2015 North Carolina Medicaid Community-Based Long Term Services and Supports

Program Eligibility and Benefits Reference Guide

nc department of health and human services

NORTH CAROLINA MFP MONEY FOLLOWS THE PERSON DEMONSTRATION PROJECT

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NORTH CAROLINA MEDICAID

NC Medicaid

Medicaid is a health insurance program for certain low-income individuals or families who are in need of medical care. It is governed by federal and state laws and regulations. Medicaid is administered by the North Carolina Division of Medical Assistance and monitored by the U.S. Centers for Medicare and Medicaid Services. There are two major program areas in Medicaid: 1) Aged (MAA), Blind (MAB), and Disabled (MAD) and 2) Families and Children. There are some other Medicaid programs that only provide limited services.

What does Medicaid Cover?

The Medicaid State Plan must cover:

- Ambulance
- Durable Medical Equipment
- Family Planning
- Federally Qualified Health Centers
- Health Check
- Home Health
- Hospitalizations - Inpatient/Outpatient
- Nurse Midwife/Nurse Practitioner
- Nursing Facility
- Labs and X-rays
- Physicians

For Children Only:

- Dental Services
- Hearing Aids
- Routine Eye Exams and Visual Aids

A State may also elect to cover:

- Case Management
- Chiropractor Services
- Community Alternatives Programs
- Dental Services/Dentures for Adults
- Eye Care for Adults
- Home Infusion Therapy
- Hospice
- Intermediate Care Facilities
- Mental Health Services
- Non-Emergency Transportation
- Orthotics and Prosthetics
- Personal Care Services
- Physical, Occupational and Speech Therapy
- Podiatry
- Prescription Drugs
- Private Duty Nursing
- Rehabilitative Services

Important Considerations:

North Carolina Medicaid is constantly changing. It is very important to regularly check for changes to Medicaid programs. A good way to stay informed is by reading the Medicaid Provider Bulletins which can be found at :http://www.ncdhhs.gov/dma/bulletin/index.htm

For More Information About Medicaid:

Go to the N.C. Division of Medical Assistance Website - **http://www.ncdhhs.gov/dma/**

Call the N.C. Division of Medical Assistance at (919) 855-4000

Go to U.S. Centers for Medicare and Medicaid Services Website - **http://www.medicaid.gov**

WHO IS ELIGIBLE FOR MEDICAID?

Basic Medicaid Eligibility

General Eligibility Requirements include:

- being a resident of North Carolina and a U.S. citizen or qualified alien;
- not being an inmate of a public institution, except for individuals incarcerated in a NC DOP facility requiring inpatient hospitalization and have their Medicaid benefits placed in suspension;
- meeting income criteria;
- having assets at or below the allowable limits;
- providing verification of all health insurance; and,
- having a Social Security Number or applying for one.

Recipients of Supplemental Security Income (SSI) and State/County Special Assistance are automatically entitled to Medicaid. No separate Medicaid application or Medicaid eligibility determination is required.

How to Apply:

- In person at the local department of social services in the county where the individual resides. An appointment is not necessary, although one may be requested.
- By mail or fax — Applications are available at www.ncdhhs.gov/dma/medicaid/applications.htm
- By telephone through your local DSS http://www.ncdhhs.gov/dss/local/
- Online at www.ePASS.nc.gov

Representatives may apply on behalf of individuals unable to apply for themselves.

What information may be needed to determine eligibility?

- Social Security Card
- Proof of Identity
- Bank Statements
- Medical Bills
- Health Insurance Information
- Medicare Card
- Proof of N.C. State Residency
- Life Insurance Policies
- Proof of Income
- Proof of Citizenship or immigration status
- Guardianship or Power of Attorney Papers (if acting on someone else's behalf)

Important Consideration:

- Even when an individual qualifies for Medicaid, it does not always mean they qualify for a specific Medicaid program. Most Community-Based Long-Term Services and Supports programs have criteria in addition to the requirements for basic eligibility.

For More Information About Medicaid Eligibility, Call (919) 855– 4000
Or go to the following web page - http://www.ncdhhs.gov/dma/medicaid/who.htm

ADULT MEDICAID ELIGIBILITY REQUIREMENTS

Financial Eligibility

When applying for Medicaid, monthly income is calculated by subtracting certain deductions from the household's gross income. Social Security, veteran's benefits, wages, pensions and other retirement income are counted. Deductions vary with each Medicaid program. For Adult Medicaid, the countable monthly income cannot exceed $981 for an individual or $1328 for a family of two. Financial resources may not exceed $2,000 for an individual or $3,000 for a couple. Resources include cash, bank accounts, retirement accounts, stocks and bonds, cash value of life insurance policies, and other investments. The value of the primary residence, one car, home furnishings, clothing and jewelry are not counted.

There are two Medicaid coverage groups:

- ***Categorically Needy (CN)***: Provides full Medicaid coverage for individuals whose income and resources are at or below allowable limits.
- ***Medically Needy (MN):*** Allows individuals whose income is higher than the CN limit to qualify for Medicaid by meeting a deductible.

Aged, Blind, and Disabled Coverage Categories:

- ***MAA*** - Individuals aged 65 or older
- ***MAD, MAB*** - Individuals under the age of 65 who are disabled or blind according to Social Security standards.
- ***MQB*** - Limited coverage for Medicare beneficiaries

Medicaid Deductible:

If the family income is over the limits, but there is a high cost for medical bills, the recipient may still qualify for Medicaid and have to incur medical expenses to meet a Medicaid deductible. Medical expenses include: 1)hospitalizations; 2) doctor, dentist or therapist; 3) clinic and laboratory charges; 4) Rx; 5) OTC drugs with receipts; 6) medical supplies; 7) equipment (e.g. dentures, eyeglasses, hearing aids, walkers, wheelchairs, etc.); 8) prescribed vitamins or supplements; 9) medical transportation; and 10) private insurance premiums. Individuals with deductibles who live in the community will have to spend down to $242 per month. (A family of two=$317/mo., three=$367/mo., four=$400/mo., five=$433/mo.)
Medicaid deductibles must be met on a monthly basis for CAP waivers.

Important Considerations:

- When an individual lives in a nursing facility and has a spouse living at home, a portion of the income of the spouse in the facility may be protected to bring the income of the spouse at home up to a level specified by federal law. Currently, that amount is $1,939/mo. and can be as much as $2,898 depending upon the at-home spouse's cost for housing. The amount protected for the at-home spouse is not counted in determining the eligibility of the spouse living in the nursing facility.
- Additionally, the countable resources of a couple are combined and a portion is protected for the spouse at home. That portion is half the total value of the countable resources, but currently not less than $22,728 or more than $113,640. The amount protected for the at-home spouse is not countable in determining the eligibility of the spouse living in the facility.
- When a person gives away resources and does not receive compensation with a value at least equal to that of the resources given away, he/she may be penalized. Medicaid will not pay for care in a nursing facility or care provided under the Community Alternative Program or other in-home health services and supplies for a period of time that depends on the value of the transferred resource.

