

**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** _____