Personal Accounting Services, Inc.
Part of the AssuranceSD Family

PARTICIPANT REFERRAL FORM

Individual Requesting Enrollment Date: _____ / _____ / _____

Support Coordinator Name: _____

Agency: _____ Contact Number: _____

By submitting this form, you acknowledge understanding that Personal Accounting Services (PAS) will begin the participant/employer and employee enrollment process, including criminal background checks and obtaining worker's compensation policies. This is considered authorization to bill the sending agency for enrollment, criminal record checks and worker's compensation policies.

PARTICIPANT INFORMATION

Full Legal Name

First Name: _____ Middle Initial: ____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email Address: _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Medicaid ID: _____

Referral Type: ☐ New Referral ☐ Transfer ☐ Re-Enrollment

TRANSFER

Transfer From: _____

Existing EIN: _____ - _____ UIA Account Number: _____

REPRESENTATIVE / GUARDIAN

First Name: _____ Middle Initial: ____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email Address: _____

(continued on next page)

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PARTICIPANT REFERRAL FORM

AUTHORIZED SERVICES *(Please enter service codes and hours individually)*

	Service Code	Hours/Units per Week	Max Hourly Rate of Pay at Time of Referral
1			
2			
3			
4			
5			

Mileage: ☐ Yes ☐ No Mileage Unit Rate: _____

Worker 1

First Name: _____ Middle Initial: ____ Last Name: _____

☐ Full Time ☐ Part Time

Worker 2

First Name: _____ Middle Initial: ____ Last Name: _____

☐ Full Time ☐ Part Time

Requestor Signature: _____ Date: _____ / _____ / _____