1915(i) ASSESSMENT COMPANION GUIDE

1915(i) Assessment:

Under section 1915 of the Social Security Act and federal regulation at 42 C.F.R. 441 Subpart M, a Medicaid beneficiary must have an independent assessment; an independent evaluation and determination of eligibility for 1915(i) services; and have a person-centered care plan developed based on the independent assessment. The NC Medicaid 1915(i) Assessment ("Assessment Tool") gathers information to be used by the independent evaluator to determine a beneficiary's eligibility for the 1915(i) Home and Community-Based Services (HCBS) benefit and is the basis of the beneficiary's person-centered Care Plan/Individual Support Plan (ISP). Beneficiaries determined eligible for the 1915(i) HCBS benefit by the independent evaluator may receive 1915(i) services for which they meet service criteria and medical necessity, as determined by the health plan's service authorization process.

Care Managers must complete the Assessment Tool in full, as further described in these instructions to allow the independent evaluator to evaluate a beneficiary's eligibility for the 1915(i) HCBS benefit.

BENEFICIARY INFORMATION SECTION: The Assessment Tool shall be populated for all the following fields except when marked *Optional*.

Beneficiary Name: Enter the beneficiary's First and Last Name in the provided text field

Medicaid ID# (no spaces): Enter the beneficiary's Medicaid ID number without spaces or dashes

Date of Birth (MM/DD/YYYY): Enter the beneficiary's date of birth in the month, day, year format, i.e. 01/22/2026

Relevant Diagnosis(es)(Optional): Enter only documented Intellectual/Developmental Disability (I/DD), Mental Health, Substance Use Disorder (SUD) or Traumatic Brain Injury (TBI) diagnoses (Dx) that qualify the beneficiary for the 1915(i) HCBS benefit. **Do not list medical Dx**.

Beneficiary Health Plan (Alliance Health Plan, Healthy Blue Care Together, Partners Health Management, Trillium Health Resources, Vaya Health): Enter the health plan in which the beneficiary is enrolled at the time the Assessment Tool is completed. The beneficiary must be enrolled in one of the above health plans to receive 1915(i) services.

Date Beneficiary Requested Initial or Request to Continue 1915(i) Service(s):

- **Initial Assessments:**
  - Enter date the beneficiary/legally responsible person (LRP) expressed interest in receiving 1915(i) services to the Health Plan, Care Manager (CM), or Care Coordinator (CC); **OR**
  - Date referral source on behalf of the beneficiary notified the health plan, CM) or CC of the beneficiary's interest in 1915(i) services. The referral source could be any of the following: 1915(i) service provider or any provider of services the beneficiary is currently receiving, primary care provider (PCP), health plan staff or Employment and Independence for People with Disabilities (EIPD) (formerly Division of Vocational Rehabilitation) staff.
  - The date may or may not be the date of a care team meeting, Care Management Assessment or the date the assessment was completed.
  - The Assessment Tool must be completed and submitted to Carelon within 14 calendar days of the date entered in Date Beneficiary Requested Initial or Request to Continue 1915(i) Service(s).
- **Transitional ("gap") Assessment:**
  - Enter N/A; date is not required

- **Reassessment:**
  - Enter date the beneficiary/LRP notified the CM or CC of a change that may affect the beneficiary's 1915(i) service eligibility including: changes to the beneficiary's living arrangements, level of assistance required to complete Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), Social and Work skills, Cognitive/Behavior needs.
  - Enter the date the CM or CC was notified of updates/revisions to the beneficiary's disability category.
  - The date may be the date of a care team meeting, Care Management Assessment or the date the assessment was completed.
  - The reassessment must be completed and submitted to Carelon within 14 calendar days of the date entered in Date Beneficiary Requested Initial or Request to Continue 1915(i) Service(s).
- **Annual reassessment:**
  - Enter date the beneficiary/LRP or 1915(i) service provider notified the CM or CC that the beneficiary would like to continue 1915(i) services.
  - The date may or may not be the date of a care team meeting, Care Management Assessment or the date the assessment was completed.
  - The reassessment must be completed and submitted to Carelon within 14 calendar days of the date entered in Date Beneficiary Requested Initial or Request to Continue 1915(i) Service(s).