MEDICAID ELIGIBILITY

GROUP	BENEFITS	BASIC REQUIREMENTS **					
		Basic Eligibility Requirement	Whose Income and Resources Count	Income Limit (updated 04/15)	Resource Limit (updated 04/2015)	Deductible/ Spend down	
Beneficiaries of Cash Assistance Programs AAF, S-ABD, MSB SSI cases	Full Medicaid coverage	Beneficiaries of the following cash assistance programs are automatically entitled to Medicaid. No separate Medicaid application or Medicaid eligibility determination is required. The cash assistance programs are: • Supplemental Security Income (SSI) – Federal cash assistance program for the aged, blind, and disabled. • State/County Special Assistance – State cash assistance program for aged and disabled individuals, primarily who are in adult care homes. • Special Assistance to the Blind – State cash assistance program for blind individuals. NOTE: Work First Family Assistance – NC program under the federal Temporary Assistance to Needy Families law that provides cash assistance to families with children. EXCEPTION: This program has been de-linked and a separate Medicaid application is now required. SPECIAL ASSISTANCE/COUNTY ASSISTANCE AND SERVICES TO THE BLIND- have been de-linked from Medicaid. A separate application is required.					
Aged MAA	Full Medicaid Coverage	Age 65 or older	100% of Poverty 1 – $ 981/mo 2 – $1,328 /mo	SSI Limits 1 - $2,000 2 - $3,000	Yes	If income exceeds income limit and the indicator is "yes," the individual or family may be able to be eligible for Medicaid if they can meet a deductible. See discussion of Medical Deductible on page 2 of this same column. **Individuals in nursing facilities** generally do not have to meet a deductible to be eligible for Medicaid. However, they must pay all of their monthly income, less a $30 personal needs allowance and the cost of medical expenses not covered by Medicaid or other insurance to the nursing facility. Medicaid pays the remainder of their cost of care.	**Protection of income for spouse at home:** $1,966.25/mo up to $2,980.50/mo **Protection of resources for spouse at home:** $23,844 up to $119,220. **Transfer of resources:** When a person gives away resources and does not receive compensation with a value at least equal to that of the resources given away, he may be penalized. Medicaid will not pay for care in a nursing facility or care provided under the Community Alternative Placement program or other in-home health services & supplies for a period of time that depends on the value of the transferred resource.
Blind MAB	Full Medicaid Coverage	Blind by Social Security Standards	100% of Poverty 1 – $ 981/mo 2 – $1,328 /mo	SSI Limits 1 - $2,000 2 - $3,000	Yes		
Disabled MAD	Full Medicaid Coverage	Disabled by Social Security Standards	100% of Poverty 1 – $ 981/mo 2 – $1328 /mo	SSI Limits 1 - $2,000 2 - $3,000	Yes		
Health Care for Working Disabled (HCWD) MAD	Full Medicaid Coverage	* See Footnote	150% of Poverty 1- $1,472 2- $1,992	Min. CSRP limit $23,844	No		
Qualified Medicare Beneficiaries MQB-Q	Payment of Medicare premiums and deductibles and co-insurance charges for Medicare covered services	Entitled to Medicare Parts A & B	100% of Poverty 1 – $ 981/mo 2 – $1,328 /mo	1 - $7,160 2 - $10,750	No		
Specified Low Income Medicare Beneficiaries MQB-B	Payment of Medicare Part B premium	Entitled to free Medicare Part A	120% of Poverty 1 - $1,177/mo 2 - $1,593/mo	1 - $7,160 2 - $10,750	No		
Qualifying Individual MQB-E	Payment of Medicare Part B Premiums **NOTE:** Total number of eligible individuals is limited to available funds	Entitled to free Medicare Part A	135% of Poverty 1 - $1,325 mo 2 - $1,793/mo	1 - $7,160 2 - $10,750	No		
Working Disabled MWD	Payment of Medicare Part A premiums	Lost entitlement to free Medicare A due to earnings but still has disabling impairment.	200% of Poverty 1 - $1,962/mo 2 - $2,655/mo	2X SSI Limits 1 - $4,000 2 - $6,000	No		

* For Basic Coverage, the beneficiary does not have to meet the Social Security SGA requirement to be disabled. For Medically Improved coverage, the beneficiary does not have to meet the Social Security medical requirements for disability.

GROUP	BENEFITS	BASIC REQUIREMENTS **				
		Basic Eligibility Requirement	Income Limit (update 4/15)	Resource Limit (updated 01/13)	Deductible/Spend down	
Families & Children MAF- N/C	Full Medicaid coverage	Parents/Caretaker relatives must be living with and caring for a child to whom they are related who is under age 19. Children must be under age 21.	1 - $434/mo 2 - $569/mo 3 - $667/mo 4 - $744/mo 5 - $824/mo	OBSOLETE for MAF-C/N	Yes	If income exceeds income limit and the indicator is "yes" the individual or family may be able to be eligible for Medicaid if they he can meet a deductible **Medicaid Deductible**: When an individual/family is ineligible for Medicaid due to income over the income limit, they may become eligible by meeting a Medicaid deductible. The deductible is determined by subtracting the Medically Needy Income Limit (MNIL) (*see limits below*) from the countable monthly income to determine the monthly excess income. Medicaid deductibles are generally determined for 6 months, so the monthly excess income is multiplied by 6 to determine the 6-mo. deductible. Once medical bills for which they are responsible totaling the amount of the deductible are incurred, they are authorized for the rest of the 6-mo. period. Medicaid cannot pay for any of the bills applied to the deductible. **M - Resource Limit:** All Deductible cases have a resource limit: $3,000 for families and children and $2,000 (1) and $3,000 (2) for aged, blind and disabled.
MAF-M	Full Medicaid coverage at the moment the deductible is met.	Parents/Caretaker relatives must be living with and caring for a child to whom they are related who is under age 19. Children must be under age 21.	1 - $242/mo 2 - $317/mo 3 - $367/mo 4 - $400/mo 5 - %433/mo	Only MAF-M must meet resource	Yes	
Pregnant Women MPW	Coverage is limited to treatment for conditions that affect the pregnancy.	Medical verification of pregnancy	196% of Poverty 1 - $1,923/mo 2 - $2,602 /mo 3 - $3,282/mo 4 - $3,961 /mo 5 - $4,641/mo		Yes	
Children under age <1 MIC-1	Full Medicaid Coverage	Be under age 1	194%-210% of Poverty 1 - $2,060/mo 2 - $2,788/mo 3 - $4,244/mo 4 - $4,972/mo 5 - $5,700/mo		Yes	
Children under age <1 MIC-N	Full Medicaid Coverage	Be under age 1	194% of Poverty 1 - $,1903/mo 2 - $2,576/mo 3 - $3,248/mo 4 - $3,921/mo 5 - $4,593/mo		Yes	

