REFERRAL FOR INPATIENT HOSPITAL AND INTERMEDIATE CARE FACILITY
IN STATE MENTAL HOSPITAL/STATE MENTAL RETARDATION CENTERS/ *N.C. SPECIALTY HOSPITALS

To _____ County Director of Social Services Date: _____

Address _____

Name of Facility _____ Address _____

This is to notify you that the patient whose name appears below is applying for assistance.

Check one: ☐ Money Payment ☐ Medical Assistance ☐ Inpatient Hospital Care ☐ Intermediate Care Facility

Patient's Name _____ Birthdate: _____
(Last) (First) (Middle)

Address: _____ Social Security and/or _____
Home address at time of admission Claim No. _____

Race _____ Sex _____ Date admitted _____ Patient's hospital no. _____

Spouse _____ Social Security and/or _____
(Last) (First) (Middle)

Parent _____ Claim No. _____
(Last) (First) (Middle)

Address _____ Telephone No. _____

Responsible relative, guardian, or other person (to be notified in case of emergency):

Name _____ Relationship _____

Address _____ Telephone No. _____

Has the patient applied for OASDI? ☐ Yes ☐ No ☐ Unknown

Has the patient enrolled for SMI, Part B of Title XVII, Medicare? ☐ Yes ☐ No ☐ Unknown

Income (Specify amounts)

OASDI Benefits _____ **(per month)**

Name of payee for OASDI benefits:

_____

Retirement income _____ **(per month)**

Veterans Benefit _____ **(per month)**

Contributions _____ **(per month)**

Rent from Property _____

Interest or dividends _____

Farm income _____

Other income _____

Resources (Describe or specify amounts)

Cash on hand _____

Money in bank(s) _____

Real property (me. **home)** _____

Stocks and bonds _____

Life insurance _____

Burial insurance _____

Hospital insurance _____

Additional information regarding income and resources:

Please investigate this case and notify us whether the patient is eligible for assistance with established State policies.
This referral is being made with the knowledge and consent of the patient and/or his family.
*** Formerly known as N.C. Sanatorium Systems.**

Referred by: _____

Title: _____

North Carolina
_____County Department of Social Services
Notification of Case Status
State Mental Hospital/State Mental Retardation Centers/ *

_____
Name of Facility

_____
Address

_____

Re: Name _____
Address _____
Program _____ Co. No. _____ ID _____

We received your referral for the above named person and would like to advise you of the status of the application.

☐ Money payment ☐ Medical Assistance

1. Patient is eligible for assistance beginning _____
Month Day Year

2. ☐ We are processing the application for assistance at this time. You will be notified later about the eligibility status.

3. ☐ The family has visited out office concerning assistance, but has failed to return proper information so that we could determine eligibility.

4. ☐ We are continuing out efforts to contact responsible persons to complete a plan for assistance. You will be notified about the eligibility status later.

5. ☐ Additional information is needed to complete this application. Complete and return the DMA-5006 and DMA-5009 with a copy of your psychological report on the patient. You will be notified when the eligibility status has been determined.

6. ☐ Patient is found to be ineligible for assistance.

Reason:

_____

_____

_____
County Director

_____
Address

_____
Date

* Formerly known as N.C. Sanatorium Systems.
County: Complete in duplicate- Return I copy to hospital- Retain I copy for file.

DMA-5010 (7/98)