Date 1915(i) Assessment Completed: Enter the date the assessment was completed.

Requires 1915(i) Service(s) for: (Check All That Apply): Check the appropriate **box or boxes** based on the beneficiary's documented diagnosis(es).

- I/DD = Intellectual/developmental disability;
- TBI = Traumatic Brain Injury;
- SMI = Serious Mental Illness;
- SPMI = Severe and Persistent Mental Illness;
- SED = Serious Emotional Disturbance;
- SUD = Substance Use Disorder

A beneficiary with co-morbidities or dual diagnoses may be in more than one target group.
Examples:

- Beneficiary with Major Depressive Disorder and Opioid Use Disorder, Moderate, check the SMI box and the SUD box.
- Beneficiary under age 18 with Attention-deficit/Hyperactivity Disorder and Oppositional Defiant Disorder, check the SED box.

ASSESOR INFORMATION SECTION: The following fields must be populated.

Care Manager (CM) or Care Coordinator (CC) Name: Enter the First name, Last name **AND** Title of the CM or CC completing this assessment in the provided text field.
CM/CC Agency Name: If the assessor is employed by a care management agency, enter the **FULL** agency name without abbreviations. If the assessor is employed by a health plan, enter the **FULL** health plan name without abbreviations.

TYPE OF ASSESSMENT BEING SUBMITTED /ELIGIBILITY DATES BEING REQUESTED SECTION:

Only enter applicable dates for ONE Assessment Type

Initial Assessment: 1915(i) eligibility is being assessed for the first time or to determine 1915(i) eligibility after 1915(i) eligibility ended or after a lapse. Complete this row if the beneficiary:

- has never been determined eligible for the 1915(i) HCBS benefit and is requesting 1915(i) service(s) **for the first time; OR**
- has completed previous 1915(i) assessments, but eligibility has been denied; **OR**
- was previously determined eligible for the 1915(i) HCBS benefit, but:
    - The 1915(i) HCBS benefit eligibility period expired without timely reassessment and redetermination of eligibility for the 1915(i) HCBS benefit;
    - The beneficiary did not receive at least one 1915(i) service(s) monthly;
    - The beneficiary was discharged from 1915(i) service(s); or
    - Other circumstances led to a gap in 1915(i) HCBS benefit eligibility.
- **Requested start date is prefilled as N/A**. The date will be determined by Department upon completion of the 1915(i) assessment evaluation.
- **To be completed and submitted to Carelon within 14 calendar days of the date beneficiary requested Initial or requested to continue 1915(i) Service(s).**

Transitional ("gap") Assessment: This type of assessment is to aid in aligning the beneficiary's current/active 1915(i) eligibility dates to their birth month. Complete this row for a beneficiary:

- To transition eligibility to a birth month annual assessment schedule.
- **Requested start date** will be the day after the existing eligibility end date.
- **To be completed and submitted to Carelon at least 60 calendar days prior to the approved 1915(i) eligibility end date**

Reassessment: This type of assessment is used to reassess a beneficiary when the beneficiary approved for 1915(i) eligibility requests a reassessment; or experiences a significant change in circumstances, needs or health status. If the assessment indicates that a beneficiary is no longer eligible for 1915(i), reassessment must be submitted to Carelon for review.

- All reassessments must be attached to the Care Plan/ ISP.
- **Requested Start Date** will be prefilled N/A.

Annual Reassessment: Required annual reassessment of the beneficiary's 1915(i) eligibility. Complete this row for beneficiary:

- During annual planning (Refer to Tailored Care Management Manual for planning guidance)
- **Requested Start Date** will be the first day of the month following the beneficiary's birth month.
- **To be completed and submitted to Carelon at least 60 calendar days prior to the first day of the beneficiary's birth month.**

Functional Deficit Assessment:

All rows in *Table 1: Beneficiary's Need for Activities of Daily Living, Instrumental Activities of Daily Living, Social and Work, Cognitive/Behavior Assistance ("Table 1")* on the Assessment Tool must be populated to indicate the beneficiary's level of assistance required for each activity, task or skill.

