Beneficiary Name: _____ MID: _____

Community Alternatives Program Level of Care Request Worksheet

Date: _____
Applicant Information: _____
Beneficiary Name: _____
Date of Birth: _____
Primary Caregiver: _____
Address: _____

1. **Check the CAP Services the applicant is requesting:**
   - ☐ Community Alternatives Program for Children (CAP/C)
   - ☐ Community Alternatives Program for Disabled Adults (CAP/DA)

2. **Provide a list of all ICD-10 diagnoses. Include the date the applicant received each diagnosis.** The list should include the identification of **primary and secondary diagnoses.** Please attach a full list to the completed worksheet.

3. **Applicant has a current primary physical diagnosis causing the patient's disability or need for medical intervention:** ☐ Yes ☐ No
   If yes:
   - State the current primary diagnosis ICD-10 code: _____

4. **Applicant is prescribed medication:** ☐ Yes ☐ No
   If yes:
   - Please attach a list of all prescribed medications to the completed worksheet.
   - Include how the applicant gets the medication. Is it prescription or over the counter?

5. **Applicant receives specialized treatments**: ☐ Yes ☐ No
   If yes:
   - Please attach a list of all specialized treatments to the completed worksheet.

   Specialized treatments are treatments related to the diagnoses listed above. Examples include: MACE, in and out catheters, regularly prescribed enemas or digital stimulation, Vagus Nerve stimulation swipe, oropharyngeal suctioning, etc.

6. **Check any treatment, therapies or interventions that the applicant is receiving, prescribed or ordered**.
   Selecting any item on the list may show that the applicant can get CAP services. This is because CAP is for people who have medical conditions that need to be closely watched and treated by a nurse or a physician.

   - ☐ Receiving physical therapy
   - ☐ Receiving occupational therapy
   - ☐ Receiving speech therapy
   - ☐ Dialysis
   - ☐ Eating a specialized therapeutic diet (type: _____)
   - ☐ IV drug administration (frequency: _____)
   - ☐ Receiving controlled medication
   - ☐ Frequent drug injections

Beneficiary Name: _____ MID: _____

- ☐ Requiring respiratory therapy (frequency: _____)
- ☐ Nasogastric feeding
- ☐ Has Alzheimer's Disease
- ☐ Has a bowel and bladder program
- ☐ Gastrostomy feeding
- ☐ Receiving wound care
- ☐ Needs or uses life-sustaining devices (such as an endotracheal tube, ventilator, suction machine, oxygen therapy, cough assist device, high-frequency chest wall oscillation vest, etc.)

7. **In your clinical judgment, are the applicant's health care conditions (diagnoses, medications, specialized treatments and medical regimen) chronic and severe enough to meet a level of care consistent with a nursing home or hospital care needs?**
   ☐ Yes ☐ No

Select your provider status:

- ☐ Applicant's Primary Care Practitioner
- ☐ Outpatient Specialty Practitioner

Name: _____

Practitioner Signature and Credentials: _____

Date: ____/____/____

Practice Name: _____

NPI #: _____ **Telephone**: _____ **Fax number**: _____

Address OR Physician Practice Stamp:

Practice Stamp

Thank you for completing this worksheet. If there is any other health care information you think would be helpful to include you can attach it with your worksheet. An example of additional information could be a recent visit summary.

Please fax the completed Physician's Worksheet and the list of medication, diagnoses, treatment and visit summaries to NCLIFTSS at 1-833-470-0597 within 15 business days of the date of this letter. Check the items below that are included in your faxed worksheet packet:

- ☐ Medication list
- ☐ Specialized treatment list
- ☐ ICD-10 Diagnosis List