P P Home Services, LLC

Medicaid Waiver Referral Form

Client Information			
Last Name	First Name	Middle Initial	Today's Date
Address	City, State	Zip Code	County

Living Arrangement: _____ Independent _____ w/Family Member _____ w/Roommate Diagnosis:	DOB
Legal Status: _____Minor _____ Emancipated Adult _____ Has Legal Guardian If Client has a Legal Guardian-Please provide name and phone number below Name ____ Phone ________________ Address ____	Gender: Male_____ Female_____ SS # (Last 4 digits)
Current Waiver Information: Is there an existing NOA? ___Yes ___No NOA Annual Date ____________________ NOA Approval Date ______________________ Services Needed: _____ RHS _____ RATT _____ FCAR _____ ATTC _____ Other ____________ **Staffing Needs:** **Names of Potential Staff:** _____ Has Current Staff ____ _____ Needs Staff	Medicaid ID # Medicare ID #` Type of Waiver
How did you hear about us?	

Primary Contact Information	
Primary Contact First and Last Name	Primary Contact Phone Number
Primary Contact Address	Alternate Phone Number
Primary Contact City, State, Zip Code	Email Address
Relationship to Client (ie: Father, Brother, Cousin, etc.)	

Case Manager Information	
Case Manager First & Last Name	Case Manager Phone Number
Case Manager Agency and Address	Case Manager Alternate Phone Number
	Case Manager Email Address

Office Use Only		
Date Referral Received:	Initial Contact with Client	Date of Initial Meeting with Client
Results of Meeting		
Concerns		
Anticipated Start Date with P & P Home Services, LLC		