Each row of *Table 1* of the assessment tool must have one check: assistance needed none, assistance needed some, or assistance needed total - for each activity, task or skill.

- **None**: Indicates the beneficiary does not need any assistance with the activity, task or skill.
- **Some**: Indicates the beneficiary needs some assistance with the activity, task or skill. Examples of assistance could include verbal or visual cues/reminders or hand-over-hand assistance.
- **Total**: Indicates the beneficiary needs complete assistance with the activity, task or skill.
- **Comments (optional)**: Provide additional information about the beneficiary's ability or need of assistance for the specific activity, task or skill.

The "*Other"* Section of *Table 1* of the Assessment Tool is used to indicate any activity, task or skill not otherwise listed in the *Table 1* for which the beneficiary requires assistance. For each "other" row, populate all columns as follows:

- Column 1, "Activity, Task, or Skill" should describe the specific skill, activity or task not otherwise appearing in *Table 1* for which the beneficiary requires assistance.
- For each activity, task or skill for which a row is created in *Table 1*, the Assessment Tool should be marked in either column 2 - assistance needed none; column 3 - assistance needed some; or column 4 - assistance needed total.
- Additional information about the beneficiary's ability or need of assistance with respect to each added "other" row may be indicated in column 5 - Comments of the applicable row in *Table 1*.

Each of the following questions shall be populated by checking "yes" or "no" in column 2 of *Table 2: Additional Questions Regarding Beneficiary's Need for Assistance ("Table 2")*, and additional comments responsive to each question should be entered in column 3 - Comments of *Table 2*.

Does the beneficiary require support to manage a medical or health condition? Check the box (yes or no), only one box should be checked.

- **Yes:** Indicates the beneficiary needs assistance from another person to manage their medical/health condition.
- **No:** Indicates the beneficiary manages their medical/health condition without any assistance from another person.
- **Comments (Optional):** Provide additional information about the beneficiary's ability to manage, or their need for assistance to manage, their medical/health condition.

Does the beneficiary express a desire to work?

- **Yes:** Indicates the beneficiary has a desire to work.
- **No:** Indicates the beneficiary does not have a desire to work.
- **Comments (Optional):** Provide additional information about the beneficiary's desire to work**.**

Does the beneficiary express a desire to obtain education leading to work?

- **Yes:** Indicates the beneficiary has a desire to obtain education leading to work.
- **No:** Indicates the beneficiary does not have a desire to obtain education leading to work.
- **Comments (Optional):** Provide additional information about the desire to obtain education leading to work.

Does the beneficiary have a pattern of unemployment, underemployment or sporadic employment?

- **Yes:** Indicates the beneficiary does have a pattern of unemployment, underemployment or sporadic employment.

- **No:** Indicates the beneficiary does not have a pattern of unemployment, underemployment or sporadic employment.
- **Comments (Optional):** Provide additional information about beneficiary's employment history.

Does the beneficiary need support to acquire or maintain employment? Check the box (yes or no), only one box should be checked.

- **Yes**: Indicates the beneficiary needs support in any aspect of getting or keeping a job. This can include but is not limited to the following: researching employment opportunities or careers, resume writing, completing applications, interviewing, pursuing required education/training or certification for employment, benefits counseling, managing work schedule, interacting with co-workers or referrals to community-based vocational supports.
- **No**: Indicates the beneficiary does not need support in any aspect of getting or keeping a job.
- **Comments (Optional):** Provide additional information about the beneficiary's current or previous history obtaining or keeping employment, and/or information about the beneficiary's current need to find or keep employment.

Is the caregiver of the beneficiary in need of respite? Check the box (yes or no), only one box should be checked.

- **Yes:** Indicates the beneficiary's primary caregiver needs periodic temporary or emergency relief from caregiving responsibilities.
- **No**: Indicates the beneficiary's primary caregiver does not need periodic temporary or emergency relief from caregiving responsibilities.
- **Comments (Optional):** Provide additional information about the beneficiary's caregiver need for periodic temporary or emergency relief.

Does beneficiary lack the ability to care for themselves in the absence of a primary caregiver and have needs that exceed that of a child without behavioral health concerns/developmental disabilities that could have care provided by a traditional babysitter or day care?

