Acumen Fiscal Agent
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PARTICIPANT/CLIENT REFERRAL FORM – EMPLOYER SWITCH

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	

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

SERVICES	AUTHORIZED WEEKLY UNITS
CAP DA	
S5135 - Personal Care Services	
S5150 - Personal Aide Respite	
T2040 – Fiscal Management Services Fee	
CAP C	
T2027 - Personal Care	
S5125 - Personal Care Aide	
T1019 - Pediatric Nurse Aide	
T1004 - Pediatric Nurse Aide Respite	
T2026 - RN/LPN Care	
T1005 - RN/LPN respite	
S9122 TF - Congregate Personal Care Services	
S9122 TG - Congregate Pediatric Nurse Aide Services	
T1019 – In-Home Aide II	
T1004 Respite In-Home Aide II	
S5135 UN Congregate Care In-Home Aide II	
T2040 – Fiscal Management Services Fee	

Notes/Comments:

_____

_____

_____

_____

FEA NPI 1578971214

FEA Atypical 40461515

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.

I attest that by submitting this form I have confirmed that the new employer has completed the appropriate training and documentation to become the new employer. I have added the new employer to the plan of care.

_____ _____

Case Worker Signature Date

Return form to nccapagents@acumen2.net

Acumen Fiscal Agent, LLC
(877) 901-5827