Division of Aging and Adult Services

HOME AND COMMUNITY CARE
BLOCK GRANT SERVICE PROVIDERS

Screening and Priority of Service Tool Instruction Manual:

Adult Day Care

Adult Day Health Care

Group Respite

Home-Delivered Meals

In-Home Aide

Institutional Respite

October 2019

Screening and Priority of Service

Purpose

The purpose of this tool is to screen individuals seeking supportive services for 1) potential eligibility for entitlement programs, 2) baseline eligibility for Home and Community Care Block Grant (HCCBG) support (age 60+), 3) impairment screening, 4) establishing a priority of service based on an individual's impairments and living situation, and 5) a methodology for priority of service for individuals who are waiting for services.

The NC DAAS HCCBG Screening and Priority of Service Tool can be completed for each person seeking **1) Adult Day Care, 2) Adult Day Health Care, 3) Group Respite, 4) Home-Delivered Meals, 5) In-Home Aide, and/or 6) Institutional Respite ONLY. This tool is not intended for screening other HCCBG services.** The tool can be completed electronically or manually.

Instructions for Completing the Screening Tool – This section provides guidance in completing the top portion of the tool.

- **Applicant's Legal Name** – Enter the applicant's name. Middle initial may be entered if known but is not required. This is the legal name found on an individual's driver's license or other form of identification.
- **DOB –** Enter the applicant's 'date of birth' as follows MM/DD/YYYY.
- **Phone –** The phone number entered, with area code, allows the community service provider to contact the applicant in the future.
- **Home Address** – Enter applicant's physical address.
- **Provider Agency Name –** Identify the community service provider conducting the screening.
- **Date –** Enter the date the screening is being conducted as follows MM/DD/YYYY. This date will be used for determining how long an applicant is waiting for services.
- **County** – Enter the county name of the applicant's residence.
- **Does the applicant have "limited English proficiency"?** Select 'Yes' or 'No' as to whether the applicant has difficulty communicating in English or requires an interpreter.
- **Language Spoken** – Enter the primary language spoken. This is useful information if a language barrier exists. This question alerts the community service provider that interpretation services may be required to communicate with the applicant.
- **Is the applicant a resident of NC?** Indicate if the applicant is a resident of North Carolina. Recipients of certain entitlements, such as Medicaid, require proof of state residency.
- **Service(s) Requested** – Indicate the service or services requested by the applicant.

Step 1: Financial Screening – This step determines if possible referrals should be made to providers of public benefits/entitlement programs.

This screening is not means-testing nor is the applicant required to provide proof of income. Income is self-declared to determine:

- if an applicant is potentially eligible for assistance through NC Medicaid;
- if an applicant is potentially eligible for additional supports through the Veterans Administration. Individuals receiving a Veterans' Pension may be eligible for additional supports such as Aid and Attendance or other caregiver supports through the Veteran's Administration;
- if an applicant is already receiving Supplemental Security Income (SSI) or health coverage through NC Medicaid. These individuals may be eligible for additional community-based supports through NC Medicaid.

If an applicant's income is at or below 100% of poverty and assets are at or below set limits https://aspe.hhs.gov/poverty-guidelines, the community service provider will refer the applicant to the county Department of Social Services https://www.ncdhhs.gov/divisions/social-services/local-dss-directory for eligibility testing. *For asset limits, see Appendix D or visit* NC Medicaid

Step 2: Entitlement Screening – This step is to further understand the individual's current status with an entitlement program or potential eligibility for it.

An entitlement is a benefit of support, monetary or supportive services that may require means-testing or specific eligibility determination.

