**PERSONAL PREFERENCE CASH & COUNSELING PROGRAM**

***CONSUMER INQUIRY FORM***

**This form is a referral to the program and does not guarantee eligibility. Eligibility is determined on a case by case basis by the State Program Office. You will be notified by letter once this form has been received. After eligibility has been determined, you will be contacted by a representative from the Program. Please note, it may take up to 45 days from receipt of this form to be contacted with more information and an eligibility determination. Please do not call the office to check the status of your inquiry form before 45 days. Phone calls only serve to slow the process and will have no bearing on speeding up your enrollment.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Initial Last

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street Apt./floor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Language Spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the name & telephone number of the Home Care Agency that is currently providing you with personal care assistance services?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Name Telephone

Please check the HMO that covers your Medicaid benefits:

□ AmeriGroup □ Health First □ Wellcare

□ Horizon NJ Health □ United Healthcare

Please list someone we can contact in case we are unable to reach you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Telephone

***Please return this form to****:*

Division of Disability Services

Personal Preference Program

P.O. Box 705

Trenton, NJ 08625-0705

**OR**

*Fax to*: (609) 631-4366

-2-

**This page only needs to be completed if you are enrolled in one of the Medicaid Waivers listed below. If you are not enrolled in one of these Medicaid Waivers, please do not complete this page.**

Please indicate through which Medicaid Waiver you are receiving your Medicaid benefits:

□ Global Options for Long Term Care Waiver (GO)

□ Community Resources for People with Disabilities Waiver (CRPD)

□ Traumatic Brain Injury Waiver (TBI)

□ AIDS Community Care Alternative Program Waiver (ACCAP)

If you are enrolled in one of these Waiver Programs, you have a Waiver Case Manager who is responsible for overseeing all of your Medicaid services. You must tell your Waiver Case Manager that you want to enroll in the Personal Preference Program and they can help you complete the rest of this form. Please complete the information in the box below.

Name of Case Manager\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Management Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are enrolled in the **GO Waiver**, please complete the box below:

Which type of home care service are you receiving?

□ State Plan Medicaid PCA Services OR □ Home Based Supportive Care

If you are receiving Home-Based Supportive Care under the GO Waiver, please indicate the # of hours they are receiving\_\_\_\_\_\_/week.

If you are receiving Home Based Supportive Care, how many other services are you receiving under the GO Waiver? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are enrolled in the **CRPD**, **TBI** or **ACCAP Waivers**, you must also submit a copy of your Waiver “Plan of Care”, which indicates you have been approved to receive Medicaid PCA services as part of your Waiver services. You may contact your Waiver Case Manager and ask him/her to send this information to the address or fax listed below.

***Please return this form to:***

Division of Disability Services

Personal Preference Program

P.O. Box 705

Trenton, NJ 08625-0705

***OR***

*Fax to*: (609) 631-4366