# 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 wait list. **Fax all materials to NCLIFTSS (833-470-0597) or email NCLIFTSS@acentra.com 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: ____/____/_____

Applicant Initials: _____ MID: _____

## 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

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**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:**

____/____/_____