Acumen Fiscal Agent
Innovation • Opportunity • Freedom

PARTICIPANT/CLIENT REFERRAL FORM – NEW TO SELF DIRECTION

Requested start date for services: _____

Client/Participant Information

Participant/Client Name	
Medicaid Number	
Date of Birth	
Social Security Number	
Language	
Home Address	
Mailing Address (if different)	
Home Phone Number	
Cell Phone Number	
Email	

Employer Information

(Fill out if the Employer is a different individual then client)(Employer's are responsible for payroll, employee hiring/termination, administrative duties.)

Employer Name	
Social Security Number	
Date of Birth	
Home Address	
Mailing Address (if different)	
Phone Number	
Email	

Legal Guardian/Parent/Authorized Representative Information

(if different individual than the employer)

Name	
Relationship to Client	
Date of Birth	
Home Address	
Mailing Address (if different)	
Phone Number	
Email	

Case Worker Information

Case Worker Name	
Case Worker Agency	
Case Worker Email	
Case Worker Phone Number	

Acumen Fiscal Agent
Innovation • Opportunity • Freedom

PARTICIPANT REFERRAL FORM – NEW TO SELF DIRECTION

Projected Plan of Care Date Range: From: _____ To: _____

Service	Authorized Weekly Units
S5135 – Personal Care Service	
S5150 - Respite	
T2027 – Personal Care Service	
T1019 – Pediatric Nurse Aid	
T1004 – Pediatric Nurse Aid Respite	
T1000 – RN/LPN	
T1005 – RN/LPN Respite	
S9122 TF – Congregate Care Personal Care Service	
S9122 TG – Congregate Care Pediatric Nurse Aid	

Notes/Comments:

_____

_____

_____

_____

FEA NPI 1578971214

I understand that this form functions as a pre-authorization for services and authorizes my FMS to conduct the Participant/Enrollment meeting. My FMS will provide a drafted budget which will be confirmed once the enrollment meeting is completed.

_____ _____

Case Worker Signature Date

Return form to CaseWorker@OutreachFiscalAgent.com