

## 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: \_\_\_\_\_

### 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](mailto:referral@gtindependence.com)**