- **Veteran Status –** Select answers to questions 'a – d' based on responses from the applicant. If "Yes" to either questions 'a' or 'b', refer applicant to a Veteran Service Office to apply for services/supports from the VA and continue this screening. If "Yes" to questions 'c' or 'd', continue completing this screening tool. Individuals who have any military service history, especially those enlisted during times of military conflict, are entitled to benefits from the Veteran's Administration. Spouses and surviving spouses of veterans may also be entitled to benefits. Eligibility determination begins with a veteran contacting a nearby Veteran Service office https://www.milvets.nc.gov/resource-guide
  https://www.milvets.nc.gov/services/benefits-claims
  https://files.nc.gov/ncdmva/documents/files/dmva-guide-2018.pdf#services-by-county
  and inquiring about potential assistance.
- **Medicaid –** Select answers to questions 'e - g'. This information is used to determine what supports/services the applicant is currently receiving.
- **Home Care and Hospice –** Select an answer to question 'h'. The purpose of this question is to determine what supports/services the applicant is currently receiving.

Step 3: Eligibility Screening – This step is to determine if the individual is eligible for HCCBG services.

Baseline eligibility for services through the HCCBG requires an applicant to be at least 60 years of age or older. If the applicant is 59 years of age or younger, **stop screening**. Services cannot be provided to individuals under age 60 through the HCCBG services this tool addresses.

By completing the DAAS 101, individuals 60 years of age or older are determined eligible for specific services funded through the HCCBG. See instructions for completing the DAAS 101 at https://files.nc.gov/ncdhhs/documents/files/aging/arms/CRF_Instructions.pdf. To review the DAAS Home and Community Care Block Grant Manual visit http://www.ncdhhs.gov/document/home-and-community-care-block-grant-procedures-manual-community-service-providers

If there is a waiting list for the service(s) requested/needed, **continue screening**.

Step 4: Impairments Screening – This step is used to assess an individual's ability to self-manage without assistance from another person.

Indicate either "yes" or "no" to the Instrumental Activities of Daily Living (IADL) Impairments and Activities of Daily Living (ADL) Impairments based on self-declared responses from the applicant. Applicants are to be asked if the following tasks can be carried-out without substantial human assistance or help. For example, an individual who uses a walker or cane to ambulate (walk), who does not need personal assistance to do so, has the ability to ambulate without substantial human assistance.

Answer questions 'a – h' under the column "IADL Impairments" and questions 'a – f' under the column "ADL Impairments".

Answer the question, "Does the applicant have significant memory loss or confusion (cognitively impaired)?" The response is not a clinical diagnosis, but a way to identify possible cognitive impairment of individuals receiving services.

- Answer 'Yes' if the person or agency making the referral for the service (e.g., family member, caregiver, social worker, physician, etc.) indicates that the client has a significant impairment in short and/or long-term memory, thinking, judgment or decision-making affecting daily activities. The impairment may or may not have been diagnosed by a medical professional. Or
- If it appears that the client, based on the service provider's professional staff assessment, has significant impairments in short and/or long-term memory, thinking, judgment or decision-making. Or
- Answer 'No' if there is no indication of a significant memory problem from the referral source, the family, or the provider's professional assessment.

See Appendix B for hints and tips on how to identify cognitive impairment.

Step 5: Priority of Service Screening – This step allows a community service provider to establish a priority score for applicants waiting for service.

Complete questions 'a – h'. For every question answered "yes", insert the identified points for that question into the column labeled "Points". To determine the priority score for the applicant, total the points at the bottom of the column.

a. **Adult Protective Services (APS) –** As required by General Statute (see Appendix A), applicants referred by the local Department of Social Services for service(s) as part of an Adult Protective Services Plan and/or are at risk of abuse, neglect and/or exploitation are two of three top priority groups to receive service(s).
b. **ADL/IADL impairments (High Risk) –** As required by General Statute, those applicants with the greatest impairments (i.e. High Risk) are identified as the third top priority group to receive service(s).
c. **ADL/IADL impairments (at Risk) –** As required by General Statute, those applicants who are impaired but not with the greatest limitations are the next priority group. These applicants have fewer impairments and are considered 'at risk'.
d. **Living alone –** Applicants who live alone are at greater risk. Answer "yes" to this question if no one else resides with the applicant in his/her residence.
e. **Assistance –** Applicants with no caregiver assistance or social supports and who are impaired are at a greater risk.
f. **Loss of Executive Function –** Applicants who have been diagnosed with Alzheimer's disease or a related dementia, traumatic brain injury, stroke, etc. experience the loss of executive function. Loss of or a significant decline in reasoning, judgement and logic increases risk. "Executive Function" is an umbrella term for the management of cognitive processes, including working memory, reasoning, task flexibility, and problem solving as well as planning and execution.
g. **Transportation –** Dependence on others for transportation creates social isolation and reduces an individual's ability to maintain independence. Answer 'yes' if the applicant physically cannot drive, chooses not to drive, or if a vehicle is not available.
h. **Near poor –** Older individuals slightly above 100% poverty and up to 150% of poverty are considered to be 'at risk' as the near poor.

