Print Form

NC DMA - COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN (CAP/C) REFERRAL FORM

Please submit this form via fax to 919 715 0052, or by mail to Division of Medical Assistance, CAP Unit, 2501 Mail Service Center, Raleigh, NC 27699-2501. Fields with an asterisk (*) are required. The referral will not be processed until these items are completed.

Request Date / /

Recipient Identifying Information

Child's First Name* Child's Last Name*
Child Has Medicaid?* ☐ No ☐ yes, MID - - - Private Insurance? * Policy #:
Child's Date of Birth* / / Child's Age
Child's Gender* ☐ male ☐ female Child's County of Residence (Name)
Primary Household Language Interpreter required? ☐ yes ☐ no
Child's Diagnoses*

Caregiver Details

Caregiver 1		Caregiver 2	
First Name*		First Name	
Last Name*		Last Name	
Address 1*		Address 1	
Address 2		Address 2	
City*		City	
State*	Zip -	State	Zip -
Primary Phone*	- -	Home Phone	- -
Work Phone	- - extension	Work Phone	- - extension
Secondary Phone	- -	Cell Phone	- -
E-mail	@	E-mail	@

Legal Guardianship

Is there a legal guardian other than the parent/caregiver?* ☐ yes ☐ no
Guardian Name
Guardian Agency
Address
City State Zip -
Phone - - extension

Child's Primary Care Physician

Physician First Name
Physician Last Name
Physician Practice
Physician Mailing Address 1
Physician Mailing Address 2
City State Zip -
Office Phone - -

 Referral Name: _____ Date: _____

Referring Details

Referral Agent		Referring Source	
Name of person completing the referral*		Relationship to the child	
		Name of contact person if different from the referrer	
Date		First/Last Name	
Agency		Address 1	
Address*		Address 2	
City*		City	
State*	Zip* -	State	Zip -
Phone	- - extension	Phone	- - extension
Fax	- -	Fax	- -

CAP/C Details

Has the child ever been referred to CAP/C before? ☑ no ☐ yes, referral date / / Decision Rendered
What services, if any, does the child currently have? Is the service the child is receiving about to terminate or end? ?* ☐ yes ☐ no
How would CAP/C services keep this child from being institutionalized in a hospital or nursing facility?
What type of help would you need from CAP/C?
Has a referral been made to other services to assist this child? ☐ no ☐ yes, specify
Is the child in a hospital or nursing facility waiting to transition home?* ☐ yes ☐ no
I attest that the parent/legal guardian is aware of and has consented to this referral.* ☐ yes ☐ no
The parent/legal guardian has been given a copy of or the link to the CAP/C Parent Handbook and the CAP/C for Consumers webpage.* ☐ yes ☐ no
The family has been notified of the need to provide consent for level of care determination, if this referral meets the criteria for medical fragility.* ☐ yes ☐ no ☐ N/A

Describe Special Care Needs for This Child

Activity of Daily Living (ADL) Needs	
Describe the child's ability to bathe him/herself.*	☑ age appropriate ☐ independent ☐ set-up help only ☐ supervision/cueing ☐ limited assistance ☐ extensive assistance ☐ maximal assistance ☐ total dependence Further Information/Comments
Describe the child's ability to dress him/herself.*	☑ age appropriate ☐ independent ☐ set-up help only ☐ supervision/cueing ☐ limited assistance ☐ extensive assistance ☐ maximal assistance ☐ total dependence Further Information/Comments
Describe the child's ability to groom him/herself (personal hygiene).*	☐ age appropriate ☐ independent ☐ set-up help only ☐ supervision/cueing ☐ limited assistance ☐ extensive assistance ☐ maximal assistance ☐ total dependence Further Information/Comments
Describe the child's ability to move (locomotion/ambulation).*	☐ age appropriate ☐ independent ☐ set-up help only ☐ supervision/cueing ☐ limited assistance ☐ extensive assistance ☐ maximal assistance ☐ total dependence Further Information/Comments

Describe the child's ability to eat by mouth.*	☐ age appropriate ☐ independent ☐ set-up help only ☐ supervision/cueing ☐ limited assistance ☐ extensive assistance ☐ maximal assistance ☐ total dependence Further Information/Comments
Describe the child's ability to toilet by him/herself.*	☐ age appropriate ☐ independent ☐ set-up help only ☐ supervision/cueing ☐ limited assistance ☐ extensive assistance ☐ maximal assistance ☐ total dependence Further Information/Comments
Describe the child's ability to be bed mobile by him/herself.*	☐ age appropriate ☐ independent ☐ set-up help only ☐ supervision/cueing ☐ limited assistance ☐ extensive assistance ☐ maximal assistance ☐ total dependence Further Information/Comments
Describe the child's ability to transfer by him/herself.*	☐ age appropriate ☐ independent ☐ set-up help only ☐ supervision/cueing ☐ limited assistance ☐ extensive assistance ☐ maximal assistance ☐ total dependence Further Information/Comments
Is the child continence?*	☐ yes ☐ no ☐ age appropriate
Describe the child's ability to communicate.*	☐ understood ☐ usually understood ☐ often understood ☐ sometimes understood ☐ rarely/never understood Further Information/Comments
Other ADL needs?	

Other Needs	
None	☐
Feeding Tube	☐ continuous ☐ bolus, frequency type of tube
Ventilator	☐, hours per day
CPAP/BiPAP	☐, hours per day
Suctioning	☐ tracheal, times per ☐ other suctioning, times per
oxygen	☐ continuous ☐ PRN, times per ☐ stable rate ☐ requires rate adjustments times per
Catheterizations	☐ indwelling ☐ intermittent, times per Self-cath? ☐ yes ☐ no
Seizures	☐ oxygen ☐ activation of VNS device ☐ administration of PRN medication ☐ safety precautions and monitoring frequency of seizures frequency of interventions needed other than safety/monitoring
Dressing Changes	☐ every 2 hours ☐ twice a day ☐ daily ☐ PRN Sterile technique used Clean technique used

Does private insurance cover any in-home care for this child?*	☐ yes ☐ no
If yes, How much?	
Please list any additional supporting information for consideration to process this referral	