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 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:	
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: 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