

**N.C. Department of Health and Human Services – Division of Medical Assistance  
REQUEST FOR INDEPENDENT ASSESSMENT FOR IN-HOME CARE SERVICES (IHC)  
NEW REFERRAL**

Complete this form and send to The Carolinas Center for Medical Excellence (CCME) via fax at 877-272-1942 or mail:  
CCME, ATTN: IHC Independent Assessment, 100 Regency Forest Drive, Suite 200, Cary NC 27518-8598.  
For questions, contact CCME at 800-228-3365 or [IHCAssessment@thecarolinascenter.org](mailto:IHCAssessment@thecarolinascenter.org).

Referral Entity: \_\_\_ PCP \_\_\_ Attending MD

Date of Referral: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

**Section A. Recipient Demographics**

Medicaid ID#: \_\_\_\_\_

Recipient Name (as shown on Medicaid Card) First: \_\_\_\_\_ MI: \_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy) Gender: \_\_\_ Male \_\_\_ Female Primary Language: \_\_\_ English \_\_\_ Spanish \_\_\_ Other

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Alternate Contact/Parent/Guardian (required if recipient under 18): First: \_\_\_\_\_ Last: \_\_\_\_\_

Relationship to Recipient: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Section B. Recipient Medical History**

Current Medical Diagnoses – Related to need for hands-on assistance with Activities of Daily Living (ADL) needs (ICD-9 codes)	Onset or Exacerbation (Enter O or E)	Date (mm/yyyy)

Medically Stable: \_\_\_ Yes \_\_\_ No

Check if Active Adult Protective Services

Date Of Last Visit With Referring Practitioner: \_\_\_/\_\_\_/\_\_\_ (mm/yyyy)

Patient Currently Hospitalized Or In Medical Facility: \_\_\_ Yes \_\_\_ No If yes, Planned Discharge Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

Other Federal/State Programs Recipient Is Currently Receiving: \_\_\_ CAP \_\_\_ Medicare HH \_\_\_ PDN \_\_\_ Hospice

**Section C. Referring Practitioner**

NPI#: \_\_\_\_\_ Practitioner First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Facility Contact Name: \_\_\_\_\_ Contact Position: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

**Section D. Primary Care Physician Demographics**

Same As Referring Practitioner: \_\_\_ Y \_\_\_ N; If yes, go to Section E.

NPI#: \_\_\_\_\_ Practitioner First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Facility Contact Name: \_\_\_\_\_ Contact Position: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

**Section E. Authorization For IN-HOME CARE SERVICES Assessment**

Referring Practitioner Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

If hospital or medical facility discharge, signed order from referring practitioner available in medical records? \_\_\_ Yes \_\_\_ No

Signature of facility representative: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)