

V. Is the applicant transitioning from a nursing facility with Money Follows the Person (MFP) designation or Division of Vocational Rehabilitation transition services?

- Yes
- No

MFP Representative: _____
County of future residence: _____
Community placement date: ___/___/___

VI. Is the applicant transitioning from a nursing facility utilizing service of community transition?

- Yes
- No

Nursing Facility: _____
County of future residence: _____
Community placement date: ___/___/___

VII. Does the applicant have an Auto Immune Deficiency Syndrome (AIDS) diagnosis with a T-Count below 200?

- Yes
- No

Date of diagnosis: ___/___/___
Most recent T-cell count: _____ as of ___/___/___

VIII. Is the applicant an individual with a diagnosis of Alzheimer's disease or related disorder?

- Yes
- No

Diagnosis: _____
Date of diagnosis: ___/___/___

IX. Is the applicant an individual identified as at risk by his or her local Department of Social Services (DSS) who has an order of protection by Adult Protective Services (APS) for abuse, neglect or exploitation and CAP/DA services can mitigate risk?

- Yes
- No

Issuing DSS: _____ Order Date: ___/___/___
Explanation of service(s) needed to mitigate risk: _____

X. Is the applicant a beneficiary enrolled in Hospice Services with an expected expiration date within six (6) months who is in jeopardy of entering a non-Hospice institution?

- Yes
- No

Name of non-hospice institutional placement: _____
Hospice certification date: ___/___/___

Applicant Initials: _____ MID: _____

C. AGENCY ACKNOWLEDGMENT

CME completing this form: _____ Agency Name _____ Agency Phone _____ Agency Fax _____

I, a representative of the case management entity named above, certify that the information in this application and any supporting documentation provided is true and correct.

(Print) Name of Agency Contact Completing this Form

Title

Email

Signature

___ / ___ / ___
Date

Agency Contact Phone

TO BE COMPLETED BY NC MEDICAID STAFF

Review Date: ___ / ___ / _____ Status: Complete Pending receipt of additional information
Verified applicant meets I II III IV V VI VII VIII IX X criteria.

Comments:

Priority Determination:

Approved Denied

Determination Date:
