MONEY FOLLOWS THE PERSON
Pre-Transition Case Management Work Around Request

DATE: _____
Participant's Name: _____
Participant's Medicaid Number: _____
CAP DA Lead Agency's Name: _____
TAX ID/ EIN # (required): _____
CAP DA Provider Number: _____
CAP DA Lead Agency Representative's Name:_____
CAP DA Lead Agency Representative's Phone Number:_____
CAP DA Lead Agency Representative's Email Address: _____
Transition Date: _____ Check here if transition did not occur: ☐
Check here if assessment was denied: ☐ Reason why assessment was denied: _____
_____
Did MFP beneficiary meet level of care through E-CAP? ☐ Yes ☐ No

- List number of units for each activity, total amount in dollars for those units, date along with a brief explanation of work completed for those units.
- Example: 2 units x current case management rate (DMA Rate schedule)
- Please fax to: 919-715-4159 or secure email to diane.upshaw@dhhs.nc.gov.

Number of Units	Amount	Date	Brief Summary of Activities Performed
TOTAL			

By submitting this invoice, I understand that MFP Pre-Transition Case Management (PTCM) allows for up to 14 hours of case management to be provided up to 60 days prior to the transition. I affirm that the hours invoiced through MFP PTCM will not be charged to the regular annual CAP case management allocation. CAP DA Lead Agencies **may not** claim the same hours under MFP PTCM and under standard case management billing through CAP DA. CAP DA Lead Agencies **may not** invoice MFP PTCM for units **submitted** in NC TRACKS.

_____ _____
Lead Agency Representative Signature Date

_____ _____
MFP Director/Approved By Date

MFP Use only: Date Submitted to Budget Office_____ Amount $_____
Billing Code _____ Memo Line_____