

COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN AND DISABLED ADULTS (CAP/C & CAP/DA) REFERRAL REQUEST

Write legibly and complete both pages of this form. **All fields are required.** NC Medicaid staff may contact you for additional information to assist in processing your referral request. Incomplete responses to the referral request may result in a delay in processing your request or a complete void of your referral request. Submission of this form does not guarantee enrollment into the CAP/C or CAP/DA waiver.

Fax completed forms to NC Medicaid at 919-715-0052.

APPLICANT INFORMATION

Service Requested: CAP/C CAP/DA **Date:** ___/___/_____

Applicant's First Name:		Applicant's Last Name:	
Applicant has Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> No		
Medicaid ID, if applicable:			
Social Security Number: (If Medicaid number is not listed above):			
Medicare ID, if applicable			
Date of Birth: / /	Age:		
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Primary contact for this applicant:	<input type="checkbox"/> Applicant <input type="checkbox"/> Other representative		
If contact person is other than applicant, what is the Contact's First Name:	Contact's Last Name:		
Does the applicant have a legal guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, List the name and contact information of the legal guardian below: Name: Address: Telephone number: Email address:		
Current Status/Living Arrangement:	<input type="checkbox"/> In private residence <input type="checkbox"/> In nursing facility <input type="checkbox"/> Other temporary living facility <input type="checkbox"/> In hospital		
Primary Language Spoken in Household:	<input type="checkbox"/> English <input type="checkbox"/> Spanish/Spanish Creole <input type="checkbox"/> Other (<i>specify</i>): _____		
Is interpreter (spoken) or translator (written) needed or wanted?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

APPLICANT ADDRESS

Address Line 1: _____

Address Line 2: _____

City: _____

State: _____

ZIP Code: _____

Applicant Residence County: _____

Contact Phone: () -

HOSPITAL/NURSING FACILITY/TEMPORARY LIVING FACILITY DETAILS

Hospital/Nursing Facility/Temporary Living Facility Name: _____

Anticipated Discharge Date: ____/____/____

Name of Discharge Planner (First & Last): _____

Discharge Planner Telephone: () -

IMPORTANT DETAILS ABOUT THIS REFERRAL

PRIMARY PHYSICIAN DETAILS

Primary Care Physician: _____ Physician NPI: _____

Primary Physician Practice Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: () - Fax: () -

REFERRER DETAILS

Referrer Name (First & Last): _____

Referrer's Relationship to Applicant:

- | | | | |
|----------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Self | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Daughter-in-Law | <input type="checkbox"/> Other relative |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Grandfather | <input type="checkbox"/> Sister-in-Law | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Father | <input type="checkbox"/> Spouse | <input type="checkbox"/> Niece | <input type="checkbox"/> Professional |
| <input type="checkbox"/> Sister | <input type="checkbox"/> Son | <input type="checkbox"/> Nephew | <input type="checkbox"/> Other (<i>specify</i>): _____ |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Daughter | <input type="checkbox"/> Granddaughter | <input type="checkbox"/> Unknown |

Referrer Phone: () -

Referrer Email: _____

SUBMITTING AGENCY IDENTIFICATION, IF APPLICABLE

Submitting Agency: _____

NPI Number: _____ Locator Code: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: () - Fax: () -

Submitter Name (First & Last): _____

Submitter Email: _____