- **Yes:** Indicates the beneficiary lacks the ability to care for themselves in absence of primary caregiver and needs exceed that of a child without behavioral health concerns/developmental disabilities that could have care provided by a traditional babysitter or day care.
- **No:** Indicates the beneficiary can care for themselves in absence of primary caregiver and needs do not exceed that of a child without behavioral health concerns/developmental disabilities that could have care provided by a traditional babysitter or day care.
- **Comments (Optional):** Provide additional information about the beneficiary's ability to care for themselves.

Is the beneficiary in need of <u>rehabilitative</u> service for ADLs, IADLs, Social Skills or Employment Skills? Check the box (yes or no), only one box should be checked. *Rehabilitative services help a beneficiary **restore** a skill to their best possible functional level. The response to this question should align with Table 1.*

- **Yes:** Indicates the beneficiary needs assistance to restore an ADL, IADL, social skill or employment skill. It must be indicated in the table above that the beneficiary needs some or total assistance in either an ADL, IADL, social skill or employment skill.
- **No:** Indicates the beneficiary **does not need** assistance to restore an ADL, IADL, social skill or employment skill.
- **Comments (Optional):** Provide additional information about the beneficiary's need for rehabilitation in an ADL, IADL, social or employment skill.

Is the beneficiary in need of habilitative service for ADLs, IADLs, Social Skills or Employment Skills? Check the box (yes or no), only one box should be checked. *Habilitative services help a beneficiary **learn or improve** skills and function for daily living. The response to this question should align with Table 1.*

- **Yes:** Indicates the beneficiary needs assistance to learn or improve a new ADL, IADL, social skill or employment skill. It must be Indicated in the assessment table that the beneficiary needs some or total assistance in either an ADL, IADL, social skill or employment skill.
- **No**: Indicates the beneficiary **does not need** assistance to learn or improve a new ADL, IADL, social skill or employment skill.
- **Comments (Optional):** Provide additional information about the beneficiary's need for habilitation in an ADL, IADL, social or employment skill.

Current Living Arrangement (i.e., At home w/ Family, Group Home, ACH,etc.): Enter where the beneficiary is living at the time of the assessment.

- **Comments (Optional):** Provide additional information about the beneficiary's current living arrangement, including the date of any known or anticipated change and the expected discharge location for any planned or pending discharge or transition.

Are there plans for the beneficiary to move from a State Developmental Center (ICF-IID), community ICF-IID, nursing facility, or another provider-operated/controlled setting (ACH, psychiatric residential treatment facility, foster home, Alternative Family Living (AFL) or group home) to an independent living arrangement within the next 60 days? Check the box (yes or no), only one box should be checked.

- **Yes:** Indicates the beneficiary has a plan to move to an independent living arrangement within 60 days of the assessment date **OR** the beneficiary has a discharge plan indicating an independent living arrangement to be implemented within 60 days of the assessment.
- **No:** Indicates the beneficiary does not have a plan to move to an independent living arrangement within 60 days of the assessment date **OR** the beneficiary does not have a discharge plan indicating an independent living arrangement to be implemented within 60 days of the assessment.
- **Comments (Optional):** Provide additional information about the beneficiary's plan to transition to an independent living arrangement.

Is the beneficiary in need of initial set-up expenses/items? Check the box (yes or no), only one box should be checked.

- **Yes:** Indicates the beneficiary has a need for initial set-up expenses/items.
- **No:** Indicates the beneficiary does not have a need for initial set-up expenses/items.
- **Comments (Optional):** Provide additional information about the beneficiary's plan to transition to an independent living arrangement.