Step 6: Waiting for Service – To complete the paperwork to register the individual in ARMS.

Once a priority score has been determined, a best practice is to complete the DAAS 101 "Waiting for Service" questions and register the applicant in the Aging Resource Management System (ARMS), which is a client tracking system for demographic data and a reimbursement system.

Separately, community service providers are strongly encouraged to maintain waiting lists for services. It is suggested to rank according to the following criteria:

1) **The determined priority score**
2) **The length of time an applicant has been waiting for service(s)**

A 'Waiting List & Priority of Service' Excel spreadsheet can be completed by each provider, for each service, as a management tool for establishing priority of service based on specific criteria related to those at greatest risk. (See the Waiting List & Priority of Service spreadsheet template)

Using the example on the spreadsheet template, Roy Rogers has a priority score of '10' and has been waiting the longest based on his date of screening. Although Ava Gardner and Elizabeth Taylor have been waiting longer; they are at a lower risk and therefore a lower priority for receipt of services.

User instructions are included with the Waiting List & Priority of Service spreadsheet template

Private-pay services – Since waiting lists for publicly-funded programs can be extensive and applicants/families have immediate needs, community service providers are not prohibited from offering private-pay services to applicants who are waiting for services funded through the HCCBG. Community service providers are also not prohibited from referring applicants to other agencies that provide private-pay services. Document the names of the agency(s) that applicants are referred to in the space provided on the Screening and Priority of Service Tool.

Private-pay clients may also be maintained on the HCCBG waiting list and when funds are available, they may begin receiving supports through the HCCBG.

Agency representative signature and date – Signature of the individual completing the Screening and Priority of Service Tool and the date of the screening is the last step in the HCCBG screening process.

Questions about use of the tool – Email: PriorityTool@dhhs.nc.gov

Screening and Priority of Service Tool materials and an instructional recorded webinar are located at:

https://www.ncdhhs.gov/documents/daas-screening-and-priority-service-tool-materials-aaa-providers

Appendices

A. Definitions & Legal Base

1. Definitions

1.1 "At Risk" are persons who are unable to perform instrumental activities of daily living (i.e. shopping, housekeeping, preparing meals) and/or are unable to perform self-care tasks (i.e. dressing, bathing, eating) due to one or two impairments in activities of daily living.

- Client has 1 - 2 IADL impairments; AND/OR
- Client has 1 - 2 ADL impairments: OR
- Client is cognitively impaired (see questions #20) and has less than 3 IADL impairments.

1.2 "High Risk" (Frail) are persons who require assistance with self-care tasks (i.e. as dressing, bathing, eating) due to impairments in three (3) or more activities of daily living.

- Client has 3 or more ADL impairments; OR
- Client is cognitively impaired (see question #20) and has at least 3 IADL impairments.

2. Legal Base

Older Americans Act of 1965 as Amended: 42 U.S.C. 3001;{Public Law 100-175)

2.1 Federal**:** Older Americans Act, as amended 2006: (22) the term ''frail'' means, with respect to an older individual in a State, that the older individual is determined to be functionally impaired because the individual—

(A) (i) is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or

(ii) at the option of the State, is unable to perform at least three such activities without such assistance; or

(B) due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

2.2 **State** Rule**:**

North Carolina General Statute 143B-181.1(c)

Subchapter 05G .0302 – Home and Community Care Block Grant for Older Adults:

(a) Once service providers have determined that individuals meet the eligibility criteria for a given Home and Community Care Block Grant for Older Adults service, individuals shall be served in the following priority order:

1. Older adults for whom the need for Adult Protective Services has been substantiated by the local department of social services and the service is needed as part of the adult protective service plan.
2. Older adults who are at risk of abuse, neglect, and/or exploitation.
3. Older adults with three or more impairments in activities of daily living (ADLs), or instrumental activities of daily living (IADLs), who are at risk of institutionalization substitute care.
4. Older adults with three or more ADL or IADL impairments.

5. Older adults no more than two ADL or IADL impairments.
6. Well Older Adults

(b) Service providers must establish a process to screen prospective clients for the purpose of determining priority for receipt of service(s) in accordance with the criteria specified in 10A NCAC 05G .0302(a).

2.3 State Priority of Service: HCCBG Manual Section 2: VI. PRIORITY FOR RECEIPT OF BLOCK GRANT SERVICES (Section 2, page 2)

Once community service providers have determined that individuals meet the eligibility criteria for a given service as specified in the service standard, individuals must be served in the following priority order:

1. Older adults for whom the need for Adult Protective Services has been substantiated by the local department of social services and the service is needed as part of the adult protective service plan.
2. Older adults who are at risk of abuse, neglect, and/or exploitation.
3. Older adults with extensive impairments in activities of daily living (ADLs), or instrumental activities of daily living (IADLs), who are at risk of placement or substitute care.
    - "ADLs" include: eating, dressing, bathing, toileting, bowel and bladder control, transfers, ambulation and communication (ability to express needs to others e.g. speech, written word, signing, gestures, and communication devices).
    - "IADLs" include: meal preparation, medication intake, cleaning, money management, phone use, laundering, reading, writing, shopping and going to necessary activities.
4. Older adults with extensive ADL or IADL impairments.
5. Older adults with less extensive (1-2) ADL or IADL impairments.
6. Well Older Adults

Community service providers must establish a process to screen prospective service recipients for the purpose of determining priority for receipt of service(s) in accordance with the above criteria.

B. Possible Warning Signs of Significant Cognitive Impairment

- **Memory loss.** Forgetting recently learned information is one of the most common early signs of dementia.
- **Difficulty performing familiar tasks.** People with dementia often find it hard to plan or complete everyday tasks. Individuals may lose track of the steps involved in preparing a meal, placing a telephone call or shopping, managing medications, etc.
- **Problems with language.** People with Alzheimer's disease often forget simple words or substitute unusual words, making their speech or writing hard to understand.
- **Disorientation to time and place.** People with Alzheimer's disease can become lost in their own neighborhood, forget where they are and how they got there, and not know how to get back home.
- **Poor or decreased judgment.** Those with Alzheimer's or other types of dementia may dress inappropriately, wearing several layers on a warm day or little clothing in the cold. They may show poor judgment, like giving away large sums of money to telemarketers.
- **Problems with abstract thinking.** Someone with Alzheimer's disease or other types of dementia may have unusual difficulty performing complex mental tasks, like forgetting what numbers are for and how they should be used.
- **Misplacing things.** A person with Alzheimer's disease or other types of dementia may put things in unusual places.
- **Changes in mood or behavior.** Someone with Alzheimer's disease may show rapid mood swings - from calm to tears to anger - for no apparent reason. People with other types of dementia may experience mood problems as well.
- **Changes in personality.** The personalities of people with dementia can change dramatically. They may become extremely confused, suspicious, fearful or dependent on a family member.

C. Resource Links

DAAS 101 Long Form
https://files.nc.gov/ncdhhs/documents/files/DAAS101_Long.pdf

DSS Directory
https://www.ncdhhs.gov/divisions/social-services/local-dss-directory

Home and Community Care Block Grant Manual
http://www.ncdhhs.gov/document/home-and-community-care-block-grant-procedures-manual-community-service-providers

Instructions for completing DAAS 101
https://files.nc.gov/ncdhhs/documents/files/aging/arms/CRF_Instructions.pdf

NC Department of Military and Veteran Affairs Resource Guide
https://www.milvets.nc.gov/resource-guide

NC Medicaid Community-based Long-Term Services and Supports Reference Guide
https://files.nc.gov/ncdma/documents/Providers/Programs_Services/MFP/2018-Medicaid-Community-Based-LTSS-Quick-Guide.pdf

NC Medicaid Income Eligibility
https://medicaid.ncdhhs.gov/medicaid/get-started/learn-if-you-are-eligible-medicaid-or-health-choice/medicaid-income-and

Poverty Guidelines
https://aspe.hhs.gov/poverty-guidelines

Veteran Services Benefits/Claims
https://www.milvets.nc.gov/services/benefits-claims

Veteran Service Office Directory
https://files.nc.gov/ncdmva/documents/files/dmva-guide-2018.pdf#services-by-county

D. Asset Limits & Additional Medicaid Information

Type of Medicaid	Single
	Asset Limit
Waivers/ Home & Community-Based Services Medicaid/Aged Blind, and Disabled	$2,000

Waivers such as Community Alternatives Program for Disabled Adults (CAP-DA)

Home and Community-Based Services such as Personal Care Services (PCS), Programs of All-Inclusive Care for the Elderly (PACE), Private Duty Nursing (PDN)

Additional Medicaid Information:

NC Medicaid Contact Center: 888-245-0179

Enrollment broker: 833-870-5500

E. Medicaid Community-Based Long-Term Services and Supports Information Sheets

https://files.nc.gov/ncdma/DHB-PHP-LTSS-HCBS-Guide-Combined.pdf

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Community Alternatives Program for Disabled Adults (CAP-DA)

What is CAP-DA?

The Community Alternatives Program (CAP) is a Medicaid Home and Community-Based Services (HCBS) Waiver authorized under section1915(c) of the Social Security Act and complies with 42 CFR § 440.180, Home and Community-Based Waiver Services. This waiver program provides a cost-effective alternative to institutionalization for beneficiaries, in a specified target population, who are at risk for institutionalization if specialized waiver services were not available. The CAP/DA services allow physically disabled and aged population beneficiaries to remain in or return to a home and community-based setting.

Who Qualifies for CAP-DA?

To be eligible for CAP/DA, the individual must:

- Qualify for Long-Term Care Medicaid
- Be 18 years of age or older.
- Meet Nursing Facility Level of Care as determined under Section 3.0 of the CAP/DA Clinical Policy.
- Require at least 1 Home and Community-Based waiver service monthly.

How do I Apply for CAP-DA?

- Contact the DSS in the county where the individual resides (http://www.ncdhhs.gov/dss/local/) and apply for Medicaid.
- Contact the county CAP/DA Case Management Entity (https://files.nc.gov/ncdma/CAP-DA_Lead_Agency_Directory.xlsx) and request for a Service Request Form (SRF) be initiated.

Consumer Direction

Consumer direction is an option in the 1915 (c) Waiver that allows beneficiaries or a designated representative to exercise choice and control over a specified amount of Waiver services and act in the role of employer of record to direct the services. A self-assessment which measures the willingness and ability to direct one's own services must be completed to determine capacity for consumer direction.

Important Considerations

- If it is determined that the individual does not qualify for Long-Term Care Medicaid other services may still be available.
- If the individual is over the 100% Federal Poverty Level (FPL) a deductible may apply.
- If the individual is residing in a facility when determined eligible, s/he may qualify for transition services.
- An assessment will be conducted to determine appropriateness for CAP services.
- A Case Manager will be assigned who will create the service plan, including the Plan of Care, and manage the case.
- If an individual qualifies for consumer direction, training and education is available to build competencies.

