30 days of program entry) to 719-456-0109.

For more information, please call (719) 662-1162, or visit our website <https://www.coloradocoalition.org/fortlyonreferral>

Medical Resource and Treatment Information for Fort Lyon

Fort Lyon is located in Bent County in SE Colorado. It is a rural area and medical resources are limited. There are some specialists available within 40 miles of Fort Lyon, but a majority are in Pueblo or Colorado Springs. These locations are over 100 miles away, and may only see patients 1-2 days per week, or even 1-2 days per month. Transportation is limited if you need to see a specialist.

This is to inform you that if you have a need to see a specialist, the services may not be available to you, please consider this prior to submitting your application.

- If you have any pending surgeries complete them PRIOR to entering program.
- If you plan to enter into treatment for Hepatitis C, Cancer, or other long-term treatment with a specialist you need to complete your treatment PRIOR to coming to Fort Lyon.
- Primary care and behavioral health providers are available in the area such as the Fort Lyon Health Center (on campus), Valley Wide Health Systems, and South East Health Group.

Assistance for your initial visit will be provided when you enter the program. Dental and Vision appointments are also available after you have been in the program for 90 Days.

I have read and acknowledge the information above.

Print Client's Name

Client's Signature and Date

Print Referral Source's Name

Referral Source's Signature

Personal Property

1. At admission, Ft. Lyon will only transport 40 pounds of property in one bag per resident. You are also allowed one small purse/bag on your lap.
2. Residents are responsible for the security of their personal belongings during their stay at Fort Lyon.
3. Residents are expected to take all personal belongings with them upon their departure from the campus on or before their discharge date. Ft. Lyon will transport up to 60 pounds of property. If resident is unable to take all property with them:
 - i. The inventory will be placed in storage for no more than 30 days.
 - ii. It is the resident's responsibility to collect inventory within 30 days; and
 - iii. After 30 days, the items will be recycled into the community via the warehouse.

I acknowledge my understanding of the policy above.

Resident Printed Name

Resident Signature

Date

Referral Source Signature

Date

Fort Lyon Benefits Program Eligibility Notice

As a participant in the program at Fort Lyon, there are benefits that you are and are not eligible for. Please note any/all programs that affect you and initial each line:

___ SSDI/SSI payments are not affected and residents receive full benefits.

___ VA disability payments are not affected, and residents receive full benefits.

___ Medicaid and Medicare are not affected.

___ OAP payments are subject to state exemption criteria and may be reduced to \$79/month.

___ AND payments are subject to state exemption criteria and may be reduced to \$79/month.

___ Food assistance program (SNAP) is not available for residents of Fort Lyon living in the dorms. Special diets are not considered as a part of DHS eligibility for food assistance.

I have read this notice and acknowledge the information regarding benefits.

Name

Date

*State benefits will remain in the county where you are currently receiving them. You will need to do a change of **mailing address**, with DHS, leaving your residential address in the county they are currently in.

Social Security (retirement/SSI/SSDI) requires address change to new address.

Your new mailing address will be:

Fort Lyon: (Name) 30999 County Road 15, Las Animas, CO 81054

We will help make that change when you arrive.