APPENDIX K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: **North Carolina**

B. Waiver Title: CAP/DA

C. Control Number: NC.0132.R07.03

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: In no more than one paragraph each, briefly describe the:

On January 31, 2020, Secretary Azar used his authority pursuant to Section 318 of the Public Health Services Act to declare a public health emergency (PHE) in the entire United States. On March 11, 2020, as authorized under Title V of the Stafford Act, President Donald J. Trump announced the World Health Organization officially announced novel coronavirus (COVID-19) is a global pandemic. As a result of the continued consequences of COVID-19, Secretary Azar renewed the public health emergency effective July 25, 2020.

North Carolina is respectfully requesting to amend its approved Appendix K effective for March 13, 2020. The changes in this amendment are additive to the previously approved appendix K for this waiver and are indicated in highlighted text.

2) number of individuals affected and the State's mechanism to identify individuals at risk –

There are currently 10,073 CAP/DA waiver participants being served across the State of North Carolina. Potentially, all those participants are affected by novel coronavirus (COVID-19) outbreak due to their higher risk of severe illness. To facilitate access for waiver participant experiencing COVID symptoms and to limit close contact of other individuals experiencing COVID symptoms, it is important to take actions to reduce the risk of exposure of the virus to these aged and disabled adults and making it easier for health care providers to deliver Medicaid services.

To identify at-risk waiver participants, the State will identify all enrolled waiver participants by an active service plan. A communication notice will be provided to all actively enrolled waiver participants and their assigned case manager informing them of higher risk of severe illness. The case manager will assist each waiver participant to create a COVID-19 emergency plan that will consist of the following elements: health care needs of the waiver participant and family members; how waiver participant or caregivers will be cared for if services were not able to be provided; identification of resources in the community to assist with COVID-19; update to emergency contact list; identification of a safe zone in the home to separate sick individuals from non-sick individuals; plan to obtain prescriptions and food and identification of a plan if the "family's routine day" is altered due to school closures or workplace changes.

The State is expanding service definitions and modifying service limits and provider qualifications as described in Appendix C-1/C-3; the ability to offer time-limited retainer payments to in-home aide agencies and direct service providers to promote continuity of care of sequestrated waiver participants; and the ability to conduct initial and annual level of care and reasonable indication of need assessments telephonically.

1) roles of state, local and other entities involved in approved waiver operations; and
   - NC Medicaid is the administrator of the waiver and overseer to assigned case management entities who functions in the role of the local operational administering agency. The case management entity also provides case management services.
   - Case management entities complete assessments, plans of care (POC), make service authorization requests and approvals. Case management entity staff conduct safety and welfare checks.
   - VieBridge/eCAP is the system by which assessments are completed, POCs developed, and reviews/service authorizations conducted. This system transfers authorizations to prior approvals and forward to the state's MMIS for reimbursement for services rendered.
   - NC Tracks is the state's MMIS which provides for reimbursement to providers of services rendered.

2) expected changes needed to service delivery methods, if applicable. The State should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

F. Proposed Effective Date: Start Date: ____3/13/2020_Anticipated End Date: 3/12/2021

G. Description of Transition Plan.

Waiver participants who qualify for waiving of Appendix C-1/C-3 and other waiver rules and requirements because of COVID-19 will be monitored monthly through the duration of the pandemic to ensure health, safety and well-being and linkage to the most appropriate services and care regiment. When the pandemic is resolved, the assigned case managers will conduct face-to-face home visits to fully assess needs to assure the accuracy of the service plan.

H. Geographic Areas Affected:

All 100 counties of North Carolina

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable*****:**

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a._X_ Access and Eligibility:

i._X_ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

Exceed cost neutrality per waiver entry and annual assessment years, however, ensuring the waiver year cost neutrality in the aggregate.

ii.__X Temporarily modify additional targeting criteria.
[Explanation of changes]

Waiver participant does not have to use planned waiver services in amount, frequency and duration listed in the plan of care during the period of the approved Appendix K document and will not be subjected to discharge due to an inability to access services because of COVID-19.

b._x_ Services

i.__X__ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. __X_ Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

Modification of service identified in Appendix C-1/C-3 in scope and coverage to allow flexibilities of utilization to prevent spread and to efficiently manage the health, safety and well-being of the waiver participant. Services that are proposed to be modified:

1. Case management – To conduct monthly telephonic contact, only with the waiver participant and quarterly telephonic contact with service providers to monitor the service plan, which will be conducted in accordance with HIPAA requirements. The availability to perform the initial and annual assessments of the level of care and a reasonable indication of need telephonically, which will be conducted in accordance with HIPAA requirements. The ability to delay the annual LOC assessment by 365 days of the original assessment when the waiver participant is sequestrated or not able to participate in the recertification process. To ensure access to needed services as identified in an approved service plan, the case manager will develop a one-time purchase order process for each approved service through this Appendix K to promote an on-demand quick procurement when PPE items are readily available in retail. The purchase order may include the participant being given a check made out directly to the provider (that the provider has to sign), a purchase account at the retailer where the participant and the provider must sign, (the invoice is submitted to the case manager for verification), or the designation of a VISA card number assigned specifically to a waiver participant for on-line procurement of approved services, arranged by the case manager. The VISA card will not be given to the individual. The case manager will document the VISA card number and the associated pin. When the need for the goods and services, training, and germicidal filters are identified, the case manager will revise the POC and seek approval. Upon the approval of the POC, the case manager will identify the most efficient purchase order process to ensure quick access to the approved services.

