

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

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.

Requested By: ___ PCP ___ Attending MD ___ IHC Agency ___ Recipient/Responsible Party

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**

Reason for Change in Condition Requiring Reassessment for Services:

- Change in medical condition Change in caregiver status
 Change in recipient location affecting ability to perform ADLs
 Hospitalization Discharge Date: ___/___/___ (mm/dd/yyyy) Other

Briefly describe the change in condition and its impact on recipient’s need for assistance (required for all reasons):

Section C. Referral Source if not Recipient or Recipient’s Responsible Party:

NPI#: _____ **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, request is complete; submit to CCME

NPI#: _____ **Practitioner First Name:** _____ **Last Name:** _____

Facility Contact Name: _____ **Contact Position:** _____

Phone: (_____) _____ - _____ **Fax:** (_____) _____ - _____ **E-mail:** _____