North Carolina
Home Care Independence Program

Participant Referral Form for Financial Management Services

PARTICIPANT'S NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: (___)_____ **E-MAIL:** _____

REPRESENTATIVE or GUARDIAN NAME (IF APPLICABLE): _____

RELATIONSHIP TO PARTICIPANT: _____

ADDRESS: _____

CITY/STATE/ZIP_____

PHONE: (___)_____ **E-MAIL:** _____

CARE ADVISOR: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____

CITY/STATE/ZIP: _____

AGENCY PHONE: (___)_____ **E-MAIL:** _____
AGENCY FAX: (___)_____

FISCAL MANAGEMENT SERVICE ASSISTANCE REQUESTED FOR PARTICIPANT:

a. *PAYROLL SERVICES (CODE 501/Personal Assistant)* **Eff. Date** _____

TOTAL HOURS AUTHORIZED: _____ **PER WEEK**

MONTHLY BUDGET FOR PAYROLL(unit rate) _____ **X hours** _____ **X 4.333) = $**_____

b. *VENDOR PAYMENTS FOR COMMUNITY GOODS/SERVICES, IF APPLICABLE*:* **Eff. Date**_____
PERSONAL CARE/ENVIRONMENTAL/NUTRITIONAL SERVICES (CODE 504): $_____

EMERGENCY RESPONSE EQUIPMENT(CODE 506): $ _____

MEDICAL ADAPTIVE EQUIPMENT (CODE 507) $ _____

*List monthly cost of Pers. Care items, monthly rental of Emer. Response. Equipment, and full purchase price of Med. Adapt. Equipment

SIGNATURE OF CARE ADVISOR _____**DATE**_____

Eff.2/1/13