MEMBER REFERRAL

This form is used to tell Public Partnerships LLC (PPL) when a Member has chosen to self-direct their services. The details from this form will be used to start the enrollment process with PPL.

This form can be used to tell PPL when a Member has a change to their details. This includes address(es), employer, authorized representative, and program enrollment status.

Referral Type:

☐ New Member Referral ☐ New Authorized Representative ☐ New Employer
☐ Change of Member Details ☐ Change of Authorized Rep Details ☐ Change of Employer Details
☐ Change in Service/Rate(s) ☐ Service Hold
☐ Member Disenrollment Disenrollment Date: ____________________
Reason for Disenrollment: ____

Member Name

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

Maiden or Previous: ____________

Member 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 mailing address.**
If not, complete the Mailing Address section below.

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

City: ____________ **State:** ____________ **Zip Code:** ____________

Member Personal Details

Date of Birth: ____________ **Social Security Number:** ____________ **Gender:** ☐ Male ☐ Female ☐ Prefer not to disclose

Member Contact Details

We need to have 2 ways of reaching you. Email is preferred.

Email:

Cell Phone:

Home or Other Phone:

Program Details

Medicaid ID Number:

Employer Details

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

If the Employer is not the Member, complete the 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 physical address is the same as mailing address.**

If not, complete 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 ☐ Prefer not to disclose

Does Employer have an existing EIN?

☐ Yes ☐ No

Relationship to Member:

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

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

*If the employer is the legal guardian/power of attorney for the Member, please submit appropriate documentation along with this Member Referral form.

Employer Contact Information

We need to have 2 ways of reaching you. Email is preferred.

Email:

Cell Phone: **Home or Other Phone:**

Authorized Representative (AR) Details (Optional)

☐ **Select if designating a representative. Complete the section below.**

AR Name

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

Maiden or Previous Last:

AR Mailing Address

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

City: **State:** **Zip Code:**

AR Personal Details

Date of Birth: **Social Security Number:**

Gender: ☐ Male ☐ Female ☐ Prefer not to disclose

Relationship to Member:

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

☐ Grandchild ☐ Legal Guardian/Power of Attorney ☐ Non-relative ☐ Friend ☐ Other

AR Contact Details

We need to have 2 ways of reaching you. Email is preferred.

Email:

Cell Phone: **Home or Other Phone:**

Contact Preferences

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

Who is the primary contact? ☐ Member ☐ 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:

Service Hold

If the Member has been admitted into a hospital, nursing facility, etc., please give the reason for the gap in services and provide the start and end dates for the hold.

Hold Start Date:

Pay Attendant for this date? ☐ Yes ☐ No

Hold End Date:

Pay Attendant for this date? ☐ Yes ☐ No

Reason:

Member Disenrollment

Effective Date:

Select one voluntary or involuntary reason:

Voluntary:

☐ Deceased ☐ Switched to Agency Model

☐ Entered Facility ☐ No Longer Waiver Eligible

Involuntary:

☐ Consistent Non-Adherence to Program Policy

☐ Health and Safety Concern

☐ Other (give details below)

Further details:

Case Manager Details

First Name:

Last Name:

Phone Number:

Phone Ext.:

Email:

Agree and Sign

I confirm:

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

Referring Party Signature:

Date: