

### Referral Guidelines

1. To refer an individual, please complete this form and return it to Pennsylvania Independent Enrollment Broker (PA IEB) via **fax** or **secure email**.
2. To initiate a secure email exchange, please email [PAIEB@maximus.com](mailto:PAIEB@maximus.com) to indicate you have a document containing Protected Health Information (PHI) or Personally Identifiable Information (PII) that you would like to send via email. PA IEB will return your email and initiate a secure email portal.
3. If a document containing Protected Health Information (PHI) or Personally Identifiable Information (PII) is sent to PA IEB in a method that is not secure then the document will not be opened.
4. After the referral is received the individual will be contacted via phone within 1-3 business days. PA IEB may use an automated dialer to make contact with these individuals. Please note that an application will not begin until the individual expresses to IEB staff interest in applying and the individual has Medical Assistance or completes and returns an application for financial eligibility for Long Term Services to PA IEB.
5. **If "Referral Made By" section below is completed by the Area Agency on Aging then application is started & applicant is not called to confirm interest in applying for waiver services.**

### Applicant Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Recipient ID No: \_\_\_\_\_ Phone No: \_\_\_\_\_  
(Medicaid Recipients Only)  
Alternate Phone: \_\_\_\_\_ Street Address: \_\_\_\_\_  
Email Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Sec #: \_\_\_\_\_

Please correspond with the additional contact(s) below to begin process, rather than the applicant.

*Note: Applicant or legal representative must sign consent below*

### Additional Contacts (Add another page, if needed)

Contact Name or Entity: _____ Contact Type (Family, POA, AAA, Social Worker): _____ Phone Number: _____ <i>Signature of applicant authorizing sharing of information with this contact:</i> _____	Contact Name or Entity: _____ Contact Type (Family, POA, AAA, Social Worker): _____ Phone Number: _____ <i>Signature of applicant authorizing sharing of information with this contact:</i> _____
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**Referral Made By:** \_\_\_\_\_ **Date of Referral:** \_\_\_\_\_

Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_

Above staff has confirmed that the referral has requested that an application be initiated on their behalf.

### Physician Information

Physician Name: \_\_\_\_\_ Physician Address: \_\_\_\_\_  
Physician Phone: \_\_\_\_\_ Street Address: \_\_\_\_\_  
Physician Fax No: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

### Nursing Home Transition Program

NHT Coordinator: \_\_\_\_\_ Agency: \_\_\_\_\_

### Area Agency on Aging Use Only

Case Indicator: \_\_\_\_\_  
PA600L Included:



P.O. Box 61560  
Harrisburg, PA 17106



Call us toll free at  
1-877-550-4227



Send a fax to  
1-888-349-0264



Email us at  
[paieb@maximus.com](mailto:paieb@maximus.com)