NC Medicaid

Community Alternatives Program Referral Process

A Medicaid Home- and Community-Based Service

The Community Alternatives Program (CAP) is a Medicaid Home- and Community-Based Services (HCBS) Waiver authorized under section 1915(c) of the Social Security Act and complies with 42 CFR § 440.180, Home- and Community-Based Waiver services. The Consumer Direction Lite program is a flexible service option created under Appendix K of the CAP waivers to mitigate risk to waiver participants by assuring necessary personal care service are available to meet assessed needs during the public health emergency.

WHO IS ELIGIBLE FOR CAP SERVICES?

Children from zero to 20 years of age who are medically fragile and have a reasonable indication of need for home- and community-based services to maintain their community placement are eligible for the Community Alternatives Program for Children (CAP/C).

Individuals 18 years of age and older who are physically disabled, meet a defined level of care and have a reasonable indication of need for home- and community-based services to maintain their community placement are eligible for the Community Alternatives Program for Disabled Adults (CAP/DA).

HOW TO MAKE A REFERRAL

Do one of the following:

- Contact a case management entity in your community.
- Discuss your interest in receiving CAP services with your doctor or a hospital representative.
- Contact the Social Worker at your nursing facility.
- Contact NC Medicaid Contact Center at 1888-245-0179 to request a referral.

HOW DOES THE REFERRAL PROCESS WORKS?

- A referral must be submitted with your name, date of birth and full street address.
- A Disclosure Letter is mailed to the address included in the referral within two business days of the referral's approval.
- Three forms are included with the disclosure letter that must be returned to NC Medicaid for review of eligibility for CAP services. These three forms are:
  a. Service Request Consent form
  b. Selection of Case Management form
  c. Physician's Worksheet

  Instructions are in the disclosure letter on how to return the three required forms.
- When the signed and dated consent form is received, the review of your medical condition begins in order to access medical fragility, if you applied for CAP/C or assessment of a defined level of care, if you applied for CAP/DA.
- If medical fragility or a defined level of care is determined, the selected case management entity will be notified to conduct a comprehensive assessment.
- The timeline to receive CAP services, if all requirements are met, can be up to 105 days.