REQUEST FOR CAP/DA PRIORITY CONSIDERATION

The CAP 1915 (c) Home and Community-Based Services (HCBS) Waiver arranges for service consideration on a first-come first-serve basis due to similar care needs of individuals applying for participation in the CAP/DA Waiver. However, individuals meeting specific criteria outlined in Section B of this form *may* be prioritized to the top of an existing waitlist for consideration of CAP/DA participation.

Instructions: Complete this form and submit all supporting documentation (if applicable) to request priority ranking for an applicant on the CAP/DA waitlist. **Fax all materials to NC Medicaid (833-470-0597) for review.** Requesting case management entities (CMEs) will be notified of a determination via the e-CAP system or the email address provided on page 3 of this form.

A. APPLICANT INFORMATION

Applicant Name (print): _____
(First) (M.I.) **(Last)**

MID: _____ **DOB:** _____
(MM/DD/YYYY)

B. CRITERIA FOR CONSIDERATION

Respond to each of the ten questions that follow to indicate the reason for requesting priority consideration. For every `yes' box checked, provide the accompanying information where prompted.

I. Is the applicant transitioning from a CAP/C waiver? ❑ **Yes** ❑ **No**

II. Is the applicant a beneficiary aged 18 or older and currently participating in an approved 1915(c) HCBS waiver managed by NC Medicaid who wants to make the transition to CAP/DA?

❑ **Yes**
❑ **No**

Current 1915 (c) HCBS Waiver: _____

III. Is the applicant a previous CAP/DA Medicaid beneficiary who was actively participating in one of North Carolina's 1915(c) HCBS waivers and is now transitioning back to North Carolina from another State due to a military assignment?

❑ **Yes**
❑ **No**

Most recent 1915 (c) HCBS Waiver: _____

Previous Waiver enrollment: ____/____/_____ **to** ____/____/_____

IV. Is the applicant a previously eligible CAP/DA or Consumer-directed beneficiary transitioning from a short-term rehabilitation placement within 90 calendar days of the placement?

❑ **Yes**
❑ **No**

Rehab Placement: _____

County of future residence: _____

Community placement date: ____/___/_____

V. Is the applicant transitioning from a nursing facility with ❑ Money Follows the Person (MFP) designation *or* ❑ Division of Vocational Rehabilitation transition services?

- ❑ Yes
- ❑ No

MFP Representative: _____

County of future residence: _____

Community placement date: ____/___/_____

VI. Is the applicant transitioning from a nursing facility utilizing service of community transition?

- ❑ Yes
- ❑ No

Nursing Facility: _____

County of future residence: _____

Community placement date: ___/____/_____

VII. Does the applicant have an Auto Immune Deficiency Syndrome (AIDS) diagnosis with a T-Count below 200?

- ❑ Yes
- ❑ No

Date of diagnosis: __ / ___ / _____

Most recent T-cell count: _____ **as of** ____/__/_____

VIII. Is the applicant an individual with a diagnosis of Alzheimer's disease or related disorder?

- ❑ Yes
- ❑ No

Diagnosis: _____

Date of diagnosis: __ / ___ / _____

IX. Is the applicant an individual identified as at risk by his or her local Department of Social Services (DSS) who has an order of protection by Adult Protective Services (APS) for abuse, neglect or exploitation and CAP/DA services can mitigate risk?

- ❑ Yes
- ❑ No

Issuing DSS: _____ **Order Date:** / /_____

Explanation of service(s) needed to mitigate risk: _____

X. Is the applicant a beneficiary enrolled in Hospice Services with an expected expiration date within six (6) months who is in jeopardy of entering a non-Hospice institution?

- ❑ Yes
- ❑ No

Name of non-hospice institutional placement: _____

Hospice certification date: / / _____

C. AGENCY ACKNOWLEDGMENT

CME completing this form: _____ _____ _____
Agency Name | Agency Phone | Agency Fax

I, a representative of the case management entity named above, certify that the information in this application and any supporting documentation provided is true and correct.

(Print) Name of Agency Contact Completing this Form | Title | Email

Signature | ___ / ____ / _____ Date | Agency Contact Phone

TO BE COMPLETED BY NC MEDICAID STAFF

Review Date: ____/____/ _____ **Status:** ❑ Complete ❑ Pending receipt of additional information

Verified applicant meets ❑ I ❑ II ❑ III ❑ IV ❑ V ❑ VI ❑ VII ❑ VIII ❑ IX ❑ X **criteria.**

Comments:

Priority Determination:

❑ Approved ❑ Denied

Determination Date:

____ ____ _____