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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: <input type="checkbox"/> Male <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
CARE MANAGER INFORMATION			
Care Manager Name:	Care Manager Phone Number:	Care Manager E-mail:	
Care Manager Address:		Care Manager Agency:	

Please fax or mail this form to:

Public Partnerships, LLC
 Attn: IN FSSA
 7776 S. Pointe Pkwy, Ste. 150
 Phoenix, AZ 85044

1-866-799-9381