North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

September 26, 2014

Jackie Glaze
Associate Regional Administrator
Division of Medicaid
Centers for Medicare and Medicaid Services
Region IV
Atlanta Federal Center
61 Forsyth Street, SW Suite 4T20
Atlanta, GA 30303-8909

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2014-019

Dear Ms. Glaze:

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected pages are Text Page 9p; Attachment 1.2-A, Page 10; Attachment 3.1-A.1, Page 13a.1-13a.2; Supplement 1 to Attachment 3.1-A, Part G, Page 5; Attachment 3.1-D, Page 1, Pages 3-4; Attachment 3.1-F, Pages 1-21; Attachment 4.19-A, pages 38; Attachment 4.19-B, Section 23, Page 1c; Attachment 4.33-A, Page 1; Supplement 2, Attachment 4.34-A, Pages 3-20; Supplement 1 to Att. 4.40-B, Pages 2 and 14; and Supplement 1 to Att. 4.40-E, Page 3.

The state plan changes are to include references to federally recognized tribes where appropriate in the NC Medicaid State Plan to ensure that all duties, roles, and responsibilities previously assigned to county divisions of social services are shared with federally recognized tribes who will assume those duties, roles and responsibilities for individuals living within the tribal boundary. These changes are necessary to implement Session Law 2014 – 100, Section 12C.3. The Eastern Band of Cherokee of Indians (EBCI) will assume responsibility for certain social services, healthcare benefit programs, ancillary services, including Medicaid administrative and service related functions, and related reimbursements.

This amendment is effective October 1, 2015.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact Teresa Smith or me at 919-855-4116.

Sincerely,

Aldona Z. Wos, M.D.

Enclosures

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

1. The State Plan program assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 412.62 (f)(1)(ii).

   X The State Plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs. (Place check mark to indicate state's affirmation.)

2. The State plan program will only limit enrollment into a single HIO, if and only if the HIO is one of the entities described in section 1932 (a)(3) (C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

d. disenrollment

1. The State Plan program assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56 (c).

   The State assures that beneficiaries will be permitted to disenroll from a managed care plan or change Carolina ACCESS/ACCESS II PCPs on a month to month basis. However, the recipient must select another managed care plan option for health care services, if the recipient is in one of the mandatory eligibility categories for enrollment. The county DSS or federally recognized tribe is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the State eligibility system.

2. What are the additional circumstances of "cause" for disenrollment? (If any.)

VI. INFORMATION REQUIREMENTS FOR BENEFICIARIES

The State Plan program assures that its plan is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932 (a)(1)(A) state plan amendments.

The division works with other DHHS divisions, state agencies and local health departments and in partnership with public and private groups to ensure a healthy North Carolina.

OFFICE OF RURAL HEALTH AND RESOURCE DEVELOPMENT

The N.C. Office of Rural Health and Resource Development, founded in 1973 as the Office of Rural Health Services, provides technical assistance to small hospitals and community health centers in rural and medically under-served communities. The office also recruits health care providers to work in rural and medically under-served communities and provides grants for community health centers.

DIVISION OF SOCIAL SERVICES

The Division of Social Services provides immediate economic and social support to individuals and families. Its principal mission is to strengthen families and to help people get jobs and move off welfare.

Work First is Governor Jim Hunt's welfare reform effort, emphasizing work and personal responsibility. Work First sets strict time limits on benefits and tough sanctions for those who refuse to participate. It helps welfare parents become wage earners through job training and help pay for child care. Its goal is to streamline and simplify the welfare system, cutting red tape.

The division supports North Carolina families in numerous other ways:

Child support enforcement ensures children receive financial support from absent parents.
Foster care services link children to nurturing private homes, group homes, or child-caring institutions.
Adoption services help place children with permanent, caring families. Protective services identify youngsters who are at risk for abuse or neglect and provides help to ensure their safety and well being.
Adolescent parenting programs work to delay a second pregnancy among teenagers and has effectively cut the rate of second pregnancies in half.

Social services offices operate in every county. Local offices are operated by the individual counties and federally recognized tribes under the supervision of the state division.

DIVISION OF VOCATIONAL REHABILITATION

The goal of the Vocational Rehabilitation Program is employment. Vocational rehabilitation counselors work with business and community agencies to help them prepare their work

7. Home Health *(continued)*

c. Medical supplies, equipment, and appliances suitable for use in the home.

1) Medical Supplies

Medical supplies are covered when medically necessary and suitable for use in the home in accordance with 42 CFR 440.70(a)(3). Medical supplies must be prescribed by a practitioner licensed according to North Carolina General Statute Chapter 90 under approved plan of care. These items will be covered when furnished by a Medicare Certified Home Health Agency, or by one of the following: an ME supplier; a PDN provider when providing PDN services (for supplies needed by a Division of Medical Assistance approved PDN patient) or by the PDN provider for medically necessary incontinent, ostomy and urological supplies (when no home health provider is available); a local lead agency for the Community Alternatives Program (CAP) for adults with disabilities and persons with mental retardation or developmental disabilities; or a local lead agency that provides case management for the Community Alternative Program for children. The "local lead agency" is the agency/facility in the county or counties or tribal boundary that coordinates and manages the CAP program.

7. Home Health *(continued)*

c. Medical supplies, equipment, and appliances suitable for use in the home.

2) Medical Equipment

Medically necessary medical equipment (ME) is covered by the Medicaid program when prescribed by a licensed healthcare practitioner and supplied by a qualified ME provider in accordance with 42 CFR 440.70(c)(3). Prior approval must be obtained from the Division of Medical Assistance, or its designated agent.

To be a qualified provider, an entity must possess a state business license and a Board of Pharmacy permit, and be certified to participate in Medicare as a ME supplier, or be a Medicaid enrolled home health agency, a state agency, a local health department, a local lead agency for the Community Alternatives Program (CAP) for adults with disabilities and persons with mental retardation or developmental disabilities, or a local lead agency that provides case management for the Community Alternative Program for children.

The "local lead agency" is the agency/facility in the county or counties or tribal boundary that coordinates and manages the CAP program.

Payment for medical equipment is limited to the official, approved ME list established by the Division of Medical Assistance. Additions, deletions or revisions to the ME list are approved by the Director of the Division of Medical Assistance upon recommendation of DMA staff. Only items determined to be medically necessary, effective and efficient are covered.

State Plan under Title XIX of the Social Security Act
State/Territory: North Carolina
TARGETED CASE MANAGEMENT SERVICES
Persons with HIV Disease

Provider Certification

In the absence of State licensure laws governing the qualifications and standards of practice for HIV case management providers, the State Division of Medical Assistance will be responsible for the certification process. DMA agrees to implement methods and procedures for certifying providers of HIV case management services as qualified to render services according to professionally recognized standards for quality care. This will ensure that HIV case management services are provided by qualified providers in accordance with section 1902(a)(23) of the Social Security Act. The initial certification is valid for one year.

To be certified and to qualify for reimbursement a provider shall submit a complete and signed application to DMA to include documentation of requirements indicated in the application. The application shall include the following information as identified under *Administrative, Case Management and Human Resource Requirements:*

Administrative Requirements

- A list of counties to be served;
- Hours of operation, the agency shall maintain regularly scheduled hours of operation;
- Emergency after hours response plan;
- A list of potential community resources for the entire service area;
- A copy of Articles of Incorporation, unless the agency is a local government unit or a federally recognized tribe;

The agency shall meet the following requirements:

- Have a physical business site at the time of application. The business site shall be verified by a site visit. This site cannot be in a private residence or vehicle.
- Submit a copy of the agency's organizational chart
- Submit a list of person who have five percent or more ownership in all or any one agency
- Submit a business plan that provides specific information for development costs and projected monthly revenue and expense statement for the 12 months subsequent to the approval of the application and actual revenue and expense statement for the 12 months preceding the application date. This plan must:
    - Include assumed consumer base, services, revenues and expenses;
    - Outline management of initial expenses;
    - Identify the individuals responsible for the operation of the agency and shall include their respective resumes;
    - Show a program development enhancement timetable; and include existing financial resources

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Limitations in the Amount, Duration and Scope of Certain Items of Provided Medical and Remedial Care and Services are Described Below:

CITATION	Medical and Remedial Care and Services	
42 CFR 431.53	Item 24.a Transportation	Methodologies for medically necessary ambulance transportation are found in Attachment 3.1-A.1, page 18. Transportation services for categorically needy are defined in Attachment 3.1-A and transportation services for medically needy are defined in Attachment 3.1-B. An amount to reimburse nursing facilities, ICF-MR and Adult Care Homes for non-ambulance non-emergency transportation is included in Medicaid payments to those facilities. Methods of Assuring Transportation The North Carolina Division of Medical Assistance, or its designated agent, shall assure that necessary NEMT services are provided for beneficiaries who have a need for assistance with transportation. The designated agent is the county departments of social services or the federally recognized tribe. The distance to be traveled, transportation methods available, treatment facilities available, and the physical condition and welfare of the beneficiary shall determine the type of NEMT authorized. The type of transportation available may vary by region because of rural and urban conditions.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Attendants, including family members, are entitled to reimbursement of expenses incurred during transportation at the least expensive rate that is appropriate to the beneficiary's circumstances. Attendants, other than family members, may charge for their time when an attendant is medically necessary. Maximum reimbursement for an attendant's time shall not exceed the state hourly wage rate, nor shall an attendant be reimbursed for time spent in travel without the beneficiary. A medical professional who serves as an attendant and administers medical services during the trip may bill Medicaid for that service, but cannot also charge for his time.

Applicants/ beneficiaries are made aware of NEMT services by the following methods:

- Information on applications/re-enrollment forms
- Rights and Responsibilities Handout/Mailing
- Department of Social Services contact
- Beneficiary Handbook
- DMA Website

Compliance with NEMT policy is assured through county, tribal and state monitoring and state auditing.

Counties and federally recognized tribes are required to track each trip request from intake through disposition. Effective April 1, 2012, counties and federally recognized tribes are required by policy to audit 2% of the trips made each month using a state compliance monitoring tool. Reports are maintained at the county or with the federally recognized tribe and must be provided to the state upon request and at a time of state audits.

In March 2012, a contract was executed by the state with a vendor to perform audits of the county NEMT programs based on policy. The state meets at minimum biweekly with the vendor to review

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

findings and take action. Counties and federally recognized tribes are required to submit a corrective action plan for issues identified through the audits and to payback funds as necessary. Implementation of corrective action plan is monitored and can result in withholding of funding or termination of provider status. The audit does not affect the recipients' coverage.

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of North Carolina enrolls Medicaid beneficiaries on a mandatory basis into managed care entities. (managed care organization (MCOs) and/or primary care case managers (PCCMs) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities and/or primary care case management entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
_X_ ii. PCCM (including capitated PCCMs that qualify a PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

_X_ i. fee for service;
____ ii. capitation;
_X_ iii. a case management fee;
_X_ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
_X_ vi. other. (Please provide a description below).

Providers serving as a Pregnancy Medical Home are paid an incentive pay for performing an initial prenatal screening using a standardized tool and for an incentive payment for a postpartum visit.

Citation	Condition or Requirement
	In addition, providers are paid an enhanced fee for vaginal deliveries. Providers are exempted from the requirement to obtain prior approval for ultrasounds. Pregnancy Medical Home providers are not paid a PM/PM. North Carolina is transitioning from a basic PCCM program, Carolina ACCESS, to an enhanced PCCM program, Community Care of North Carolina (CCNC). CCNC is a composite of regional networks operating statewide. The state currently contracts with each network to carry out the functions of the program. To operationalize this transition, the state will contract with North Carolina Community Care Networks, Inc. (NCCCN) to administratively oversee the networks, and by holding NCCCN contractually responsible, to ensure regional networks and CCNC affiliated providers meet program goals and performance measures. NCCCN is a physician-led private non-profit organization with the expertise and resources to ensure a healthcare delivery system that is cost efficient and driven to achieve patient centered quality health care. With this transition, the state will no longer contract directly with the networks. NCCCN will enter into contracts with each of the networks to continue operation of CCNC. Each network builds private and public partnerships where community providers and resources plan cooperatively for meeting patient needs. Health care management is provided at the community level, allowing local solutions to achieve desired outcomes. Because health care is planned and provided at the community level, larger community health issues can be addressed. NCCCN will ensure standardized performance and utilization metrics are implemented and achieved state-wide. The state will continue to require a PCCM contract with providers to serve as health homes for Medicaid, Health Choice and targeted populations. To participate as a health home in CCNC, providers must also contract with NCCCN and the network with which it affiliates. Providers serving as Carolina Access (CA) PCPs are encouraged to join a network to establish their role as a health home for Medicaid and Health Choice beneficiaries. If a CA provider chooses not to affiliate with a network, the enrolled beneficiaries who are in a mandatory group will be required to choose a CCNC provider. Beneficiaries who are voluntary for enrollment can choose to enroll with a network affiliated provider or can choose to opt out of CCNC. The state is sensitive to the possibility that this could create a temporary access to care issue and the state has created a process that identifies beneficiaries for whom there is no PCP available within 30 miles of their residence. In these situations, the state and NCCCN will work cooperatively to develop and ensure appropriate access; however, beneficiaries will remain exempt until access is available.

