

For residents applying for Long Term Care. Please submit this form so the Pennsylvania Independent Enrollment Broker (PA IEB) can provide plan choice counseling. Please provide as much information as possible.

**Participant information**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Social Security Number: XXX-XX-\_\_\_\_\_  
Medicaid ID number: \_\_\_\_\_ Email address: \_\_\_\_\_  
Current address (street, city, state, ZIP Code): \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

What is the best way to contact the participant?

Email  Home phone  Cell phone  Mail  Onsite visit

**Authorized representative**

If the person applying chose someone who will speak with the PA IEB for them, fill in the information below:

Name of authorized representative: \_\_\_\_\_  
Address (street, city, state, ZIP Code): \_\_\_\_\_  
Phone: \_\_\_\_\_  
Type of authorized representative (check one):  
 Power of attorney  Community spouse  Other \_\_\_\_\_

**Nursing facility staff person**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_  
Name of nursing facility: \_\_\_\_\_  
Address (street, city, state, ZIP Code): \_\_\_\_\_  
Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

Name of person completing form: \_\_\_\_\_ Title: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Fill out this PDF and print it. Or print the blank form and fill it out by hand.  
Send this form by mail, fax or email. If you have questions, call us at  
**1-877-550-4227** (TTY: 1-877-824-9346). The call is free.



P.O. Box 61560  
Harrisburg, PA 17106



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(TTY: 1-877-824-9346)



Send a fax to  
1-888-349-0264



Email us at  
paieb@maximus.com