gt independence

Participant Direction Referral Form

PDHPC **PDGS** **SD Transportation**

Name: ____

Phone 1: ____________________ Phone 2: ____________________

Email: ____________________ Language: ____________________

Address: ____

City: ____________________ State: ________ ZIP: ______________

County Board: ____________________ Region: ____________________

Gender: ____________ Date of Birth: ____________ SSN: ______________

DODD ID #: ______________________ Waiver: ____________________

Medicaid ID: ____________________

Representative Information (If Applicable)

Name: ____

Phone 1: ____________________ Phone 2: ____________________

Email: ______________________________

PD Provider/ SD Transportation Provider (If Applicable)

Name: ____

Primary Phone: ____________________ Phone Type: ____________________

Email Address: ____

Preferred Language: ____________________ Provider credentialed (Y/N): ____________

SSA & Authorization Information

SSA Name: ____

Estimated Authorization (hours per week or month, Dollars per month, etc.): ____________________

Phone: ____________________ Email: ____________________

Please submit this completed referral form to referral@gtindependence.com