CONSUMER REFERRAL FORM

This form is used to inform Public Partnerships LLC (PPL) that an individual receiving services (Consumer) has chosen to self-direct their services. The details from this form are used to:

- Start the enrollment process through PPL, or
- When the Case Manager, Consumer, or Employer has a change to their details.

Referral Type:

☐ New Consumer Referral ☐ Change of Consumer Details ☐ Change in Service/Rate(s)

☐ New Employer ☐ Change in Employer Details

Program Details

Program ID Number:

Managed care entity (MCE) - (Check one box only):

☐ Anthem ☐ Humana ☐ United Healthcare ☐ FSSA

Service Name	Service Code

Region:

Case Manager Details

First Name: **Last Name:**

Phone Number: **Phone Ext.:** **Email:**

Consumer Name

First: **Middle:** **Last:**

Maiden or Previous:

Consumer Address (where you live)

Street Address (no PO Box):

Street Address 2 (APT., STE., etc.):

City:

State:

Zip Code:

County:

☐ **Select if the address where you live is the same as your mailing address.**

If not, complete the Mailing Address section below.

Address:

Address 2 (APT., STE., etc.):

City:

State:

Zip Code:

Consumer Personal Details

Date of Birth:

Social Security Number:

Gender:

☐ Male ☐ Female ☐ Unspecified or Another Gender Identity ☐ Undisclosed

Does Consumer have an existing EIN?

☐ Yes ☐ No

Existing EIN:

Consumer Contact Details

We need to have a way of reaching you. Please provide:

Email:

Cell Phone:

Home or Other Phone:

Public Partnerships can text me. They may text me at the cell phone number above. ☐ Yes ☐ No
I understand that carrier charges may apply.

Employer Details

☐ **Select if the Consumer is also the Employer.**

If the Employer is not the Consumer, complete the Employer section below.

Employer Name

First:

Middle:

Last:

Employer Address (where they live)

Street Address (no PO Box):

Street Address 2 (APT., STE., etc.):

City:

State:

Zip Code:

County:

☐ **Select if the physical address is the same as the mailing address.**

If the physical address is not the same as the mailing address, complete the Mailing Address section below.

Address:

Address 2 (APT., STE., etc.):

City:

State:

Zip Code:

Employer Personal Details

Date of Birth:

Social Security Number:

Gender:

☐ Male ☐ Female ☐ Unspecified or Another Gender Identity ☐ Undisclosed

Does the Employer have an existing EIN?

☐ Yes ☐ No

Existing EIN:

Relationship to Consumer:

☐ Spouse ☐ Parent or Step-parent ☐ Child ☐ Sibling ☐ Grandparent

☐ Grandchild ☐ Legal Guardian or Power of Attorney* ☐ Non-relative ☐ Friend

☐ Other

*If the Employer is the legal guardian or power of attorney, please provide with this Consumer Referral Form the legal documents for the role of legal guardian or power of attorney.

Employer Contact Details

It is important to be able to reach you. Please fill in the below.

Email:

Cell Phone:

Home or Other Phone:

Public Partnerships can text me. They may text me at the cell phone number above. ☐ Yes ☐ No
I understand that carrier charges may apply.

Contact Preferences

Provide the best contact information for the primary point of contact.

Who is the primary contact? ☐ Consumer ☐ Employer ☐ Representative

Primary Language: ☐ English ☐ Spanish ☐ Other:

Best Time to Contact:

Other Contact Details:

Special Accommodations:

☐ Language Translator ☐ Partially sighted ☐ Braille ☐ Hearing impaired/Deaf

☐ No accommodations needed ☐ Other:

Agree and Sign

I confirm:

- I have read all of this form.
- The details provided are accurate and complete.

Referring Party Signature:

Date: