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 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 is completed by the Area Agency on Aging or by a LIFE provider, then the application is started. The applicant is not called to confirm interest in applying for waiver and / or LIFE program services.

Area Agency on Aging Use Only

Case indicator:

PA600L included *(check box to confirm)*: ☐

Mail to:
P.O. Box 61560, Harrisburg, PA 17106

Call toll-free:
1-877-550-4227

FAX to:
1-888-349-0264

Email to:
PAIEB@maximus.com

Applicant Information

Name *(first, middle, last)*:

Recipient ID Number *(Medicaid recipients only)*:

Date of birth *(mm/dd/yyyy)*:

Social Security Number:

Street address:

City: | State: | Zip Code:

Email address:

Phone number:

Alternate phone:

▶ 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:

Signature of applicant authorizing sharing of information with this contact:

Contact name or entity:

Contact type: ☐ Family ☐ POA ☐ AAA ☐ Social Worker

Phone number:

Signature of applicant authorizing sharing of information with this contact:

Referral Made By

Name:

Agency:

Date of referral *(mm/dd/yyyy)*:

Phone number:

Email address:

Signature:

☐ Above staff has confirmed that the referral has requested that an application be initiated on their behalf. *(Check box to confirm.)*

Physician Information

Physician name:

Physician street address:

City: | State: | Zip Code:

Phone number:

Fax number:

Nursing Home Transition Program

NHT Coordinator:

Agency: