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) = $_____
HOURLY RATE OF PAY $_____

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 _____