NC Medicaid 1915(i) Assessment[1]

Please use the 1915(i) Companion Guide when completing this form. It is recommended this form be completed electronically.

All fields are required to be completed unless marked optional

Beneficiary Information	
Beneficiary Name:	
Medicaid ID# (no spaces):	
Date of Birth (MM/DD/YYYY):	
Relevant Diagnosis(es) (optional):	
Beneficiary Health Plan *(Alliance Health Plan, Healthy Blue Care Together, Partners Health Management, Trillium Health Resources, Vaya Health):*	
Date Beneficiary or Legally Responsible Person (LRP) requested Initial or Continued 1915(i) Service(s) (List N/A for Transitional (gap) assessment type):	
Date 1915(i) Assessment Completed:	
Requires 1915(i) Service(s) for: (*Check All that Apply)*	☐ I/DD ☐ TBI ☐ SMI ☐ SPMI ☐ SED ☐ SUD
Assessor Information	
Care Manager (CM) or Care Coordinator (CC) Name:	
CM/CC Agency Name (List Health Plan if plan-based care management):	

Type of Assessment Being Submitted/Eligibility Dates Being Requested

Type of Assessment	Definition of Type	Requested Start Date
Initial Assessment	Complete this row for beneficiary entering 1915(i) service(s) for the first time **or** who are returning to 1915(i) service(s).	N/A
Traditional "Gap" Assessment	Complete this row to transition eligibility to a birth month annual assessment schedule. Requested start date will be the day after the existing eligibility end date.	
Reassessment	Complete this row to reassess a beneficiary with a current/active 1915(i) eligibility and needs to be reassessed for their needs-based criteria. Requested start date will be prefilled N/A.	N/A
Annual Reassessment	Complete this row for beneficiary on the annual birth month assessment schedule. The requested Start Date will be the first day of the month following the beneficiary's birth month.	

[1] As required for 1915(i) per 42 CFR § 441.720.

FUNCTIONAL DEFICIT ASSESSMENT

Beneficiary reports/assessor has identified a need for services based on beneficiary having at least one functional deficit below:

Table 1: Beneficiary's Need for Activities of Daily Living, Instrumental Activities of Daily Living, Social and Work, and Cognitive/Behavior Assistance				
Activity, Task or Skill	**Assistance Needed None**	**Assistance Needed Some**	**Assistance Needed Total**	**Comments (e.g., who assists, equipment used, problems or issues for caregivers, type of assistance needed)**
Activities of Daily Living				
Ambulation	☐ None	☐ Some	☐ Total	
Bathing	☐ None	☐ Some	☐ Total	
Dressing	☐ None	☐ Some	☐ Total	
Eating	☐ None	☐ Some	☐ Total	
Grooming	☐ None	☐ Some	☐ Total	
Toileting	☐ None	☐ Some	☐ Total	
Transfer	☐ None	☐ Some	☐ Total	
• To from bed	☐ None	☐ Some	☐ Total	
• To from car	☐ None	☐ Some	☐ Total	
Instrumental Activities of Daily Living				
Home maintenance	☐ None	☐ Some	☐ Total	
Housekeeping	☐ None	☐ Some	☐ Total	
Laundry	☐ None	☐ Some	☐ Total	
Meal prep	☐ None	☐ Some	☐ Total	
Money management	☐ None	☐ Some	☐ Total	
Shopping/errands	☐ None	☐ Some	☐ Total	
Transportation	☐ None	☐ Some	☐ Total	
• Use of	☐ None	☐ Some	☐ Total	
• Scheduling	☐ None	☐ Some	☐ Total	
Social and Work				
Interacting with others	☐ None	☐ Some	☐ Total	
Responding to negative feedback	☐ None	☐ Some	☐ Total	
Responding to change	☐ None	☐ Some	☐ Total	
Screening out environmental stimuli	☐ None	☐ Some	☐ Total	
Maintaining stamina	☐ None	☐ Some	☐ Total	
Handling time pressures and multiple tasks	☐ None	☐ Some	☐ Total	
Ability to learn new tasks	☐ None	☐ Some	☐ Total	

Acceptable speed of completing tasks	☐ None	☐ Some	☐ Total	
Cognitive/Behavior				
Speech/Language/ Communication	☐ None	☐ Some	☐ Total	
Self-Direction	☐ None	☐ Some	☐ Total	
Social Development	☐ None	☐ Some	☐ Total	
Learning	☐ None	☐ Some	☐ Total	
Vocational Development	☐ None	☐ Some	☐ Total	
Maladaptive Behavior	☐ None	☐ Some	☐ Total	
Psychosis/Hallucinations	☐ None	☐ Some	☐ Total	
Mild Memory Loss	☐ None	☐ Some	☐ Total	
Moderate Memory Loss	☐ None	☐ Some	☐ Total	
Other:				
	☐ None	☐ Some	☐ Total	
	☐ None	☐ Some	☐ Total	
	☐ None	☐ Some	☐ Total	
	☐ None	☐ Some	☐ Total	
	☐ None	☐ Some	☐ Total	
	☐ None	☐ Some	☐ Total	

Table 2: Additional Questions Regarding Beneficiary's Need for Assistance		
Does the beneficiary require support to manage a medical or health condition?	☐ Yes ☐ No	Comment:
Does the beneficiary express a desire to work?	☐ Yes ☐ No	Comment:
Does the beneficiary express a desire to obtain education leading to work?	☐ Yes ☐ No	Comment:
Does the beneficiary have a pattern of unemployment, underemployment or sporadic employment	☐ Yes ☐ No	Comment:
Does the beneficiary need support to acquire or maintain employment?	☐ Yes ☐ No	Comment:
Is the caregiver of the beneficiary in need of respite?	☐ Yes ☐ No	Comment:
Does the beneficiary lack the ability to care for themselves in the absence of a primary caregiver and have needs that exceed that of a child without behavioral health concerns/developmental disabilities that could have care provided by a traditional babysitter or day care.	☐ Yes ☐ No	Comment:
Is the beneficiary in need of **rehabilitative** service for Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), Social Skills or Employment Skills?	☐ Yes ☐ No	Comment:

Is the beneficiary in need of **habilitative** service for ADLs, IADLs, Social Skills or Employment Skills?	☐ Yes ☐ No	Comment:
Current Living Arrangement (i.e., At home w/ Family, Group Home, Adult Care Home (ACH), etc.):		Comment:
Are there plans for the beneficiary to move from a State Developmental Center (ICF-IID), community ICF-IID, nursing facility, or another provider-operated/controlled setting (ACH, psychiatric residential treatment facility, foster home, Alternative Family Living (AFL), or group home) to an independent living arrangement within the next 60 days?	☐ Yes ☐ No	Comment:
Is the beneficiary in need of initial set-up expenses/items?	☐ Yes ☐ No	Comment:

Services coverable under the 1915(i) Home and Community-Based Services (HCBS) benefit where medically necessary and determined eligible for 1915(i) include:	• Community Transition • Respite • Individual and Transitional Supports • Community Living and Supports • Supported Employment/Individual Placement Supports

Signature of Assessor (CM or CC) _____ Date _____

Print Name of Assessor (CM or CC) _____

Title/Credentials _____