Children 1-5 MIC-1	Full Medicaid Coverage	Age must be 1-5	New MAGI Methodology (Modified Adjusted Gross Income). A tax household must be established for each individual.	141%-210% of Poverty 1 - $2,060/mo 2 - $2,788/mo 3 - $3,516/mo 4 - $4,244/mo 5 - $4,972/mo			
Children 1-5 MIC-N	Full Medicaid Coverage	Age must be 1-5	New MAGI Methodology (Modified Adjusted Gross Income). A tax household must be established for each individual.	141% of Poverty 1 - $1,383/mo 2 - $1,872/mo 3 - $2,361/mo 4 - $2,850/mo 5 - $3,339/mo		Yes	
Children 6-18 MIC-1	Full Medicaid Coverage	Age must be 6 - 18	New MAGI Methodology (Modified Adjusted Gross Income). A tax household must be established for each individual.	107% - 133% of Poverty 1 - $1,305/mo 2 - $1,766/mo 3 - $2,227/mo 4 - $2,688/mo 5 - $3,149/mo		Yes	
Children age 6 thru 18 MIC-N	Full Medicaid Coverage	Age must be 6 - 18	New MAGI Methodology (Modified Adjusted Gross Income). A tax household must be established for each individual.	107% of Poverty 1 - $1,050/mo 2 - $1,421/mo 3 - $1,792/mo 4 - $2,163/mo 5 - $2,534/mo		Yes	
Title IV-E Children IAS	Full Medicaid Coverage	Be an Title IV-E adoptive or foster child	Medicaid eligibility is automatic. There is no income or resource determination.			No	
State Foster Care Children (HSF)	Full Medicaid Coverage	State Foster Care Children are evaluated as Families and Children's Group above. (If not eligible for HSF, then evaluate for other children's programs.)				Yes	
MFC-Medicaid for Former Foster Care	Full Medicaid Coverage	Be 18-20 and had been a Title IV-E or State foster child on 18th birthday	None	None	None	No	
Breast & Cervical Cancer Medicaid MAF-W	Full Medicaid Coverage	A woman who has been screened and enrolled in the NC Breast &Cervical Cancer Control Program and is otherwise ineligible for Medicaid	Medicaid eligibility is automatic. There is no income or resource determination.			No	

GROUP	BENEFITS	BASIC REQUIREMENTS **					
		Basic Eligibility Requirement	Income Limit (update 4/13)	Resource Limit	Deductible/Spend down		
Family Planning MAF-D	Family Planning exams & services. Screening & treatment for STI. Screenings for HIV. Sterilizations.	No AGE limit	195% of Poverty 1 - $1,913/mo 2 - $2,589/mo 3 - $3,265/mo 4 - $3,941/mo 5 - $4,617/mo	No resource limit	No	There is no deductible or spend down provision for Family Planning coverage. If a beneficiaries income increases to more than 185%, he will be ineligible for family planning coverage	
NC Health Choice (NCHC)	Coverage of the NC State Employees Health Plan, plus vision, hearing, & dental	Be an uninsured child over age 5 & under age 19.	211% of Poverty 1 - $2,070/mo 2 - $2,802/mo 3 - $3,533/mo 4 - $4,264/mo 5 - $4,996/mo	No resource limit	No	There is no deductible or spend down provision for NCHC. If a child is ineligible due to too much income, they will be evaluated for Medicaid with a deductible.	Income over 159% of poverty must pay enrollment fee. 1 - $1,560.01 2 -.$2111.01 3 - $2,662.01 4 - $3214.01 5 - $3765.01

**This chart addresses benefits and basic eligibility requirements. Other requirements (such as citizenship/alien status, incarceration, & state residence) which can also affect eligibility or the level of benefits are not reflected on this chart.

MEDICAID INCOME/RESERVE LIMITS

Revised effective 4/1/15

Medically Needy	1	2	3	4	5	6	7	8	Add'l
MAF-M	242	317	367	400	433	467	500	525	Manual
Adult Medicaid	1	2							
MAABD-N	981	1328							
MAABD-N 1/3 reduced	654	886							
MAABD-M	242	317							
MAABD-M 1/3 reduced	161	211							
HCWD 150% (unearned)	1472	1992							
HCWD 150% 1/3 reduced (unearned)	981	1328							
HCWD 200%	1962	2655							
HCWD 200% 1/3 reduced	1308	1771							
MQB-Q	981	1328	1675	2021	2368	2715	3061	3408	342
MQB-Q 1/3 reduced	654	886	1117	1348	1579	1810	2041	2272	226
MQB-B	981.01-1177	1328.01-1593	1675.01-2009	2021.01-2425	2368.01-2841	3715.01-3257	3061.01-3673	3408.01-4089	******
MQB-B 1/3 reduced	654.01-785	886.01-1063	1117.01-1340	1348.01-1617	1579.01-1895	1810.01-2172	2041.01-2449	2272.01-2727	*******
MQB-E	1177.01-1325	1593.01-1793	2009.01-2261	2425.01-2729	2841.01-3197	3257.01-3665	3673.01-4133	4089.01-4601	********
MQB-E 1/3 reduced	785.01-883	1063.01-1195	1340.01-1507	1617.01-1819	1895.01-2131	2172.01-2443	2449.01-2755	2727.01-3067	*********
MWD	1962	2655							
MWD 1/3 reduced	1308	1771							
Reserve: MAABD	2000	3000							
Reserve: MQB-Q/B/E	7280	10930							
Reserve: HCWD	23844	23844							
Reserve: MWD	4000	6000							
Minimum Monthly Maintenance All.	1991								
Comm. Spouse Monthly Housing	597								
Comm. Spouse Resource Min/Max	23,844/119,220								
Home Equity Min/Max	552,000/828,000								

* For each additional add 642 to previous minimum and 694 to 200% ** For each additional add 462 to previous minimum and 694 to 200% *** For each additional add 347 to previous minimum and 462 to 133%

**** For each additional add 462 to previous minimum and 694 to 200% ***** For each additional add 694 to previous minimum and 780 to 225% ****** For each add'l add 347 to previous minimum and 416 to 120%

******* For each add'l add 232 to previous minimum and 278 to 120% ******** For each add'l add 416 to previous minimum and 468 to 135% ********* For each add'l add 278 to previous minimum and 313 to 135%

********** HCWD 150% has a unearned income limit ********** HCWD Above 200% premium must be paid

Revised 06/16/2015

COMMUNITY ALTERNATIVES PROGRAM

CAP

What is CAP? This program is designed to provide an alternative to institutionalization for eligible individuals who prefer to be in their homes and who would be at risk of nursing facility placement without services. CAP supplements rather than replaces the formal and informal services and supports already available to an individual. These services are intended for situations where no household member, relative, caregiver, landlord, community/volunteer agency, or third party payer is able or willing to meet the complete needs of the individual. CAP benefits include Adult Day Health, personal care aide, home modification and mobility aids, meal preparation and delivery, institutional respite services, non-institutional respite services, Personal Emergency Response Services, supplies allowable under the waiver, participant goods and services, transition services, training and education services, assistive technology and case management. .

Important Considerations:

- The CAP Lead Agency completes a needs assessment to identify the appropriate service and funding level for each applicant. The cost for LTSS Medicaid services cannot exceed the monthly cost limit.
- Recipients may live in an institutional setting at the time of application and screening, but must be discharged to a private residence before receiving services from the program.
- If the individual has a Medicaid deductible, it must be met at the beginning of every month before CAP will pay for services.
- Services suspended during a short-term nursing facility or rehab center stay lasting no more than 90 days are eligible to be reinstated into the program upon discharge.
- For most Adult Care Home residents, CAP is not a good consideration to support a transition because they do not meet the Nursing Facility Level of Care criteria.

For more about CAP services and eligibility, go to:

CAP Clinical Coverage Policy;
http://www.ncdhhs.gov/dma/mp/3K2.pdf

Or

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4100

Who Qualifies for CAP?

To be eligible for CAP, the individual must:

- Be 18 years of age or older.
- Reside in or intend to transition to a private residence.
- Be eligible for Long Term Services and Supports (LTSS) Medicaid under one of the Medically Needy Categories. This is determined by the county department of social services where the individual resides.
- Be determined to need Nursing Facility Level of Care.
- Have a documented medical diagnosis that supports the need for services provided under CAP.
- Be at risk of institutionalization within 30 calendar days.
- Require two waiver services monthly (excluding incontinence supplies, personal emergency response services and meal preparation and delivery).
- Be compliant with the established Plan of Care. Non-compliance by the individual and the identified primary caregiver creates a health, safety and well-being risk.

This process begins with the completion of the Service Request Form (SRF) and a signed Physician's Attestation form.

To Access CAP services:

Contact the county CAP Lead Agency-
http://www.ncdhhs.gov/dma/cap/CAPContactList.pdf

Contact the DSS in the county where the individual resides-
http://www.ncdhhs.gov/dss/local/

DSS staff will coordinate transfers for Medicaid recipients

CAP/CHOICE

What is CAP/CHOICE? CAP/CHOICE is a self-directed care option under the Community Alternatives Program (CAP) for individuals who wish to remain at home and have increased control over their services and supports. CHOICE allows participants to more fully direct their care by selecting and managing a personal assistant and by having more flexibility in tailoring plans to meet their care requirements. In addition to the services available under CAP, CHOICE offers personal assistance services, financial management services (FMS), and a care advisor. The personal assistant is hired by the recipient to provide personal and home maintenance tasks. FMS, known as a fiscal intermediary, is available to: 1) conduct background checks and verifications on prospective personal assistants, 2) maintain a separate account on each recipient's services, 3) pay the personal assistants and withhold/calculate appropriate taxes, 4) create monthly payroll statements, and 5) file claims for work completed by the personal assistant with the funding agency. The care advisor is a specialized case manager who focuses on empowering participants to define and direct their own personal assistance needs and services, supporting the individual, rather than directing and managing their plan.

Important Considerations

- Individuals new to the program are encouraged to enroll in CAP first, where they can be assessed for CHOICE participation before enrolling in the program.
- Self-direction is not for everyone. If the person is not appropriate for or comfortable with the responsibilities associated with the CHOICE he/she will be re-enrolled in traditional CAP services.

For more about CHOICE services and eligibility, go to:

CAP Clinical Coverage Policy
http://www.ncdhhs.gov/dma/mp/3K2.pdf

OR

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4100

Who Qualifies for CHOICE?

In addition to meeting the eligibility requirements for CAP, the individual must:

- Understand the rights and responsibilities of directing one's own care.
- Be willing and capable of assuming the responsibilities for self-directed care, or select a representative who is willing and capable to assume the responsibilities to direct the recipient's care.

The prospective recipient or their designated representative will be given a self-assessment questionnaire to determine the recipient's ability to direct care or identify training opportunities to build competencies to aid in self-direction.

Access to the CHOICE program occurs:

Through the county CAP Lead Agency-
http://www.ncdhhs.gov/dma/cap/CAPContactList.pdf

Through the DSS in the county where the individual resides-
http://www.ncdhhs.gov/dss/local/

THE NORTH CAROLINA INNOVATIONS WAIVER

Innovations

What is the Innovations Waiver? The North Carolina Innovations Waiver is a resource for funding services and supports for people with intellectual and other related developmental disabilities that are at risk for institutional care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Innovations waiver is designed to provide an array of community-based services and supports to promote choice, control, and community membership. These services provide a community-based alternative to institutional care for persons who require an ICF-IID level of care and meet additional eligibility criteria for this waiver. Services include Community Networking, Day Supports, In-Home Intensive Supports, In-Home Skill Building, Personal Care Services, Residential Supports, Respite, and Supported Employment, Assistive Technology, Equipment & Supplies, Community Guide, Community Transition, Crisis Services, Financial Support Services, Individual Goods and Services, Home Modifications, Natural Supports Education, Specialized Consultation Services, and Vehicle Modifications.

Important Considerations:

- There are times an individual with an intellectual disability (ID) is residing in a nursing facility.
- An individual cannot receive services from Innovations and CAP at the same time.
- When a person is identified as having an ID diagnosis, it is essential to get the LME/MCO involved as quickly as possible. Services can only be accessed through the LME/MCO network.
- At times it may not be clear if the individual is appropriate for services or if they will qualify. The LME/MCO must conduct assessments and make all mental health related eligibility determinations. It is essential to get this process started as quickly as possible to avoid unnecessary delays in transitions.

