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?	☐ Yes ☐ Pending ☐ No
Medicaid ID, if applicable:	
Social Security Number: (If Medicaid number is not listed above):	
Medicare ID, if applicable	
Date of Birth: / /	Age:
Gender:	☐ Male ☐ Female
Primary contact for this applicant:	☐ Applicant ☐ 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?	☐ Yes ☐ No If yes, List the name and contact information of the legal guardian below: Name: Address: Telephone number: Email address:
Current Status/Living Arrangement:	☐ In private residence ☐ In nursing facility ☐ Other temporary living facility ☐ In hospital
Primary Language Spoken in Household:	☐ English ☐ Spanish/Spanish Creole ☐ Other (*specify*): _____
Is interpreter (spoken) or translator (written) needed or wanted?	☐ Yes ☐ 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:

☐ Self	☐ Grandmother	☐ Daughter-in-Law	☐ Other relative
☐ Mother	☐ Grandfather	☐ Sister-in-Law	☐ Friend
☐ Father	☐ Spouse	☐ Niece	☐ Professional
☐ Sister	☐ Son	☐ Nephew	☐ Other (*specify*): _____
☐ Brother	☐ Daughter	☐ Granddaughter	☐ 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: _____