Citation	Condition or Requirement

NCCCN Responsibilities:

Using a patient centered team approach, NCCCN utilizes human and organizational resources to develop and implement a population management approach with enhanced and coordinated care for enrolled beneficiaries through:

- prevention and screenings;
- standardization of evidence-based best practices;
- community-based care coordination;
- care management;
- patient monitoring;
- investments in health information technology;
- health information exchange;
- data analytics for population stratification and prioritization;
- medication reconciliation;
- transitional care support;
- self-management coaching;
- reimbursement incentives to increase the quality and efficiency of care for patient populations;
- disease management; and
- linkages to community resources.

To accomplish this, NCCCN provides:

- Standardized, clinical, and budgetary coordination;
- Oversight and reporting;
- Locating, coordinating and monitoring the health care services of enrolled populations;
- Comprehensive statewide quantitative performance goals and deliverables;
- Utilization management;
- Quality of care analytics;
- Access to care measures;
- Financial budgeting, forecasting, and reporting methodologies;
- Predictable cost containment methodologies;
- Outcome driven clinical and financial metrics; and
- Training, education, mentorship and supervision.

Citation	Condition or Requirement

Network Responsibilities:

Each network operates under the direction of a network director, clinical director, and network steering committee. The steering committee is composed of community leaders and organizations involved in planning for or providing services to Medicaid and Health Choice beneficiaries. Networks ensure that there is a sufficient panel of primary care providers to serve enrolled populations within the regional catchment area. A local medical director and board provide clinical direction and supervision to the network on initiatives agreed upon by DMA and NCCCN. Networks hire or contract with professionals who have expertise to lead and support each initiative. These experts include but are not limited to:

- Medical Director who chairs a Medical Management Committee;
- Care managers (nurses and social workers);
- Network and Clinical Pharmacists;
- Psychiatrists;
- Pregnancy Home Nurse Coordinator;
- CC4C Coordinator;
- Health Check program Coordinator; and
- Palliative Care Coordinator.

Networks establish uniform processes for functions that include but not limited to:

- Enrollee complaints;
- Performance measures;
- Use of CMIS and data reporting to identify patients at highest risk and who could benefit from care management services;
- Development of patient centered care plans in coordination with the primary care provider;
- Transitional support;
- Training of staff to develop skills to provide care management services; and
- Population management strategies (disease and care management pathways and expectations).

Citation	Condition or Requirement

Provider Responsibilities:

Medicaid enrolled providers can qualify to be a primary care provider in the CCNC program when the conditions of the contract with the network and NCCCN are met and maintained. These requirements include but are not limited to the following:

- The provision of coordinated and comprehensive care;
- Compliance with CCNC initiatives and promotion of service integration and self-management;
- The application of evidence based best practice in coordination with network and care managers;
- Coordination with care managers in developing and carrying out patient plans of care;
- Cooperation and collaboration with NCCCN and networks to implement initiatives;
- Serving as a patient centered health home;
- Implementing strategies of population based strategies of care;
- Using the Informatics Center for reports and analytics to improve patient care;
- Carrying out disease management activities of NCCCN; and
- Demonstrating improvement in quality and cost of care.

To affect positive changes in the delivery of prenatal care and pregnancy outcomes, North Carolina established a medical home for pregnant Medicaid beneficiaries called a Pregnancy Medical Home (PMH). Case management services for Medicaid pregnant women are part of the managed care model. The CCNC networks receive a PM/PM to work directly with PMHs and to provide population management and care/case management for this population.

A PMH provider may also be a CCNC-PCP but it is not required. A PMH must agree to a set of performance measures which are different from the measures for CCNC PCPs. The following are examples and may change over time based on best practices and data.:

- Obtain and maintain a Cesarean Section rate of 20% or below;
- No elective inductions before 39 weeks;
- Engage in the 17 P program; and
- Complete high risk screenings on beneficiaries.

Citation	Condition or Requirement

A provider who agrees to be a PMH is paid fee for service and receives an incentive and enhanced delivery rate for each Medicaid beneficiary. The provider does not receive a PM/PM for being a PMH.

PMH providers are assigned a pregnancy care manager to work with their high risk pregnant population. These high risk pregnant women receive services based upon their level of need. This program is outcome driven and measured. The following are examples of the performance measures and may change over time:

- Increase number of high risk patients that receive a comprehensive assessment;
- Increase the postpartum visit rate; and
- Increase the percent of eligible at-risk women that receive the 17P injections.

Case management services for the pregnant woman population was previously fee for service and is now being moved to the managed care model.

CCNC operates the Care Coordination for Children program (CC4C) which provides care/case management for high risk and high cost children aged birth up to age 5, excluding Early Intervention. Eligible children receive population management, care management, and coordination of treatment and prevention. This program is outcome driven and measured. The following are examples of the performance measures and may change over time:

- Increase rate of first visits by NICU graduates within 1 month of discharge;
- Increase rate of comprehensive assessments completed; and
- Increase number of children who have a medical home that have special health care needs and/or are in foster care.

Case management services for high risk children aged birth up to age 5 was previously fee for service and is now being moved to the managed care model.

North Carolina expanded the use of the regional networks to provide these activities to high risk and high cost children or pregnant women not enrolled with a network. The networks are also paid a pm/pm for these services when provided to non-enrolled beneficiaries.

Citation	Condition or Requirement

The PM/PM for care/case management of the pregnant women and children birth up to age 5 was based on the current fee for service cost of the maternal care coordination targeted case management program and the child service coordination case management program. The total expenditures in the base year were divided by the total beneficiary population to establish the PM/PM rate. These rates were actuarially certified as being developed in accordance with generally accepted actuarial practices and are appropriate for the Medicaid covered populations and services under the managed care contract and PMPM rates

DMA shall set forth all payments to the provider including enhanced services reimbursement and enhanced management fees and that the contracts must be reviewed and approved by CMS.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

__X__ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

__X__ ii. Incentives will be based upon specific activities and targets.

_____ iii. Incentives will be based upon a fixed period of time.

_____ iv. Incentives will not be renewed automatically.

__X__ v. Incentives will be made available to both public and private PCCMs.

__X__ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

_____ vii. Not applicable to this 1932 state plan amendment.

Citation		Condition or Requirement
CFR 438.50(b)(4)	4.	Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* The PCCM program was founded with input from the medical provider community and other agencies involved in public service delivery. Physician and physician professional organizations have always been instrumental in developing initiatives and direction for the program. As community networks were being developed, social service agencies, physicians, and hospitals became participants in planning at the community level how Medicaid beneficiaries could best be served with quality medical care and care management. Each network has a steering committee whose membership includes representatives from the department of social services, physicians, etc. Networks also have local medical management committees whose membership is composed of representatives from the medical community, i.e., physicians, hospital etc. Each network medical director participates on the statewide Medical Management Committee that advises the PCCM program on a statewide level. A provider satisfaction survey using an external vendor will be conducted every two years to maintain continued input from providers who participate in the program but who may not be part of an advisory committee. Beneficiaries enrolled with the PCCM managed care program have public input through the state's toll free customer service phone center which is staffed from eight to five, Monday through Friday. The toll free number for the state customer service center is 1-800-662-7030. The local CCNC networks also work with their enrollees on self-management strategies for many of the chronic diseases that are managed through the program. This provides an opportunity for the beneficiary to have involvement in the care management plan being proposed. In addition, the health home/PCP works closely with the high risk enrollee and their family in the development of a health care team and patient-centered care plan to support the enrollee in managing their chronic condition(s), as appropriate.

Citation	Condition or Requirement

Beneficiaries are also able to submit a concern about the program through a written complaint process.

Enrollees have public input through a Patient Satisfaction Survey. The survey is used to collect data on satisfaction, access, health status, utilization, and trust. The tool used to collect the data is the CAHPS survey for children and adults. A patient satisfaction survey will be conducted by an external vendor every three (3) years.

The NC Medical Care Advisory Committee reviews all major program changes for the Medicaid program. Beneficiaries have an opportunity to serve on this Committee.

1932(a)(1)(A)

5. The state plan program will_X_/will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory) _____

   ii. county/counties (voluntary)_____

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. _X_The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)

3. _X_The state assures that all the applicable requirements of section 1932.

Citation	Condition or Requirement
	(including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipient to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. _X_ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR Part 438 42 CFR 438.50(c)(4) 1903(m)	5. _X_ The state assures that all applicable managed care requirements of 42 CFR 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ____ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) CFR 447.362 42 CFR 438.50(c)(6)	7. ____ The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any nonrisk contracts will be met.
45 CFR 74.40	8. ____The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis.

- Work First for Family Assistance (formerly AFDC)
- Family and Children's Medicaid without Medicaid deductibles (formerly AFDC-related)
- Medicaid for the Aged, Blind and Disabled (MAA, MAB, MAD, MSB)
- Residents of Adult Care Homes (SAD, SAA)
- Special Assistance In-Home (SAIH)
- Qualified Alien
- Health Choice (North Carolina's S-CHIP program)

Children under age 19 identified as Children with Special Health Care Needs, dual eligibles, and Indians who are members of a Federally recognized tribes are mandatory exempt.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Citation	Condition or Requirement

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. _X_ Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

North Carolina moved to an opt-out process for enrolling dual eligible beneficiaries. Dual beneficiaries receive a letter informing them of the name, address, and phone number of the health home to which they have been assigned unless they contact the local department of social services. Assignment is based on an historical relationship with a provider and if no relationship can be determined, the beneficiary is assigned to a health home within a 30 mile radius of the beneficiary's home. The letter also informs them of their right to disenroll, change their medical home, and enroll on a month to month basis.

The State assures that beneficiaries will be permitted to change medical homes or disenroll from a managed care plan on a month to month basis.

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. _X_ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Native Americans are not part of the opt-out process. When making application for medical assistance, they are informed that they may enroll, disenroll, or change their medical home on a month to month basis if they opt to enroll.

The State assures that beneficiaries will be permitted to change medical homes or disenroll from a managed care plan on a month to month basis.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. _X_ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

Citation	Condition or Requirement
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v)	v. _X_ Children under the age of 19 years who are in foster care or other out-of- the-home placement.
42 CFR 438.50(3)(iii) 1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. _X_ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. _X_ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. With the exception of children receiving foster care services or adoption assistance, North Carolina has moved to an-opt out process for enrolling children with special health care needs. Parents/guardians of these children receive a letter informing them of the name, address, and phone number of the health home to which assignment has been made unless they contact the local department of social services. Auto-assignment is made to a health home with which there is an historical relationship if that can be determined. If there is no relationship with a health home, the beneficiary is assigned to a health home within 30 miles of the beneficiary's residence. The letter also informs them of their right to disenroll, change their health home, and enroll at any time. As a result of law P.L. 110-351/H.R.6893, Fostering Connections to Success and Increasing Adoption Act of 2008, the division works closely with the North Carolina Pediatric Society, practicing pediatricians and the North Carolina Division of Social Services to enroll foster children into health homes created by the PCCM program to plan for continued medical care of children with special health care needs. The State assures that these beneficiaries will be permitted to change health homes or disenroll from the PCCM program on a month to month basis.
	E. Identification of Mandatory Exempt Groups
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

Citation	Condition or Requirement

The State defines these children in terms of special health care needs and program participation in a Children's Developmental Service Agency (CDSA) or Child Special Health Services (CSHS).

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
_X_ iii. Both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, and coordinated care system.

_X_ i. yes
___ii. no

1932(a)(2)

4. Describe how the state identifies the following groups of children who are exempt 42CFR 438.50 (d) from mandatory enrollment: *(Examples: eligibility database, self- identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI;

The State identifies this group by Medicaid eligibility category of assistance.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

The State does not enroll this population in the managed care programs.

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

The State identifies this group by the Medicaid eligibility category of assistance or living arrangement code.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

The State identifies this group by the Medicaid eligibility category of assistance or living arrangement code.

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* The state has eliminated the self-identification for special needs. Children having special needs are identified according to CFR 438.50(d)(3)
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollments into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Beneficiaries who are also eligible for Medicare. These beneficiaries are identified by Medicaid eligibility category of assistance. ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. There is no eligibility category group designated for the Native American population; they are eligible for Medicaid under existing program aid categories.

Citation	Condition or Requirement

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

MQB, RRF/MRF, CAP cases with a monthly deductible, MAF-D, MAF-W, PACE enrollees, and Aliens eligible for emergency Medicaid only are not eligible to enroll.

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

MPW (Medicaid for Pregnant Women)
Benefit Diversion Beneficiaries
Beneficiaries with end stage renal disease

H. Enrollment process.

1932(a)(4)
FR 438.50

1. Definitions

i. An existing provider recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid beneficiaries if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default:

Describe how the state's default enrollment process will preserve:

i. The existing provider-beneficiary relationship (as defined in H.1.i).

Caseworkers at the local department of social services are the primary people who provide information about the program to potential enrollees and enroll them into the program.

Citation	Condition or Requirement

The state provides an enrollment form to the county departments of social services and federally recognized tribes. It is required to be completed at enrollment or change of health home. It is signed by the beneficiary or beneficiary's guardian to verify that they were given freedom of choice and the primary care provider listed on the enrollment form is the provider of choice. If the beneficiary provides the name of their chosen health home by phone, the caseworker is permitted to complete the form and file it in the beneficiary's record without signature. The caseworkers in each local county Department of Social Services (DSS) or federally recognized tribe are responsible for auto-assignments on an individual basis when beneficiaries have not selected a provider.

The State assures that default enrollment will be based first upon maintaining existing provider/patient relationships. Income maintenance caseworkers at the local department of social services are primarily responsible for linking beneficiaries to a health home; however, certain DMA staff and designees also have the ability to link beneficiaries. Inquiries are made for potential default enrollment as to current provider-patient relationships when beneficiaries do not select a PCP at the time of the visit. Some beneficiaries, particularly Supplemental Security Income (SSI) beneficiaries, do not visit the social services office for Medicaid application and/or reapplication. In these cases, written materials describing the managed care options are mailed to them along with a deadline for notification of their PCP selection.

Attempts are made to contact beneficiaries by telephone or letter if they do not respond within the time frame; inquiries are made about existing relationships with providers when contact is made. If the beneficiary cannot be contacted, they are auto-assigned and notified of their enrollment and rights. Assignments are based on an historical relationship with a health home. If no relationship can be determined, the beneficiary is assigned to a health home within a 30 mile radius of the beneficiary's residence.

Counties and federally recognized tribes receive a monthly enrollment report that provides the name of the health home. EIS (Eligibility Information System) also maintains a history of enrollment (exemption or health home).

The state allows providers to have their patients complete an enrollment form which is then sent to the county department of social services or federally recognized tribe, DMA managed care staff, or designee for enrollment.

Citation	Condition or Requirement

The provider is required to provide education about the PCCM program and explain freedom of choice.

ii. the relationship with providers that have traditionally served Medicaid beneficiaries (as defined in H.2.ii).

Beneficiaries are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI beneficiaries do not apply for Medicaid, they are listed on a report. When they become eligible for Medicaid, a letter is sent to them asking them to contact DSS or federally recognized tribe to select a PCP. The report is monitored to determine if SSI beneficiaries are getting enrolled.

The county DSS or federally recognized tribe staff has the responsibility to review the SSI exempt report and auto-assign all beneficiaries over the age of 19 who have been on the report for 30 days or more. Counties or federally recognized tribes then send a letter to the beneficiary informing them of their PCP along with a copy of the beneficiary handbook.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

If it is not possible to obtain provider-patient history, beneficiaries are assigned to a health home based upon equitable distribution among participating PCPs available in the beneficiary's county of residence or tribal boundary and within a 30 mile radius of the beneficiary's home.

Caseworkers are told to look at the provider restrictions, e.g. patients 21 and under or established patients only, listed in the State Eligibility Information System (EIS), and geographical proximity to the provider before auto assigning a beneficiary.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

Citation	Condition or Requirement

i. The state will ___/will not X use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Beneficiaries are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI beneficiaries do not apply for Medicaid, they are listed on a report. When they become eligible for Medicaid, a letter is sent to them asking them to contact DSS to select a PCP. The report is monitored to determine if SSI beneficiaries are getting enrolled.

The county DSS or federally recognized tribal staff has the responsibility to review the SSI exempt report and auto-assign all beneficiaries over the age of 19 who have been on the report for 30 days or more. Counties then send a letter to the beneficiary informing them of their PCP along with a copy of the beneficiary handbook.

iv. Describe the state's process for notifying the Medicaid beneficiaries who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The State assures that beneficiaries will be permitted to disenroll from a managed care plan on a month to month basis.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Caseworkers at the local DSS or federally recognized tribe are trained to make every effort to support a Provider/ patient relationship with the auto-assignment. If a relationship is not present, caseworkers are instructed to auto-assign beneficiaries to a health home that is accepting new patients within a 30 mile radius. This is done on a case by case basis.

Citation	Condition or Requirement

i. Describe how the state will monitor any changes in the rate of default assignment. (Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker.)

MMIS produces a monthly provider availability report that is reviewed by the regional managed care consultant to determine if a provider is reaching his or her enrollment limit.

Caseworkers are instructed to identify on the Medicaid enrollment application when a beneficiary is auto-assigned to a medical home.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. X The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

___This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the beneficiary has a choice of at least two primary care providers within the entity. (California only.)

_X_ This provision is not applicable to this 1932 State Plan Amendment.

5. ____ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

Citation	Condition or Requirement

_X_ This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not_X_ use lock-in for managed care.

2. The lock-in will apply for ____ months (up to 12 months).

3. Place a check mark to affirm state compliance.

_X_ The state assures that recipient requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:

Ambulance
Anesthesiology
At Risk Case Management
CAP Services
Certified Nurse Anesthetist
Dental
CDSAs
Mental Health for adults
Pathology Services
School Services
Inpatient care with ED admission
Services in hospital Emergency Department
Limited eye care services
Family Planning
Head Start Programs
Hearing Aids
Hospice
Laboratory Services
Optical Supplies/Visual Aids
Pharmacy

Citation	Condition or Requirement
	Care Management by CCNC network Services provided by health departments Radiology services billed with Radiologist provider number

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not X intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair recipient. access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

4. ____ The selective contracting provision in not applicable to this state plan.

State Plan under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

10A NCAC 21B .0407 PATIENT LIABILITY

(a) Patient liability shall apply to clients who live in facilities for skilled nursing, intermediate nursing, intermediate nursing for mental retardation or other medical institutions.

(b) The client's patient liability for cost of care shall be computed as a monthly amount after deducting the following from his total income:

(1) An amount for his personal needs as established under Rule .0313 of this Subchapter;

(2) Income given to the community spouse to provide him a total monthly income from all sources, equal to the "minimum monthly maintenance needs allowance" as defined in 42 U.S.C. 1396r-5(d)(3)(A)(i);

(3) Income given to family members described in 42 U.S.C. 1396r-5(d)(1), to provide each, from all sources of income, a total monthly income equal to:

(A) One-third of the amount established under 42 U.S.C. 1396r-5(d)(3)(A)(i); or

(B) Where there is no community spouse, an amount for the number of dependents, based on the income level for the corresponding budget unit number, as approved by the NC General Assembly and stated in the Appropriations Act for categorically and medically needy classifications;

(4) The income maintenance level provided by statute for a single individual in a private living arrangement with no spouse or dependents at home, for whom the physician of record has provided a written statement that the required treatment is such that the patient is expected to return home within six months, shall be allowed;

(5) An amount for unmet medical needs as determined under Paragraph (f) of this Rule.

(c) Patient liability shall apply to institutional charges incurred from the date of admission or the first day of the month as appropriate and shall not be prorated by days if the client lives in more than one institution during the month.

(d) The county department of social services or federally recognized tribe shall notify the client, the institution and the state of the amount of the monthly liability and any changes or adjustments.

(e) When the patient liability as calculated in Paragraph (b) of this Rule exceeds the Medicaid reimbursement rate for the institution for a 31 day month:

(1) The patient liability shall be the institution's Medicaid reimbursement rate for a 31 day month;

(2) The client shall be placed on a deductible determined in accordance with Federal regulations and Rules .0404, .0405 and .0406 of this Subchapter.

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

To determine the Medicaid-allowable direct and indirect costs of providing Medicaid-eligible emergency transportation for federally recognized tribal and governmental providers, the following steps are performed:

(1) Direct costs for direct medical services include payroll costs, EMS service contracted, communications, rental cost equipment/vehicles, EMS travel, vehicle maintenance/operations/repairs; materials and supplies that can be directly charged to direct medical services.

These direct costs are accumulated on the provider's annual cost report, resulting in total direct costs. The cost report contains the scope of cost and methods of cost allocation in accordance with the principles in 2 CFR Part 225 and the CMS Provider Reimbursement Manual.

(2) Total direct costs for direct medical services from Item B 1 above are reduced on the cost report by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.

(3) Indirect costs are determined using the provider's annual central service cost allocation plan. A double step-down allocation requiring sequential ordering of benefiting departments is used to distribute indirect costs among central services and other departments that receive benefits. Only Medicaid-allowable costs are certified by providers. North Carolina adheres to the CMS approved cost identification process described on this page.

(4) Net direct costs and indirect costs are combined.

(5) An average cost per trip is calculated by dividing net direct and indirect costs by total transports. Transports are transportation of a patient for medically necessary treatment. Trips are empty ambulance en route to a call or returning from a transport. Mileage is only applied for medically necessary ground transportation outside the county's base area.

(6) Medicaid's portion is calculated by multiplying the results from Item B 4 above by the total number of Medicaid transports.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: North Carolina

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

The Medicaid identification card for an eligible individual who can give no mailing address is sent to the address of the local department of social services or federally recognized tribe in the county where the individual applied. The individual is instructed at the time of his application and at each subsequent redetermination to go to the county or tribal agency on the first work day of each month to pick up his ID card for that month.

STATE OF NORTH CAROLINA

ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL')

COUNTY OF _____

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS: You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: http://www.nclifelinks.org/ahcdr/

My Desire for a Natural Death

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply *IF* my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES.

_____ (Initial)	I have an incurable or irreversible condition that will result in my death within a relatively short period of time.
_____ (Initial)	I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

2. These are My Directives about Prolonging My Life:

In those situations I have initialed in Section 1, I direct that my health care providers:

NOTE: INITIAL ONLY IN ONE PLACE.

_____ (Initial)	may withhold or withdraw life-prolonging measures.
_____ (Initial)	shall withhold or withdraw life-prolonging measures.

3. Exceptions – "Artificial Nutrition or Hydration"

NOTE: INITIAL ONLY IF YOU WANT TO MAKE EXCEPTIONS TO YOUR INSTRUCTIONS IN PARAGRAPH 2.

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1:

_____ (Initial)	I *DO* want to receive BOTH artificial hydration AND artificial nutrition (for example, through tubes) in those situations. NOTE: DO NOT INITIAL THIS BLOCK IF ONE OF THE BLOCKS BELOW IS INITIALED.
_____ (Initial)	I *DO* want to receive ONLY artificial hydration (for example, through tubes) in those situations. NOTE: DO NOT INITIAL THE BLOCK ABOVE OR BELOW IF THIS BLOCK IS INITIALED.
_____ (Initial)	I *DO* want to receive ONLY artificial nutrition (for example, through tubes) in those situations. NOTE: DO NOT INITIAL EITHER OF THE TWO BLOCKS ABOVE IF THIS BLOCK IS INITIALED.

4. I Wish to be Made as Comfortable as Possible

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

5. I Understand my Advance Directive

I am aware and understand that this document directs certain life-prolonging measures to be withheld or discontinued in accordance with my advance instructions.

6. If I have an Available Health Care Agent

If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that:

_____ (Initial)	Follow Advance Directive: This Advance Directive will override instructions my health care agent gives about prolonging my life.
_____ (Initial)	Follow Health Care Agent: My health care agent has authority to **override** this Advance Directive.

NOTE: DO NOT INITIAL BOTH BLOCKS. *IF YOU DO NOT INITIAL EITHER BOX, THEN YOUR HEALTH CARE PROVIDERS WILL FOLLOW THIS ADVANCE DIRECTIVE AND IGNORE THE INSTRUCTIONS OF YOUR HEALTH CARE AGENT ABOUT PROLONGING YOUR LIFE.*

7. My Health Care Providers May Rely on this Directive

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

8. I Want this Directive to be Effective Anywhere

I intend that this Advance Directive be followed by any health care provider in any place.

9. I have the Right to Revoke this Advance Directive

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

This the _____ day of _____, _____.

_____

Signature of Declarant

_____

Type/Print Name

I hereby state that the declarant, _____, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed healthcare provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by _____

_____

(type/print name of witness)

_____

(type/print name of witness)

Date _____ _____

(Official Seal) *Signature of Notary Public*

_____, Notary Public

Printed or typed name

My commission expires: _____

STATE OF NORTH CAROLINA

HEALTH CARE POWER OF ATTORNEY

COUNTY OF _____

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

EXPLANATION: You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.

This document gives the person you designate as your health care agent broad powers to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. ***Do not sign this form until*** *two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State:* http://www.nclifelinks.org/ahcdr/

1. Designation of Health Care Agent.

I, _____, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

A. Name: _____ Home Telephone: _____

Home Address: _____ Work Telephone: _____

_____ Cellular Telephone: _____

B. Name: _____ Home Telephone: _____

Home Address: _____ Work Telephone: _____

_____ Cellular Telephone: _____

C. Name: _____ Home Telephone: _____

Home Address: _____ Work Telephone: _____

_____ Cellular Telephone: _____

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of Appointment.

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. _____ *(Physician)*

2. _____ *(Physician)*

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

3. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

4. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

B. Employing or discharging my health care providers.

C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.

E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."

F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorizing the withholding or withdrawal of life-prolonging measures.

H. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.

I. To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

J. Taking any lawful actions that may be necessary to carry out these decisions, including, but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of these powers; (ii) granting releases of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising these powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

5. Special Provisions and Limitations.

(Notice: The authority granted in this document is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care treatment or service. If you wish to limit the scope of your health care agent's powers, you may do so in this section. If none of the following are initialed, there will be no special limitations on your agent's authority.)

	A. Limitations about Artificial Nutrition or Hydration: In exercising the authority to make health care decisions on my behalf, my health care agent:
_____ (Initial)	Shall NOT have the authority to withhold artificial nutrition (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:
_____ (Initial)	Shall NOT have the authority to withhold artificial hydration (such as through tubes) OR may exercise that authority only in accordance with the following special provisions:
	NOTE: If you initial either block but do not insert any special provisions, your health care agent shall have NO AUTHORITY to withhold artificial nutrition or hydration.
_____ (Initial)	B. Limitations Concerning Health Care Decisions. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following provisions: (Here you may include any specific you deem appropriate such as: your own definition when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.)

	NOTE: DO NOT initial unless you insert a limitation.
_____ (Initial)	C. Limitations Concerning Mental Health Decisions. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to following special provisions: (Here you may include any provisions you deem appropriate such as: limiting grant of authority to make only mental health treatment, your own instructions regarding the administration withholding of psychotropic medications and treatment (ECT), regarding admission to and retention in a health care facility for health treatment, or instructions to refuse any specific of treatment that are unacceptable to you.)
	NOTE: DO NOT initial unless you insert a limitation.
_____ (Initial)	D. Advance Instruction for Mental Health Treatment. (Notice: This health care power of attorney may incorporate or be with an advance instruction for mental health, executed in accordance with Part 2 of Article 3 of 122C of the General Statutes, which you may use to your instructions regarding mental health treatment in event you lack capacity to make or communicate mental treatment decisions. Because your health care agent's must be consistent with any statements you have in an advance instruction, you should indicate here you have executed an advance instruction for mental treatment):

	NOTE: DO NOT initial unless you insert a limitation.
_____ (Initial)	E. Autopsy and Disposition of Remains. In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations. (Here you may include any specific limitations you deem such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation):
	NOTE: DO NOT initial unless you insert a limitation.

6. Organ Donation.

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

_____ (Initial)	donate any needed organs or parts; or
_____ (Initial)	donate only the following organs or parts: _____
	NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE.

_____ (Initial)	donate my body for anatomical study if needed.
_____ (Initial)	In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations: (Here you may include any specific limitations deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of body or body parts.) _____ _____ NOTE: DO NOT initial unless you insert a limitation.

NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOUR INITIALS.

7. Guardianship Provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

8. Reliance of Third Parties on Health Care Agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

9. Miscellaneous Provisions.

A. Revocation of Prior Powers of Attorney. I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

B. Jurisdiction, Severability, and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of _____, 20____.

_____(SEAL)

I hereby state that the principal, _____, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by _____

(type/print name of signer)

_____

(type/print name of witness)

_____

(type/print name of witness)

Date: _____ _____

(Official Seal) *Signature of Notary Public*

_____, Notary Public

Printed or typed name

My commission expires: _____

STATE OF NORTH CAROLINA

ADVANCE INSTRUCTION FOR
MENTAL HEALTH TREATMENT

COUNTY OF _____

(NOTICE TO PERSON MAKING AN INSTRUCTION FOR MENTAL TREATMENT)

This is an important legal document. It creates an instruction for mental health treatment. Before signing this document you should know these important facts:

This document allows you to make decisions in advance about certain types of mental health treatment. The instructions you include in this declaration will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Otherwise you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment law. Under the Health Care Power of Attorney you may also appoint a person a your health care agent to make treatment decision for you if you become incapable. YOU MAY NOT REVOKE THIS ADVANCE INSTRTUCTION WHEN YOU ARE FOUND INCAPABLE BY A PHYSICIAN OR OTHER AUTHORIZED MENTAL HEALTH TREATMENT PROVIDER. A revocation is effective when it is communicated to your attending physician or other provider. The physician or other provider shall note the revocation in your medical record. To be valid, this advance instruction must be signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.

NOTICE TO PHYSICIAN OR OTHER MENTAL HELATH TREATMENT PROVIDER

Under North Carolina law, a person may use this advance instruction to provide consent for future mental health treatment if the person later becomes incapable of making those decisions. Under the

Health Care Power of Attorney the person may also appoint a health care agent to make mental health treatment decisions for the person when incapable. A person is "incapable" when in the opinion of a physician or eligible psychologist the person currently lacks sufficient understanding or capacity to make and communicate mental health treatment decisions. This document becomes effective upon its proper execution and remains valid unless revoked. Upon being present with this advance instruction, the physician or other provider must make it a part of the person's medical record. The attending physician or other mental health treatment provider must act in accordance with the statements expressed in the advance instruction when the person is determined to be incapable, unless compliance is not consistent with G.S. 122C-74(g). The physician or other mental health treatment provider shall promptly notify the principal and, if applicable, the health care agent, and document noncompliance with any part of an advance instruction in the principal's medical record. The physician or other mental health treatment provider may rely upon the authority of a signed, witnessed, dated and notarized advance instruction, as provided in G.S. 122C-75.)

I, _____, being an adult of sound mind, willfully and voluntarily make this advance instruction for mental health treatment to be followed if it is determined by a physician or eligible psychologist that my ability to receive and evaluate information effectively or communicated decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means the process of providing for the physical, emotional, psychological, and social needs of the principal. "Mental health treatment" includes electroconvulsive treatment (ECT), commonly referred to as "shock treatment," treatment of mental illness with psychotropic medication, and admission to and retention in a facility for care or treatment of mental illness.

I understand that under G.S. 122C-57, other than for specific exceptions stated there, mental health treatment may not be administered without my express and informed written consent or, if I am incapable of giving my informed consent, the express and informed consent of my legally responsible

person, my health care agent named pursuant to a valid health care power of attorney, or my consent expressed in this advance instruction for mental health treatment. I understand that I may become incapable of giving or withholding informed consent for mental treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

_____

_____.

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding psychoactive medications are as follow: *(Place initials beside choice.)*

_____ I consent to the administration of the following medications:

_____

_____ I do not consent to the administration of the following medications:

_____

Conditions or limitations: _____

_____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my instructions regarding admission to and retention in a health care facility for mental health treatment are as follows: *(Place initials beside choice.)*

_____ I consent to being admitted to a health care facility for mental health treatment. My facility preference is

_____.

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This advance instruction cannot, by law, provide consent to retain me in a facility for more than ten (10) days.

