New Participant
FMS Referral Form

The new Participant F/EA Referral Form should only be used when a participant is re-enrolling and/or when the Tempus Self Service Portal is down for maintenance or temporarily unavailable.

Referring Agency

Date:	MCO:	Referral Submitted By (name):

Referral Agency:	Referral Submitted by Role: ☐ Service Coordinator ☐ Other: _____

Referred Email:	

Referral Phone Number:	Referral Alternate Phone Number:

Participant's Servicer Coordinator Name, Phone and Email (if different):

Referral Type:

☐ New

☐ Re-Enrolled (For participant's who were previously enrolled in the CHC Participant-Directed Services Program)

Does Common Law Employer have a previous Employer Identification Number (EIN)? ☐ Yes ☐ No

If Yes, EIN: _____ Last Date EIN Used: _____

Purpose of EIN: ☐ Participant-Directed Services ☐ Owned Business

Does Participant/CLE have a prospective Direct Care Worker to hire? ☐ Yes ☐ No

What is the estimated start date for Participant-Directed Services? _____

Participant Information

Last Name:	First Name:	Middle Initial:

Social Security Number:	Date of Birth:	Gender:

Medicaid ID (10-digit) #:	Primary Language:	County of Residence:

Tempus Unlimited, Inc. | 600 Technology Center Drive | Stoughton, MA 02072
Phone: 1-844-983-6787 | Fax to 1-833-583-6787 | Email: PAFMS@tempusunlimited.org

Participant Information

Physical Address:		
City:	**State:**	**Zip Code:**
Mailing Address (if different):		
City:	**State:**	**Zip Code:**
Mobile Phone Number:	**Home Phone Number:**	
Email Address:		
Emergency Contact Last Name:	**Emergency Contact First Name:**	**Relationship to Participant:**
Emergency Contact Address:		
Emergency Contact City:	**Emergency Contact State:**	**Emergency Contact Zip Code:**
Emergency Contact Email Address:		
Emergency Contact Mobile Phone Number:	**Emergency Contact Home Phone Number:**	

Common Law Employer Information *(if different from participant)*

Last Name:	**First Name:**	**Middle Initial:**
Social Security Number:	**Date of Birth:**	**Primary Language**
Physical Address:		
City:	**State:**	**Zip Code:**
Mailing Address (if different):		

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Common Law Employer Information *(if different from participant)*		
City:	**State:**	**Zip Code:**
Mobile Phone Number:	**Home Phone Number:**	
Email Address:	**Relationship to Participant:**	
Preferred Method of Contact: ☐ **Mobile Phone Number** ☐ **Home Phone Number** ☐ **Email Address**		

Designated Representative (OPTIONAL)		
Last Name:	**First Name:**	**Middle Initial:**
Social Security Number:	**Date of Birth:**	**Primary Language**
Physical Address:		
City:	**State:**	**Zip Code:**
Mailing Address (if different):		
City:	**State:**	**Zip Code:**
Mobile Phone Number:	**Home Phone Number:**	
Email Address:	**Relationship to Participant:**	

Fax completed form to: 1-833-5TEMPUS (1-833-583-6787) or
Email to: PAFMS@tempusunlimited.org

If you have any questions, please call Tempus Consumer Relations at 1-844-9TEMPUS (1-844-983-6787).

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