Community Care OF NORTH CAROLINA

HOP Referral Form

* required questions to fill

Referral & Patient Information			
Referral Date:	Referral Source/Agency:		
Referral Name:	Referral Phone:	Referral Fax:	
Patient Name:	DOB:	□ Male □ Female	
If member is a minor, Parent's name:	Patient informed of referral: □ Yes □ No		
Patient Social Security Number:	Patient Phone:	Payer: Payer ID:	
Physical Address:	County:		
What method of contact should be used?* □ Phone □ Text □ Email □ Letter	When is the best time and day to make contact?*		
Primary languages: □ English □ Spanish □ Other _____	Needs interpreter: □ Yes □ No		
Are there any special instructions that should be noted in the "Contact Notes" section within NCCARE360?*			
Please include a current list of medications to help us provide more complete services. □ No medications			

Reason for HOP Referral
□ Food Insecurity:
□ Physical/Behavioral Health Needs:
□ APS/ CPS involved; if yes, APS/ CPS Worker Name/Phone:
□ Financial/Housing/Community Resource Needs:
□ Social Concerns/Family Support:
□ Transportation Needs:
□ Toxic Stress/IPV:
□ Other/Pertinent Medical History:

Please fax completed form to 1-833-282-0884. If you have questions about your referral, call 1-877-566-0943 or visit CCNC's website at www.communitycarenc.org.