List of 1915(i) Services:

- **Community Transition**
- **Respite**
- **Individual and Transitional Supports**
- **Community Living and Supports**
- **Supported Employment/ Individual Placement Supports**

**Is it recommended that the 1915(i) Assessment Tool be completed electronically to help reduce evaluation time due to issues reading handwritten assessments. The 1915(i) Assessment Tool can be downloaded to a computer*

*to ensure availability when an accessor may not have internet access. If the 1915(i) assessment is downloaded, please regularly verify that the downloaded tool is the most recent version. **

Submission of the 1915(i) Assessment

- **Carelon's 1915(i) Assessment Tool Email Submission:**
  - **All Initial, transitional, and annual reassessments must be submitted to Carelon for review. Reassessments completed during an active 1915(i) eligibility period for the purpose of determining if a beneficiary continues to meet HCBS needs-based criteria must also be submitted to Carelon for review.**
  - **Submit the Assessment Tool to the following email address:** NCMedicaid1915irequests@carelon.com
  - **All assessments and reassessments must be maintained in the beneficiary's record.**
- Carelon will contact the submitter's email if there are questions about the 1915(i) Assessment Tool. A submitter must send its response to Carelon within three business days of receiving questions from Carelon about the 1915(i) Assessment Tool.
- Carelon sends a 1915(i) eligibility determination email to the 1915(i) submitter's email.
- Carelon mails a 1915(i) eligibility determination letter to the beneficiary and uploads a copy of the letter to the beneficiary's health plan SFTP site.

Definitions

Assessor: Care Manager or Care Coordinator that is completing the 1915(i) Assessment Tool

Assessment: process of the Care Manager or Care Coordinator completing the 1915(i) Assessment Tool

Activities of Daily Living (ADLs): fundamental, self-care tasks performed daily (examples: bathing, dressing, eating, etc.)

Beneficiary: Individual being assessed for 1915(i) eligibility

Evaluation: process of NCDHHS evaluating the completed 1915(i) Assessment Tool to determine 1915(i) eligibility

Carelon: NCDHHS contracted vendor to receive and review 1915(i) Assessment Tool

Habilitative Service helps a beneficiary learn or improve skills and functioning for daily living

Home and Community-Based Services: HCBS provide opportunities for Medicaid beneficiaries to receive services in their own homes or communities rather than institutions or other isolated settings. These programs serve a variety of targeted groups, such as older adults, people with intellectual/developmental disabilities, physical disabilities, or mental health and substance use disorders

Instrumental Activities of Daily Living : complex, everyday tasks necessary for a beneficiary to live independently within the community (examples: home maintenance, meal prep, finances etc.)

Intellectual/Developmental Disability (I/DD): A severe, chronic disability attributed to cognitive or physical impairment, or a combination of cognitive and physical impairments diagnosed or that become obvious before reaching age 22.

Rehabilitative Service: helps a beneficiary restore skill to their best possible functional level

Serious Emotional Disturbance: As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), "for people under the age of 18 years of age, the term Serious Emotional Disturbance refers to a diagnosable mental, behavioral, or emotional disorder in the past year which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities."

Serious Mental Illness: As defined by SAMHSA, "SMI is defined by someone over 18 years of age having within the past year a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities."

Substance Use Disorder: As defined by SAMHSA, "Substance Use Disorder (SUD) as a chronic condition where recurrent drug/alcohol use causes significant impairment in health, work, school, or home life, characterized by compulsive use despite harmful consequences, tolerance, withdrawal, and craving, existing on a spectrum from mild to severe and often co-occurring with mental health issues."

Traumatic Brain Injury: An injury to the brain caused by an external physical force resulting in total or partial functional disability, psychosocial impairment or both, and meets the following criteria:

a. Involves an open or closed head injury;
b. Resulted from a single event or resulted from a series of events which many include multiple concussions;
c. Occurs with or without a loss of consciousness at the time of injury;
d. Results in impairments in one or more areas of the following functions: cognition, language, memory, attention, reasoning, abstract thinking, judgement, problem-solving, sensory, perceptual, and motor abilities, psychosocial behavior, physical functions, information processing and speech; and
e. Does not include brain injuries that are congenital or degenerative.

ADDITIONAL RESOURCES

- **1915(i) Landing Page: Link**
- **1915(i) Clinical Coverage Policies (CCP)**
    - CCP 8H-1 1915(i) Supported Employment for I/DD and TBI
    - CCP 8H-2 1915(i) Individual Placement and Support (IPS) for Mental Health and Substance Use
    - CCP 8H-3 1915(i) Individual and Transitional Support (ITS)
    - CCP 8H-4 1915(i) Respite

- CCP 8H-5 1915(i) Community Living and Supports
- CCP 8H-6 Community Transitions