GT Independence
New Referral Form

Person Served

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

Date of Birth: _____ Social Security Number: _____

Waiver Program: _____

Medicaid Identification Number: _____

The information below is for the:

☐ Employer of Record (If different than Person Served) ☐ Power of Attorney ☐ Guardian

☐ Representative

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

E-mail: _____

Care Manager

Name: _____

Lead Agency Name: _____

Phone: _____ Fax: _____

E-mail: _____

Date Referral Sent: _____

Authorized Services

Service Authorized: _____ Hours: _____

Service Authorized: _____ Hours: _____