

# 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/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 (specify): _____		
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: \_\_\_\_\_