Contact Information

Website:	
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/community-alternatives-program-for-disabled-adults	
Email medicaid.capda@dhhs.nc.gov	**Phone** 919-855-4340

The content included in this overview does not constitute all service and eligibility components of the program. Eligibility and service determination will be based on NC Medicaid Community-Based Services Clinical Policy (https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/community-based-services-clinical-coverage-policies)

Program of All-Inclusive Care for the Elderly (PACE)

What is PACE?

The Program of All-Inclusive Care for the Elderly (PACE) is a managed care program for older adults. This program features a comprehensive service delivery system, and integrated Medicare and Medicaid financing. PACE can provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as safely possible. Medical care is provided by an Inter-Disciplinary Team (IDT) to case manage services provided or arranged by the PACE organization for each participant.

Who Qualifies for PACE?

To be eligible for PACE, the individual must:

- Qualify for Long-Term Care Medicaid
- Be 55 years of age or older.
- Live in a PACE program service area.
- Be determined by a physician to need Nursing Facility Level of Care.
- Be able to live in a community setting when enrolled without jeopardizing health or safety

How do I Apply for PACE?

- Contact the PACE organization in your area and the DSS in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- A referral can be made to the PACE program that has a service area covering the zip code where the beneficiary resides (https://files.nc.gov/ncdma/documents/Providers/Programs_Services/PACE/NCPACE_Providers_2018_06.pdf).
- The program will assess the individual and facilitate the enrollment process for those determined eligible.

Important Considerations

- Medicaid recipients and individuals who are dually-eligible may request PACE services through their local DSS (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices)
- All services are provided directly by the program and through its provider network.
- PACE will only pay for services which have been pre-approved by the Interdisciplinary Team (IDT).
- Individuals enrolled in PACE who move outside the service area will no longer be eligible for PACE services, unless the move is to another program's service area.
- PACE IDT members will perform periodic assessments while the individual is in the nursing facility.
- Only a small percentage of PACE participants reside in a nursing facility, even though *all* must be certified to need nursing facility level of care. If a PACE recipient needs nursing facility care, as determined by the IDT's assessments, the PACE program will pay for it and continue to coordinate the individual's care with the facility.
- A participant's PACE enrollment is effective the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

Contact Information

Website:
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/program-of-all-inclusive-care-for-the-elderly
Phone
919-855-4340

The content included in this overview does not constitute all service and eligibility components of the program. Eligibility and service determination will be based on NC Medicaid Community-Based Services Clinical Policy (https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/community-based-services-clinical-coverage-policies)

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Private Duty Nursing (PDN)

What is PDN?

Private Duty Nursing (PDN) is substantial, complex, and continuous skilled nursing care that is considered supplemental to the care provided by the beneficiary's trained, informal caregiver. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility; or that requires more continuous care than is available through home health services.

Who Qualifies for PDN?

To be eligible for PDN standard nursing services, the individual must:

- Be eligible for NC Medicaid.
- Reside in a private primary residence with at least one trained, informal caregiver who may provide direct care to the beneficiary during planned and unplanned absences of PDN staff.
- Have an order for PDN by the beneficiary's attending physician (MD) or Doctor of Osteopathic Medicine (DO) and a Prior Approval (PA) granted by NC Medicaid.
- Beneficiaries under 21 years of age may qualify for PDN under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provision if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition. In addition, service limitations on specific PDN criteria may be exceeded or may not apply if the requested service if medically necessary.

Important Considerations

- Services must be medically appropriate and medically necessary.
- There are two clinical policies related to Private Duty Nursing: 3G-1 (for beneficiaries 21 and older) and 3G-2 (for beneficiaries under 21 years of age).
- Prior approval is required for PDN services and is granted based on the beneficiary qualifying for the health criteria as described in the Clinical Coverage Policies for beneficiaries age 21 and older, or for beneficiaries under 21 years of age, as applicable.
- PDN is based upon a written individualized plan of care approved by the beneficiary's primary physician and must be provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) employed by a licensed home care agency.
- Eligible individuals may receive up to 112 hours per week or 16 hours per day. Hours are dependent upon a comprehensive review of required documentation as defined in the PDN clinical coverage policies, primary and secondary diagnosis, overall health status, level of technology dependency, amount and frequency of specialized skilled interventions required, and the amount of caregiver assistance available.

How do I Apply for PDN?

- Contact the DSS in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- Ask an attending physician (MD) or Doctor of Osteopathic Medicine (DO) to make a referral for PDN through a PDN service provider.
- The PDN service provider will review the referral and send to the Nurse Consultants at NC Medicaid for prior approval.
- Nurse Consultants at NC Medicaid review the referral request and provide prior approval determinations for PDN.

Contact Information

Website: https://medicaid.ncdhhs.gov/providers/programs-and-services/long-term-care/private-duty-nursing-pdn	
Email medicaid.homecareservice@dhhs.nc.gov	**Phone** 919-855-4380

The content included in this overview does not constitute all service and eligibility components of the program. Eligibility and service determination will be based on NC Medicaid Community-Based Services Clinical Policy (https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/community-based-services-clinical-coverage-policies)

Home Health

What is Home Health?

Home health services are medically necessary skilled nursing services, specialized therapies (e.g., physical therapy, speech-language pathology and occupational therapy), home health aide services, and medical supplies provided to beneficiaries at home or in adult care homes. Home health services reduce the length and cost of hospital stays for beneficiaries while promoting independence and self-sufficiency and receive required treatment in the comfort of their homes. These services are designed to be offered on a short-term or intermittent basis.

Who Qualifies for Home Health?

To be eligible for Home Health, the individual must:

- Qualify for NC Medicaid or NC Health Choice (age 6 – 18)

How do I Apply for Home Health?

- Contact the Department of Social Services (DSS) in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- Submit to the Home Health Service Provider an order from the attending physician detailed required services
- The Home Health Service Provider submits a request for Prior Approval to NC Medicaid.

Important Considerations

- Services provided are dependent upon medical needs.
- Face-to-face contact with the attending physician must occur within 90 days prior to the start of care or within 30 days after the start of care.
- The attending physician shall certify in writing that Home Health services are the most appropriate, and that those services are determined to be best delivered in the home.
- Medical supplies are provided only for the beneficiary receiving Home Health Services.
- Home Health services cannot be limited to services furnished to beneficiaries who are homebound.
- Home Health Skilled Nursing services must be limited to 75 total visits per year per beneficiary.
- Home Health Aide services must be limited to 100 total visits per year per beneficiary.
- Home Health services must be coordinated with other home care service providers to avoid more than one person working with the beneficiary at the same time.

Contact Information

Website:	
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/home-health-services	
Email Medicaid.homecareservice@dhhs.nc.gov	**Phone** 919-855-4380

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Hospice

What is Hospice?

Hospice services is a coordinated and comprehensive program of services that provides medical, supportive and palliative care to terminally ill individuals and their families/caregivers. Services include addressing the physical, psychosocial, spiritual and emotional needs of terminally ill beneficiaries, their families and caregivers. Services are provided in private homes, hospice residential care facilities and a variety of other settings.

Who Qualifies for Hospice?

To be eligible for Hospice, the individual must:

- Qualify for NC Medicaid or NC Health Choice (age 6 – 8)
- Be determined to be terminally ill with a life expectancy of 6 months or less

How do I Apply for Hospice?

- Contact the Department of Social Services (DSS) in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- Submit to the Hospice Service Provider a referral from the attending physician.
- The Hospice Medical Director reviews the information to determine if the individual is terminally ill, including the diagnosis of the terminal condition, health conditions related or unrelated to the terminal condition, and clinical information supporting all diagnoses.
- If the Hospice Medical Director determines that the individual is terminally ill based the individual is admitted into Hospice services.
- The Hospice Service Provider submits a request for Prior Approval to NC Medicaid.

