

The New Participant F/EA Referral Form should only be used when a participant is re-enrolling, transferring from “Options” to waiver, and/or when the PPL Web Portal is down for maintenance or temporarily unavailable.

REFERRING AGENCY

Date:	Service Coordinator:	Phone:
Agency:	Service Coordinator Supervisor:	Alternate Phone:
Email address:		Fax #:
Program:	<input type="checkbox"/> OBRA Waiver <input type="checkbox"/> Attendant Care Waiver <input type="checkbox"/> Aging Waiver <input type="checkbox"/> Act 150 Waiver <input type="checkbox"/> CommCare Waiver <input type="checkbox"/> Independence Waiver	
Referral Type: <input type="checkbox"/> New <input type="checkbox"/> Options Transfer: <i>(Please Provide Options F/EA)</i> _____ <input type="checkbox"/> Re-Enrolled: <i>(For participant's returning to the Participant Directed Models of Service Program)</i>		

NEW PARTICIPANT INFORMATION

Last Name:	First Name:	Medicaid ID (10 Digit) #:
SS Number:	Date of Birth:	Gender:
ICD-10 Code:		
Physical Address:		
City:	State:	Zip:
County of Residence:		
Mailing Address <i>(if different from Physical Address above)</i> :		
City:	State:	Zip:
Primary Language:		
Phone:	Alternate Phone:	Email Address:
Emergency Contact Name:		Emergency Contact Phone:
Emergency Contact Address:		Relationship to participant:

COMMON LAW EMPLOYER INFORMATION, IF OTHER THAN PARTICIPANT

Last Name:	First Name:	SS Number:
Physical Address:		
City:	State:	Zip:
Relationship to participant:		
Phone:	Alternate Phone:	Email address:

SUBMIT FORM: Fax completed form to: **855-858-8158** or e-mail form to: padpw-oldt@pcgus.com.
 If you have any questions please call PPL Customer Service: 877-908-1750.