pennsylvania
DEPARTMENT OF HUMAN SERVICES

Reverse Referral Form

Client Information

1. CLIENT NAME:	2. SOCIAL SECURITY NUMBER:
3. CLIENT COUNTY OF RESIDENCE:	4. CLIENT PHONE:
5. REFERRAL REQUESTED BC3 KEYS PROGRAM	6. DATE OF BIRTH:
7. RECEIVING (PLEASE CHECK ONE): ☐ TANF ☐ SNAP only	8. CAO CASE RECORD:

Provider Information

1.PROGRAM NAME: KEYS PROGRAM	
2. CONTACT NAME: Karen Jack	
3. PHONE: 724-287-8711 X8458	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 _____