pennsylvania
DEPARTMENT OF HUMAN SERVICES

Reverse Referral Form

Instructions

What is the Reverse Referral Form?

The Reverse Referral Form gives information to the local county assistance office (CAO) to help them determine if you may attend a program.

When would I use the Reverse Referral Form?

The Reverse Referral Form is completed if you are not currently attending a program but you are interested in their services.

How do I complete the Reverse Referral Form?

Please complete as much of the information as you know. If there is information you do not know, put “unknown” in the box. Please only fill out the Client Information, Provider Information, and the Signature block.

Client Information block

1. CLIENT NAME: Print your full name.
2. SOCIAL SECURITY NUMBER
3. REFERRAL REQUESTED: Put the name of the program you are interested in attending.
4. DATE OF BIRTH: Put your date of birth; use format MM/DD/YYYY (Ex. 10/12/1982).
5. RECEIVING: Check the box or boxes of what CAO benefits you are currently receiving.
6. CAO CASE RECORD: Put your case record number. This number is on documentation you get from your local CAO.

Provider Information block

1. PROGRAM NAME: Put the name of the program that you are interested in attending.
2. CONTACT NAME: Put the name of the contact person at the program you are interested in attending.
3. PHONE: Put the phone number for the person you listed in box 2.
4. FAX: Put the fax number of the program.

Signature block

Please sign your name and put today’s date. By signing, you are verifying that all information provided is correct. You are also allowing the CAO to give your referral decision to the provider listed above for a period of six months from the signature date.

What do I do with the completed Reverse Referral Form?

The completed Reverse Referral Form will be given to your local CAO to request consideration for the program. Authorized staff at the CAO will complete the CAO section of the form. They will determine who may attend the program and give the results to you and the provider you listed.

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Client Information

1. CLIENT NAME:	2. SOCIAL SECURITY NUMBER:
3. REFERRAL REQUESTED:	4. DATE OF BIRTH:
5. RECEIVING (PLEASE CHECK ONE): ☐ TANF ☐ SNAP only	6. CAO CASE RECORD:

Provider Information

1. PROGRAM NAME:	
2. CONTACT NAME:	
3. PHONE:	4. FAX:

By signing this Reverse Referral Form, I agree that all information provided is true and correct and permit the program listed above to obtain the referral determination information requested, not to exceed a period of six (6) months following the date of my signature. Thank you for your cooperation.

CLIENT SIGNATURE DATE

THIS SECTION TO BE COMPLETED BY THE CAO TO VERIFY REFERRAL STATUS
(Please fax this form to the program listed above once the CAO makes a referral determination.)

PLEASE CHECK ONE:

☐ REFERRED ☐ NOT REFERRED

PLEASE PROVIDE A BRIEF SUMMARY OF REASON FOR DETERMINATION:

PRINT FIRST AND LAST NAME OF CAO STAFF TITLE DATE

CAO STAFF SIGNATURE PHONE NUMBER EMAIL ADDRESS