Phone: 1-866-264-2296
TTY: 1-800-360-5899
Paperwork E-mail: inpplfax@pcgus.com
Paperwork Fax: 1-866-799-9381
Website: www.publicpartnerships.com

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Indiana FSSA Self-Directed Services Referral Form

Instructions to the Care Manager: *To initiate your client's enrollment process, Public Partnerships (PPL) needs to first receive a Referral Form providing basic demographic information about your client. This information is used to generate your client's Employer Enrollment Packet. Your client may select an Authorized Representative, usually a family member, to represent them. Please complete the one-page form below and return it to PPL.*

SERVICE RECIPIENT INFORMATION			
First Name:	**Mid Initial:**	**Last Name:**	**Medicaid ID:**
Gender: ☐ **Male** ☐ **Female**	**Date of Birth:**	**SSN:**	**District:**
PHYSICAL Address (P.O. Box not permitted):		**MAILING Address:**	
Phone Number (and type):	**Alternate Phone Number (and type):**		**E-mail Address:**
AUTHORIZED REPRESENTATIVE INFORMATION			
First Name:	**Last Name:**	**Date of Birth:**	**SSN:**
Phone Number (and type):		**E-mail Address:**	
PHYSICAL Address (P.O. Box not permitted):		**Relationship to Service Recipient:**	
Will the Authorized Representative be serving as the Employer of Record (EoR)? ☐ **Yes** ☐ **No**			
CARE MANAGER INFORMATION			
Care Manager Name:	**Care Manager Phone Number:**	**Care Manager E-mail:**	
Care Manager Address:		**Care Manager Agency:**	

Please fax, email or mail this form to:

MAIL
Public Partnerships
Attn: IN FSSA
7776 S Pointe Pkwy W, Suite 150
Phoenix, AZ 85044

EMAIL
inpplfax@pcgus.com

FAX
1-866-799-9381