

Carolina ACCESS 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.

Handbook provided at time of interview Handbook mailed to head of household

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

_____ DATE: _____

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

FOR STATE USE ONLY

Exemption Denied Exemption Approved Exempt Code: _____