pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM LIVING

# New Participant F/EA Referral Form

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 BetterOnline™ Web Portal is down for maintenance or temporarily unavailable.

| Referring Agency | | |
|---|---|---|
| Date: | Service Coordinator: | Phone Number: |
| Agency/MCO: | Service Coordinator Supervisor: | Alternate Phone Number: |
| Email Address: | | Fax Number: |

Program:
☐ OBRA Waiver ☐ Attendant Care Waiver ☐ Aging Waiver
☐ Act 150 Waiver ☐ CHC ☐ Independence Waiver

Referral Type:
☐ New
☐ Options Transfer (Provide Options F/EA) _____
☐ Re-Enrolled (For participant's returning to the Participant Directed Models of Service Program)

| New Participant Information | | | | |
|---|---|---|---|---|
| Last Name: | First Name: | | | Medicaid ID (10-digit) #: |
| Social Security Number: | Date of Birth: | Gender: | | ICD-10 Code: |
| Physical Address: | City: | State: | Zip Code: | County of Residence: |
| Mailing Address *(if different)*: | City: | State: | Zip Code: | Primary Language: |
| Phone Number: | Alternate Phone Number: | | Email Address: | |
| Emergency Contact Name: | | Emergency Contact Phone Number: | | |
| Emergency Contact Address: | | | Relationship to Participant: | |

| Common Law Employer Information *(if different from participant)* | | | | |
|---|---|---|---|---|
| Last Name: | First Name: | | | Social Security Number: |
| Physical Address: | City: | State: | Zip Code: | Relationship to Participant: |
| Phone Number: | Alternate Phone Number: | | Email Address: | |

**Fax completed form to: 1-855-858-8158 or email form to: padpw-oltl@pplfirst.com.**

If you have any questions please call Public Partnerships customer service: 1-877-908-1750.