Conditions or limitations:

_____

_____.

ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity. In case of mental health crisis, please contact:

1. Name: _____
   Home Address: _____
   Home Telephone Number: _____
   Work Telephone Number: _____
   Relationship to Me: _____

2. Name: _____

   Home Address: _____
   Home Telephone Number: _____
   Work Telephone Number: _____
   Relationship to Me: _____

3. My Physician:

   Name: _____
   Telephone Number: _____

4. My Therapist:

   Name: _____

   Telephone Number: _____

The following may cause me to experience a mental health crisis:

_____

The following may help me avoid a hospitalization:

_____

I generally react to being hospitalized as follows:

_____

Staff of hospital or crisis unit can help me by doing the following:

_____

I give permission for the following person or people to visit me:

_____

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as "shock treatment"):

_____

Other instructions:

_____

_____

_____ *(Initial if applicable)* I have attached an additional sheet of instructions to be followed and considered as part of this advance instruction.

SHARING OF INFORMATION BY PROVIDERS

I understand that the information in this document may be shared by my mental health treatment provider with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction.

Other instructions about sharing of information:

_____

_____

SIGNATURE OF PRINCIPAL

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full impact of having made this advance instruction for mental health treatment.

_____ _____

Date Signature of Principal

NATURE OF WITNESSES

I hereby state that the principal is personally known to me, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in my presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that I am not:

_____

a. The attending physician or mental health service provider or an employee of the physician or mental health treatment provider;
b. An owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident; or
c. Related within the third degree to the principal or to the principal's spouse.

AFFIRMATION OF WITNESS

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance instruction for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is:

a. A person appointed as an attorney-in-fact by this document;
b. The principal's attending physician or mental health service provider or a relative of the physician or provider;
c. The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or
d. A person related to the principal by blood, marriage, or adoption.

Witnessed by:

_____	_____
Witness	Witness
_____	_____
Date	Date

STATE OF NORTH CAROLINA

COUNTY OF _____

CERTIFICATION OF NOTARY PUBLIC

I, _____, a Notary Public for the County cited above in the State of North Carolina, hereby certify that _____

Appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance instruction for mental health treatment, and that he/she willingly and voluntarily made and executed it as his/her free act and deep for the purposes expressed in it.

I further certify that _____ and _____, witnesses, appeared before me and swore or affirmed that they witnessed _____ sign the attached advance instruction for mental health treatment, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing they were not (i) the attending physician or mental health treatment provider or an employee of the physician or mental health treatment provider and (ii) they were not an owner, operator, or employee of an owner or operator of a health care facility in which the principal is a patient or resident, and (iii) they were not related within the third degree to the principal or to the principal's spouse. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the _____ day of _____, 20_____.

_____

Notary Public

My Commission Expires: _____

Procedure: ABUSE, NEGLECT, MISAPPROPRIATION OF PROPERTY; REFERRALS

1. Referrals are received from providers by phone or mail.

   a. Fill out a referral form upon receipt. Fill out as completely as possible to include names of alleged perpetrator(s), victim(s), witnesses, nature of allegation, date and time of incident, injuries (if any), result of provider's investigation (substantiated/unsubstantiated), and provider's action.

   b. Determine if allegation has been reported to the county Department of Social Services, federally recognized tribe, local law enforcement agency or other agency. Obtain as much information as possible from the reporter regarding investigations by these agencies.

   c. Request additional information as needed (i.e. copy of facility investigation, statements of victim, witnesses and alleged perpetrator, incident report, termination notice, orientation and inservice documentation of alleged perpetrator) and indicate items requested on the referral form.

   d. Make an entry into the referral log.

   e. When additional information is received from the provider, Department of Social Services, federally recognized tribe, police or other agency, attach information with referral form and update log.

2. Determination of investigation by Abuse, Neglect and Misappropriation of Property Team.

   a. After review of referral and information received, the Program Manager will determine whether the allegation will be investigated by the Team.

   b. If an investigation is to be done, the referral is assigned a control number and entered into investigation log.

   c. If no investigation is to be done, the reason will be noted on the referral form. All related documents will then be attached and filed in the Abuse, Neglect and misappropriation of Property miscellaneous file.

   d. Mail letters to acknowledge information received and to indicate planned actions to the provider.

Procedure: ABUSE, NEGLECT AND MISAPPROPRIATION OF PROPERTY: ENTRY OF SUBSTANTIATED FINDINGS INTO THE NURSE AIDE REGISTRY

1. Notice to nurse aide by mail.

   a. A letter notifying the nurse aide with a substantiated finding of abuse, neglect or misappropriation of property is to be filled out by the staff member investigating the allegation. The letter includes the notice of a substantiated finding, the intent to enter the finding into the nurse aide registry, the opportunity to appeal the finding through informal procedures and formal contested case hearing through the Office of Administrative Hearings, and the opportunity to submit a rebuttal to be entered into the nurse aide registry along with the finding.

   b. The completed letter and the documentation of the investigation is reviewed and approved by the Program Manager.

   c. The letter and documentation is then forwarded to the Chief of the Licensure Section for approval and signature.

   d. The letter is sent to the nurse aide by certified mail.

2. Notice to nurse aide by publication.

   a. If the registered letter returns nondeliverable, a notice of service of process by publication is filled out.

   b. The notice by publication is sent to a newspaper circulated in the county where the nurse aid is believed to be located, or if there is no reliable information concerning the location of the nurse aide, then in a newspaper circulated in the county where the action is pending.

   c. An affidavit is to accompany the notice of service of process by publication to the publishing newspaper.

   d. A letter advising the newspaper to publish the notice once a week for three consecutive weeks and to sign and notarize the affidavit, filling in the three dates the notice ran in their paper is also to accompany the notice.

response has been unsatisfactory to the complainant, a complaint will be recorded for investigation by the CIB during the second contact. If complainants have any hesitancy in talking with facility management, a complaint will always be taken during the initial contact.

II. Upon receipt, complaints are directed to the Branch Head or her designee who will:

A. Review the complaint.

B. Label the complaint with the complaint category (ies).

C. Write a letter to the complainant acknowledging receipt of the complaint.

D. Decide whether all or portions of the complaint should be referred to other agencies/groups, etc.

1. Complaints alleging abuse, neglect, or exploitation of a specifically named patient are immediately referred to the County Department of Social Services or federally recognized tribe, in accordance with the agreement between Division of Health Service Regulation and Division of Social Services. In accordance with G.S. 108A-103 the Division of Social Services (DSS) or federally recognized tribe will make "a prompt and thorough evaluation to determine whether the individual is in need of protective services." When in the course of the investigation it becomes apparent that the abuse, neglect, or exploitation will be substantiated, the county DSS director or federally recognized tribe will be immediately notify DHSR by phone. The CIB will assess data from the DSS or federally recognized tribe to determine