

Case # \_\_\_\_\_  
Dist. # \_\_\_\_\_

## CCNC/CA Enrollment Form

Date: \_\_\_\_\_ County: \_\_\_\_\_ Fax: \_\_\_\_\_ Person Completing Form: \_\_\_\_\_

Case Head: \_\_\_\_\_ MID \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Address:

Street

City

Zip

Telephone #: \_\_\_\_\_ Cell # \_\_\_\_\_ Email: \_\_\_\_\_

	Person to be Enrolled	Date of Birth	MID	Name of primary care provider	Provider ID or Exempt Code
1					
2					
3					
4					
5					

If requesting a temporary exemption for anyone above, write the recipient's number and provide a detailed reason for the request. **Attach additional paper if necessary.**

- Handbook provided at time of interview
- Handbook mailed to Case head
- NCHC- "Benefits of Being a Member" handbook provided to case head

SIGNATURE OF PATIENT OR HEAD OF HOUSEHOLD IF PATIENT IS A MINOR:

DATE: \_\_\_\_\_

***(By signing, I certify that I have received an explanation of CCNC/CA and have been given the opportunity to choose a participating medical home)***

### FOR STATE USE ONLY

Exemption Denied     Exemption Approved Exempt Code: \_\_\_\_\_

DMA- 9006  
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Division of Medical Assistance  
Community Care of North Carolina/Access Care  
DMA Fax 919-715-5235