For more about Innovations services and eligibility go to:

DMA's Innovations Waiver Page - http://www2.ncdhhs.gov/dma/lme/mhwaiver.htm

Contact the local LME/MCO

Call the NC Division of Medical Assistance Behavioral Health Section: phone 919-855-4290

Who Qualifies for Innovations? The individual must: 1) be eligible for Medicaid; 2) live in an ICF-IID facility and wish to leave or be at high risk of placement in an ICF-IID facility; 3) choose NC Innovations rather than live in an institution; 4) need NC Innovations services per the person-centered Individual Support Plan; 5) must use at least one service monthly; 6) services can not exceed the $135,000 annual waiver cost limit; 7) live in a private residence or a licensed facility with six or fewer persons; and, 8) meet ICF-IID level of care (LOC).

To meet ICF-IID (Intermediate Care Facility) Level of Care, a person must require active treatment and have a diagnosis of Intellectual Disability (ID) or a condition closely related to ID as characterized by significant limitations in both intellectual functioning and in adaptive behavior. A closely related condition refers to individuals who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy and occurred before the age of 22 OR any condition, other than mental illness, found to be closely related to Intellectual Disability because the condition results in impairment of general functioning OR adaptive behavior similar to a person with ID and is manifested before the age of 22. This condition is likely to continue indefinitely and it results in functional limitations to three or more of the following: 1) self-care; 2) understanding/use of language; 3) learning; 4) mobility; 5) self-direction; or 6) capacity for independent living.

Access to the Innovations program can occur through:

The Local Mental Health—Entity Managed Care Organization (LME/MCO) - http://www.ncdhhs.gov/dma/lme/LME-Contact-Info.html

PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

PACE

What is PACE? The Program of All-inclusive Care for the Elderly (PACE) is a managed care model centered around the belief that it is better for the well-being of seniors with chronic care needs, and their families to be served in the community when possible. PACE can provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as safely possible. Medical care is provided by an Inter-Disciplinary Team (IDT) led by a PACE physician. This team is familiar with the history, needs and preferences of each participant. PACE services include delivery of all needed medical and supportive services, medical specialists (e.g. cardiology, dentistry, optometry), adult day health care, physical, occupational, speech and recreational therapies, nutritional counseling by a registered dietician, social work and social services, hospital and nursing home care when necessary, home health care and personal care, all necessary prescription drugs and respite care.

Important Considerations:

- All services are provided directly by the program or through its provider network
- PACE will only pay for services which have been approved by the Interdisciplinary Team
- While enrolled in PACE, providers will no longer be able to bill Medicare or Medicaid
- Individuals enrolled in PACE who move outside the service area will no longer be eligible for PACE services, unless the move is to another program's service area.
- PACE IDT members can perform assessments while the individual is in the nursing facility

For more information about PACE services and eligibility go to:

North Carolina PACE Association
http://ncpace.org

NC PACE Programs List
http://ncpace.org/pace-in-nc/pace-sites

National PACE Association site
http://www.npaonline.org

PACE Clinical Coverage Policy
http://www.ncdhhs.gov/dma/mp/3B.pdf

Call the Home and Community Care Section of the NC Division of Medical Assistance: phone 919-855-4100

Who Qualifies for PACE?

To be eligible for PACE, the individual must:

- Be 55 years of age or older.
- Live in a PACE program service area.
- Be determined by a physician to need Nursing Facility Level of Care. This process begins with the completion of the FL2 form that must be signed by a physician.
- Meet program specific criteria that includes: 1) ensuring the person lives in a home that does not jeopardize the health, safety and well-being of the individual, the family, or the service provider, and 2) compliance with the plan of care.

Only a small percentage of PACE participants reside in a nursing facility, even though *all* must be certified to need nursing facility level of care. If a PACE recipient needs nursing facility care, as determined by the IDT's assessments, the PACE program will pay for it and continue to coordinate the individual's care with the facility.

To Access PACE:

- A referral can be made to the PACE program that has a service area covering the address where the individual resides. The program will assess the individual and facilitate the enrollment process for those determined eligible.
- Medicaid recipients and individuals who are dually-eligible may request PACE services through their local DSS http://www.ncdhhs.gov/dss/local/

CONSOLIDATED PERSONAL CARE SERVICES

PCS

What is PCS? For eligible Medicaid recipients, PCS provides an in-home aide who delivers person-to-person hands-on assistance for the five activities of daily living (ADLs) that include eating, dressing, bathing, toileting, and mobility. Basic PCS provides up to 60 hours of service per month and PCS Plus provides up to 80 hours. The number of PCS service hours is determined through an independent assessment conducted by an Independent Assessment Entity and is based upon each individual's functional limitations and need for ADL assistance.

Important Considerations

PCS:

- Has an average wait time of two weeks for an independent assessment.
- Does not require nursing facility level of care for participation.
- Must be ordered by a physician.
- Is appropriate for individuals whose needs can be met safely in the home by family members and other informal caregivers, with support by scheduled visits from specially trained PCS aides.
- Does not provide enough assistance to replace facility-based services for individuals who require ongoing care, supervision, or monitoring by a nurse or other health care professional.
- Cannot duplicate in-home aide services provided under Medicaid waiver programs, private duty nursing, state block grants, and other state and local programs that provide hands-on assistance with ADLs.
- Cannot solely provide house keeping or homemaking tasks.
- Cannot be provided by a live-in aide, spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the recipient.

For more information about PCS services and eligibility go to:

http://www.ncdhhs.gov/dma/mp/3C.pdf

OR

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4100

Who Qualifies for PCS?

Medicaid covers the cost of PCS if:

- The individual qualifies for Medicaid
- The individual has either 1) three of five ADLs which require limited hands-on assistance; 2) two ADLs, one of which requires extensive assistance; or 3) two ADLs, one of which requires complete assistance
- PCS is linked to a documented medical condition(s) causing the functional limitations requiring the PCS
- The individual is under the ongoing direct care of a physician for the medical condition(s) causing the functional limitations
- The individual is medically stable and does not require continuous monitoring by a licensed nurse or other licensed health care professional
- The home is safe for the recipient and PCS provider(s) and is adequately equipped to implement needed services
- There is no available, willing, or able household member to provide ADL assistance on a regular basis
- There is no other third-party payer responsible for covering PCS or similar in-home aide services

Eligible individuals may live in a private living arrangement, a licensed adult care home, a combination home, a licensed group home or a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency.

To Access PCS:

The individual's primary care physician must make a referral for PCS.

PRIVATE DUTY NURSING

PDN

What is Private Duty Nursing? PDN is a skilled nursing service comparable to the care provided by hospital nursing or skilled nursing facility staffs, but is provided in the individual's private residence. PDN is based upon a written individualized plan of care approved by an attending physician. Case Management is not provided with this service. PDN must be provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) employed by a licensed home care agency. Eligible individuals may receive up to 112 hours per week.

Important Considerations

- PDN services may be used outside the home for normal life activities, such as supported or sheltered work settings, licensed child care, school, school related activities, and religious services/activities.
- It is recommended that there be a second trained informal caregiver for instances when the primary informal caregiver is unavailable due to illness, emergency, or need for respite.
- An individual may receive expanded PDN services if they qualify for PDN services and either: 1) use a respiratory pacer; 2) have dementia or a cognitive deficit and are otherwise alert or ambulatory; 3) requires IV, PICC or central line infusions; 4) require a licensed nurse for assessment and interventions using Diastat, oxygen, etc for seizures; 5) have a primary caregiver 80 years or older or who has a disability that interferes with the ability to provide care; or, 6) Adult Protective Services has determined that additional hours would help ensure health, safety and welfare. Beneficiaries receiving expanded PDN services are eligible for more hours of care within the program maximum of 112 hours per week.

For more about PDN services and eligibility go to:

PDN Clinical Coverage Policy
http://www.ncdhhs.gov/dma/mp/3G.pdf

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4100

Who Qualifies for PDN?

To be eligible for PDN standard nursing services, the individual must:

- Be eligible for Medicaid under one of the Medically Needy Categories as determined by the local county department of social services where the individual resides.
- Reside in a private residence.
- Have a documented medical need for skilled nursing care in the home, with a prior approval from the individual's
- attending physician.
- Have at least one trained, informal caregiver to provide direct care to the beneficiary during planned or unplanned absences of PDN staff.
- Be ventilator-dependent for at least eight hours per day, or meet four of the following criteria: 1) unable to wean from a tracheostomy; 2) require nebulizer treatments at least two scheduled times per day and one as needed; 3) require pulse oximetry readings every nursing shift; 4) require skilled nursing or respiratory assessments every shift due to a respiratory insufficiency; 5) require oxygen as needed or rate adjustments at least two times per week; 6) require daily tracheal care; 7) require PRN tracheal suctioning requiring a suction machine and a flexible catheter; or 8) at risk for requiring ventilator support.

To Access PDN Services:

The individual must ask a primary care or attending physician to make a referral for PDN.

Nurse Consultants at the North Carolina Division of Medical Assistance provide prior approval determinations for PDN.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

DME

What is DME? Durable medical equipment (DME) refers to the following categories of equipment and related supplies for use in a Medicaid recipient's home:

- Inexpensive or Routinely Purchased Items
- Enteral Nutrition Equipment
- Related Medical Supplies
- Other Individually Priced Items
- Capped Rental/Purchased Equipment
- Oxygen and Oxygen Equipment
- Service and Repair
- Equipment Requiring Frequent and Substantial Servicing

DMA has designated Roche Diagnostics Corporation Diabetes Care as the preferred manufacturer for glucose meters, test strips, control solutions, lancets and lancing devices. Additional information on ACCU-CHEK diabetic supplies is available under the "What's New" provider section on the DMA website. Questions should be directed to ACCU-CHEK Customer Care at 1-877-906-8969.

What Qualifies as DME? There are two DME categories for equipment and related supplies for use in a beneficiary's home: 1) *Inexpensive or Routinely Purchased* are items purchased for a beneficiary and 2) *Capped Rental or Purchased Equipment* are rented or purchased as follows:

- The item is **rented** if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six months or less.
- The item may be **rented** or **purchased** if the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months. Once rental is initiated on an item, a subsequent request for prior approval of purchase of that item will be denied. The item becomes the property of the beneficiary when the accrued rental payments reach NC Medicaid (Medicaid) allowable purchase price.

The following requirements must be met before an item can be considered DME:
It 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) is not useful to a beneficiary in the absence of an illness or injury; 4) is appropriate for use in the home (for the purpose of this policy, home includes a private residence for both a Medicaid and NCHC beneficiary or an adult care home for only a Medicaid beneficiary); and, 5) is intended to be used by only one beneficiary. All requirements above must be met before an item can be considered medical equipment. The item becomes the property of the beneficiary when the accrued rental payments reach the NC Medicaid allowable purchase price.

Medical supplies are non-durable supplies that: 1) are disposable, consumable, and non-reusable in nature; 2) cannot withstand repeated use by more than one beneficiary; 3) are primarily and customarily used to serve a medical purpose; 4) are not useful to a beneficiary in the absence of illness or injury; and 5) are ordered or prescribed by a physician, physician assistant, or nurse practitioner.

For a list of covered Durable Medical Equipment, reference the most recent DME Fee Schedule: **http://www.ncdhhs.gov/dma/services/dme.htm** (Bottom of the web-page) **Please note that items with an asterisk require prior approval.**

For more information - DME Clinical Coverage Policy **http://www.ncdhhs.gov/dma/mp/dmepdf.pdf**
Or Call **(**919) 855-4310

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT

EPSDT

North Carolina Medicaid's health insurance plan for its beneficiaries under 21 years of age is known as EPSDT, or "Early Periodic Screening, Diagnostic and Treatment". Under its EPSDT benefit, Medicaid provides a broad menu of preventive, diagnostic and treatment services for its covered children and youth, as specified in Federal Medicaid Act, 42 U.S.C. §1396d(r) [§1905(r), Social Security Act].

The EPSDT benefit is working at all times, for each and every child beneficiary.

More comprehensive than the Medicaid benefit for adults, the EPSDT benefit is designed to assure that children receive the preventive services, early care, acute care and ongoing, long-term treatment and services they need so that health problems are averted, or diagnosed and treated as early as possible. *The goal of EPSDT is to assure that Medicaid's infants, children and adolescents get the health care they need when they need it – the* ***right care*** *to the* ***right child*** *at the* ***right time*** *in the* ***right setting***. Through the EPSDT benefit, children's health problems should be addressed before they become advanced and life-limiting, and before treatment becomes more complex, difficult and costly.

Important Considerations:

- There is no 'waiting list' for a service covered by the Medicaid EPSDT benefit. However, Medicaid cannot insure that its enrolled providers will not have time limitations or wait lists when scheduling appointments.
- There is no monetary cap, set list or copays on medically necessary care for Medicaid's children.
- Medicaid's EPSDT benefit for children is not driven by policy limits or restrictions, so long as the service is included in Social Security's Medicaid Act at §1905 (a)(r) .

For coverage, the treatment or service must be:

- Coverable under §1905 (a)(r),
- Medical in nature,
- Not experimental or investigational,
- Accepted method of medical treatment (standard of care),
- Proven safe,
- Effective (Evidence-based) to correct/ameliorate the individual's documented health condition,
- Least costly treatment among equally effective alternatives.

For more information about NC's EPSDT benefit, visit:

http://www2.ncdhhs.gov/dma/epsdt/

EPSDT supports every covered child, at all times.

EPSDT is Medicaid's health benefit package for children. It is not a free-standing funding source or a program of specialized services. Written into federal Medicaid law at §1905 (a) (r) of the Social Security Act, EPSDT guarantees a scope of health benefits for Medicaid's enrolled children unmatched by any private health insurance policy. The EPSDT benefit requires that state Medicaid agencies provide directly or arrange for (through agreements with appropriate agencies, organizations, or individuals) any rehabilitative service meeting federal EPSDT criteria for medical necessity.

The EPSDT benefit requires coverage of any requested remedial service, product or treatment listed at §1905 (a) (r) of the Social Security Act when a review of the request by EPSDT criteria finds that service medically necessary to "correct or ameliorate a defect, physical or mental illness, or health condition", *regardless of its coverage in an individual state's Medicaid Plan.* The EPSDT benefit also covers medical and behavioral health services when an ESPDT review finds that the service is required in greater quantities, more often or for a longer period of time than a state plan's policy limits or exclusions allow, or when the beneficiary fails to meet strict state policy criteria for service authorization.

Accessing Services Coverable Under The EPSDT benefit:

Care providers may request services by contacting the agency/vendor charged with prior authorization of the specific product, treatment or service needed. For a listing of prior authorization agents, please choose the 'Prior Approval Fact Sheet' link found at:

https://www.nctracks.nc.gov/content/public/providers/provider-user-guides-and-training/fact-sheets.html

"Health Check" Early Periodic Screening Program and Wellness Visits.

Health Check is North Carolina Medicaid's program of Early Periodic Screening for children. Supporting a foundation of good health while insuring the earliest possible diagnosis and treatment of health problems, *Health Check* offers access to routine preventive care. Wellness visits, including physical assessments, vision and hearing testing, developmental/mental health screenings, vaccines and follow-up care are encouraged at intervals recommended by the *American Academy of Pediatrics*. Local Health Check Program Coordinators assist and support families to link with care providers and to access these services.

COMMUNITY CARE OF NORTH CAROLINA / CAROLINA ACCESS

CCNC/CA

What is Community Care of North Carolina/Carolina Access? It is a statewide managed care program with 14 regional networks serving all 100 counties and more than 1 million Medicaid recipients. Participating network primary care physicians (PCPs) receive a per-member-per month fee to provide a medical home to Carolina Access enrollees and participate in disease management and quality improvement programs. CCNC links recipients to a primary care medical home and creates networks that: 1) join primary care homes with other segments of the local health care system (e.g. hospitals, health departments, mental health agencies, social services); 2) are responsible for managing recipient care; 3) supports a patient-centered medical home; and 4) provides critical supports during care transitions.

Important Considerations:

- If a medical home is not chosen by the enrollee, one may be assigned.
- The medical home provides treatment and/or medical advice 24 hours a day, 7 days a week.
- CCNC has care managers (nurses and social workers) who can assist enrollees with understanding a physician's instructions, making appointments, explaining how to take medications and teaching the recipient how to manage chronic care needs.
- The PCP will make referrals to specialists as needed.

For More Information About CCNC/CA go to:

The CCNC Website - **https://www.communitycarenc.org/**

Call a CCNC Regional Managed Care Consultant -

http://www2.ncdhhs.gov/dma/ca/mcc_051214.pdf

Call the N.C. DMA Managed Care Program: 919-855-4780

Who Qualifies For CCNC?

Enrollment in CCNC/CA is mandatory for the majority of Medicaid recipients. Recipients in some Medicaid eligibility categories are exempt from enrollment, or, enrollment is optional. Recipients may also be exempt from enrollment for certain medical conditions. Reasons for exemption include a terminal illness, active chemotherapy or radiation therapy (until the completion of the therapy), and impaired mental/ cognitive status that makes it impossible for the adult recipient to comprehend and participate in the program. Other diagnoses and information is considered on a case-by-case basis. CCNC/CA enrollees are enrolled with a Primary Care Provider (PCP) and have a designated medical home.

CCNC targets enrolled beneficiaries with complex medical needs for care management services, especially those transitioning between health care settings. These services can include face-to-face visits, medication management and coordination of community resources/services. CCNC has a standardized care management process to provide critical interventions that empower the individual/caregiver with self-management skills. The ultimate goals for all CCNC care management interventions are to promote better health outcomes for individuals served and to decrease utilization of unnecessary inpatient and emergency department services.

Access to CCNC can occur through:

The Departments of Social Services (DSS) in the county where the individual resides-http://www.ncdhhs.gov/dss/local/. Local DSS offices have a complete list of participating primary care physicians.

Acronyms

AA	Alcoholics Anonymous
AAA	Area Agency on Aging
AAIDD	American Association of Intellectual Developmental Disabilities
ACH	Adult Care Home or Assisted Living Facility
ACL	Administration for Community Living
ACT	Assertive Community Treatment
ACTT	Assertive Community Treatment Team
ADA	American with Disabilities Act
ADATC	Alcohol/Drug Addiction Treatment Centers
ADD	Attention Deficit Disorder
ADETS	Alcohol Drug Education Training School
ADHC	Adult Day Healthcare
ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Center (Federal language for NC's CRC)
ADVP	Adult Day Vocational Program
AHEC	Area Health Education Center
AIRS	Alliance of Information and Referral Systems
AOC	Administrative Office of the Courts
APR	Adult Program Representative
The Arc	Formerly known as the Association for Retarded Citizens- The organization changed its name, as *"Mental Retardation" is considered degrading*
ASAM	American Society of Addiction Medicine
ASANC	Association of Self-Advocates of NC
ASNC	Autism Society of North Carolina
AT	Assistive Technology
BIANC	Brain Injury Association of NC
CABHA	Critical Access Behavioral Health Agency
CAP	Community Alternatives Program
CAP/C	Community Alternatives Program for Children
CAP/Choice	Consumer-Directed Version of CAP/DA
CAP/DA	Community Alternatives Program for Disabled Adults
CAP/IDD	Community Alternatives Program for Intellectually and Developmentally Disabled

Acronyms

CARF	Council on Accreditation of Rehabilitation Facilities
CASP	Cross-Area Service Program
CASSP	Child and Adolescent Service System Program
CBS	Community Based Services
CBT	Cognitive Behavioral Therapy
CCD	Consortium of Citizens with Disabilities
CCNC	Community Care of North Carolina
CCT	Comprehensive Crisis Treatment
CDC	Centers for Disease Control
CFR	Code of Federal Regulations
CIL	Center for Independent Living
CISS	Community Integration Services and Supports
CLP	Community Living Program
CMS	Centers for Medicare and Medicaid Services
COA	Council on Accreditation
CRC	Community Resource Connections for Aging and Disabilities
COG	Council of Governments
CP	Cerebral Palsy
CPDMI	Coalition for Persons Disabled by Mental Illness
CPPS	Certified Peer Support Specialist
CQI	Continuous Quality Improvement
CST	Community Support Team Service
DAAS	Division of Aging and Adult Services
DB	Deaf-Blind
DD	Developmental Disabilities
DDS	Disabilities Determination Section
DDST	Denver Developmental Screening Test
DETOX	Detoxification Services
DHSR	Division of Health Service Regulation
DHHS	Department of Health and Human Services
DJJDP	Dept. of Juvenile Justice and Delinquency Prevention
DMA	Division of Medical Assistance (Medicaid)
DMHDDSAS	Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DOC	Department of Correction
DOE	Department of Education - Federal

Acronyms

DOI	Department of Insurance
DPH	Division of Public Health
DPI	Department of Public Instruction
DPP	Displacement Prevention Program
DRNC	Disability Rights, North Carolina
DSB	Division of Services for the Blind
DSDHH	Division of Services for the Deaf and the Hard of Hearing
DSM-IV	Diagnostic and Statistical Manual of Mental Illness, 4th Revision
DSS	Division of Social Services OR county Department of Social Services
DT	Day Treatment
DVRS	Division of Vocational Rehabilitation Services
DWI	Driving While Impaired
EANC	Epilepsy Association of North Carolina
ECS	Electronic Claim Submission
EI	Early Intervention
ELP	Essential Lifestyle Plan
EPSDT	Early Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
FAA	Families as Allies
FAS	Fetal Alcohol Syndrome
FBC	Facility Based Crisis Service
FES	Family Empowerment Scale
FI	Fiscal Intermediary
FSN	Family Support Network
FTE	Full Time Employee
HCBS	Home and Community Based Services
HCCBG	Home and Community Care Block Grant
Healthy IDEAS	Identifying Depression, Empowering Activities for Seniors
HIPAA	Health Insurance Portability & Accountability Act
HUD	Housing and Urban Development
IADL	Instrumental Activities of Daily Living
ICF/MR	Intermediate Care Facility for Mental Retardation
I/DD	Intellectual/Developmental Disability
IDEA	Individuals with Disabilities Education Act

ALPHABET SOUP

Acronyms

IDT	Inter-Disciplinary Team
IEP	Individualized Education Program
ILC	Independent Living Center
IMD	Institute of Mental Disease
IMPACT	Improving Mood-Promoting Access to Collaborative Treatment
IPRS	Integrated Payment and Reimbursement System
IRIS	Incident Response Improvement System
ISP	Individual Service Plan
IST	Individual Service Team
IVC	Involuntary Commitment
JCAHO	Joint Commission on the Accreditation of the Healthcare Organizations
KBR	Kate B. Reynolds Charitable Trust
LCA	Local Contact Agency
LCSW	Licensed Clinical Social Worker
LDA	Learning Disabilities Association of North Carolina
LME	Local Management Entity
MCO	Managed Care Organization
MCT	Mobile Crisis Team
MDS	Minimum Data Set
MFP	Money Follows the Person
MH	Mental Health
MHA/NC	Mental Health Association of North Carolina
MHBG	Mental Health Block Grant
MI	Mental Illness
MIPPA	Medicare Improvements for Patients and Providers Act
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
NA	Narcotics Anonymous
NAMI-NC	National Alliance for the Mentally Ill – North Carolina
NC ACT	North Carolina Alliance for Effective Care Transitions
NCCEH	North Carolina Coalition to End Homelessness
NCMHAC	North Carolina Mental Health and Aging Coalition
NCOA	National Council on Aging

Acronyms

NIMH	National Institute of Mental Health
NWD	No Wrong Door
OAH	Office of Administrative Hearings
OC	Options Counseling and Assistance
P&A	Protection and Advocacy Agency
PACE	Program of All-Inclusive Care for the Elderly
PAS	Personal Assistance Services
PCHDP	Person-Centered Hospital Discharge Planning
PCS	Personal Care Services
PDD	Pervasive Developmental Disabilities
PDN	Private Duty Nursing
PEARLS	Program to Encourage Active and Rewarding Lives
PIHP	Prepaid Inpatient Health Plan
PLA	Private Living Arrangement
PMPM	Per Member Per Month
PSR	Psychosocial Rehabilitation
PSS	Peer Support Services
PT/OT/ST	Physical Therapy/Occupational Therapy/Speech Therapy
PTSD	Post Traumatic Stress Disorder
QDDP	Qualified Development Disabilities Professional
QI	Quality Improvement
QPMH	Qualified Professional in Mental Health
QPSA	Qualified Professional in Substance Abuse
RFP	Request for Proposal
RWJ	Robert Wood Johnson Foundation
SABG	Substance Abuse Prevention and Treatment Block Grant
SACOT	Substance Abuse Comprehensive Outpatient Treatment
SAIOP	Substance Abuse Intensive Outpatient Program
SBIRT	Screening, Brief Intervention, Referral & Treatment
SE	Supported Employment
SEP	Single Entry Point
SH	Supportive Housing
SHIIP	Seniors' Health Insurance Information Program
SILC	State Independent Living Council
SMI	Severe Mental Illness

Acronyms

SPMI	Severe and Persistent Mental Illness
SSA	Social Security Administration
SSBG	Social Services Block Grant
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury
TC	Transitions Coordinator
TDD	Telecommunication Device for Persons Who are Deaf or Hard of Hearing
TEACCH	Treatment and Education of Autistic Children & Other Communications Handicaps
TP	Treatment Plan
TS	Tourettes Syndrome
TTY	Teletext Typewriter Device
UCP	United Cerebral Palsy
VA	Veterans Affairs
VDHCBS	Veterans-Directed Home and Community-Based Services
VR	Vocational Rehabilitation
VRIL	Vocational Rehabilitation Independent Living Program