

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 NCLIFTSS at 833-470-0597.

APPLICANT INFORMATION

Service Requested: 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: _____