Important Considerations

- Individuals who are dually eligible for Medicare and Medicaid Hospice shall elect both programs simultaneously. Medicare will pay 1st followed by Medicaid.
- Individuals up to 21 years of age can be considered for Concurrent Care which allows for the child to be provided with, or to have payment made for, services that are related to the cure or treatment of the child's condition for which a diagnosis of terminal illness has been made.
- Hospice participation may limit reimbursement of other Medicaid services
- Hospice benefits covers all care pertaining to the terminal illness
- The Hospice provider is responsible for coordination with other service providers for care unrelated to the terminal illness to avoid duplication of service.

Contact Information

Website:
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/hospice-services
Phone
919-855-4380

The content included in this overview does not constitute all service and eligibility components of the program. Eligibility and service determination will be based on NC Medicaid Community-Based Services Clinical Policy (https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/community-based-services-clinical-coverage-policies)

Personal Care Services (PCS)

What is PCS?

For eligible Medicaid beneficiaries, PCS provides hands-on assistance by paraprofessional aides in certain types of beneficiary living arrangements. Hands-on assistance is provided for the five qualifying activities of daily living (ADLs) which include eating, dressing, bathing, toileting, and mobility. The amount of approved service is based on an assessment conducted by an independent assessment entity to determine the beneficiary's ability to perform their ADLs.

Who Qualifies for PCS?

Medicaid covers the cost of PCS if:

- The individual qualifies for Medicaid.
- The individual has either 1) three of five ADLs which require limited hands-on assistance; 2) two ADLs, one of which requires extensive assistance; or 3) two ADLs, one of which requires complete assistance.
- PCS is linked to a documented physical or developmental disability, cognitive impairment, or chronic health condition.
- The individual is under the ongoing direct care of a physician for the medical condition(s) causing the functional limitations.
- The individual is medically stable and does not require continuous monitoring by a licensed nurse or other licensed health care professional.
- The individual lives in an approved residence under General Statutes that is safe for the beneficiary and the PCS provider(s) and is adequately equipped to implement needed services.
- There is no available, willing, or able family, household member or other informal caregiver to provide ADL assistance at the time when services are provided.
- There is no other third-party payer responsible for covering PCS.

Important Considerations

- If the beneficiary has not been seen within 90 calendar days prior to the IAE receiving the form, the request will not be processed.
- The beneficiary shall be notified of the assessment results within 14 business days of a completed PCS assessment.
- Does not require nursing facility level of care for participation.
- Must be ordered by a physician, nurse practitioner, or physician assistant.
- Is appropriate for individuals whose needs can be met safely in the home by family members and other informal care-givers, with support by scheduled visits from PCS aides.
- Does not provide enough assistance to replace facility-based services for individuals who require ongoing care, supervision, or monitoring by a nurse or other health care professional.
- Cannot duplicate in-home aide services provided under Medicaid waiver pro-grams, private duty nursing, state block grants, and other state and local pro-grams that provide hands-on assistance with ADLs.
- Cannot be provided by an individual whose primary private residence is the same as the beneficiary's primary private residence, legally responsible person, spouse, child, parent, siblings, grandparent, grandchild, or equivalent step or in-law relationship to the beneficiary.

How do I Apply for PCS?

- Contact the DSS in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- The individual's primary care or attending physician, physician assistant, or nurse practitioner must make the referral for the individual to be assessed for PCS using the Request for Independent Assessment for Personal Care Services Attestation of Medical Need Form (Form 3051) on the NC Medicaid website (https://files.nc.gov/ncdma/Request-for-Independent-Assessment--NC-Medicaid-3051--9.2018.pdf).
- The Individual Assessment Entity (IAE) will review the form and schedule an assessment.

Contact Information

Website: http://dma.ncdhhs.gov/providers/programs-services/long-term-care/personal-care-services	
Email PCS_Program_Questions@dhhs.nc.gov	**Phone** 919-855-4360

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