2. Participant and Individual goods and services – coverage of sanitation (disinfectant) wipes, hand sanitizer, and disinfectant spray, when these items are not covered by the state plan, for CNAs or personal assistants who can continue to render in-home and respite services to waiver participant in their homes. The coverage of facial tissue, thermometer, and specific colored trash liners to distinguish dirty linen of infected household member to prevent spread, when these items are not provided in the state plan. The coverage of three cloth face coverings for the waiver participant in promoting compliance with our state's face covering mandated. The waiver participant to use a purchase order process developed by the case management entity to purchase the goods and services approved in the Plan of Care (POC). The coverage of a tablet or smartphone for identified waiver participants to promote telephonic/electronic engagements with service providers for telehealth, monitoring, and linkage and is restricted to individuals who do not have access to tablets or smartphones through the state plan. The approval of a smart device does not include minutes or data above and beyond what is included in the initial device purchase.
3. Training/Education/Consultative Services – coverage of training to the paid worker on PPE and other needed trainings specific to the care needs of waiver participant to prevent the spread of COVID-19 when trainings are not covered by the state plan. The waiver participant to use a purchase order process developed by the case management entity to pay for the training registration fee, course, and course material that were approved by the case manager.
4. In-home care and personal assistance services– services are not required to be used on a monthly basis or directly rendered per the amount, frequency and duration as approved in the service plan, but not less than what is approved in the service plan.
5. In-home care and personal care assistance– coverage of payment to a legal guardian, a live-in relative or a non-live-in close kinship relative for the waiver participant whose hired worker is not able to render the service because of the impact from COVID-19.
6. The coverage of one lunch meal per day for aged and disabled adults who are approved to receive meal preparation and delivery services and their meal delivery services were cancelled or stopped due to COVID-19's impact on service providers or service provider resources. This service may cover one home-delivered meal such as Uber Eats, DoorDash, Grub Hub, nutritionally balanced

frozen meals, or a similar service. The coverage of one lunch meal per day for an aged and disabled adult who is assessed to need meal preparation and delivery services during the public health emergency.

7. Community Transition – coverage of a less than 90-day institutionalized Medicaid beneficiary experiencing COVID-19 symptoms who can safely transition to a home and community-based placement using HCBS services.
8. Equipment, modification and technology – the coverage of germicidal air filters when they are not covered by the state plan. The waiver participant to use a purchase order process developed by the case management entity to purchase the germicidal air filter approved in the Plan of Care (POC).

Allowances for expansion of approved waiver services that exceed individual service limitations identified in Appendix C-1/C-3. As authorized by the state and based on the assessed needs of waiver participant who is experiencing COVID-19 symptoms, the following limits may be exceeded:

1. Equipment, modification and technology –exceed the service limit of $13,000.00 waiver limit
2. Case management units – additional monthly reimbursement of case management time to manage needs of waiver participant experiencing COVID-19 symptoms to ensure linkage to resources needed to manage symptoms of COVID-19 as evidence of case notes.
3. Participant and Individual goods and services –exceed the $800.00 fiscal limit
4. Assistive technology - exceed the $13,000.00 waiver limit
5. Training/Education/Consultative Services – exceed $500.00 fiscal limit
6. Respite – exceed the 720 in-home respite hours per fiscal year for in-home and coverage of 30 or more days in an institution.
7. Meal preparation and delivery daily meal rate may be exceeded.
8. Community transition – exceed the service limit of $2,500 waiver limit

As authorized by the state, In-home care and personal care assistance hours may be increased over the person-centered approvable utilization limits when waiver participant or family member is impacted by COVID-19 due to a change in school attendance, work hours or family status changes.

iii. ____Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. __X__Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

Services of in-home aide, personal care assistance and respite may be provided in a hotel, shelter, schools, church, or facility-based setting when the waiver participant is displaced from the home because of COVID-19 and will not duplicate services regularly provided by facility-based settings. For the purpose of out-of-home respite, the state will pay room and board for qualified settings.

A portable ramp or equipment may be approved to assist with transfers and mobility to allow ease of access in the temporary setting.

v.__X_ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

Services of in-home aide, personal care assistance and respite may be provided in a hotel, shelter, church, or any facility-based setting which will not duplicate services regularly provided by facility-based settings outside of North Carolina when the participant is displaced from home because of the COVID-19, and an telephonic assessment which will be conducted in accordance with HIPAA requirements attests that services are required, the provider is qualified and the setting is safe. The case manager will complete the telephonic assessment.

A portable ramp or equipment may be approved to assist with transfers and mobility to allow ease of access to setting.

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d._X__ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i._X__ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

During the pandemic, when a live-in family member, legally responsible person or close kinship relative is approved to render services of in-home aide, personal care assistance and congregate a registry and a criminal statewide background check, competency validation, and consumer direction training overview, in fraud, waste and abuse, abuse, neglect, exploitation, critical incident reporting and the enrollment in consumer direction are required. The waiving of the CPR certification upon enrollment will be implemented for a live-in relative, legally responsible person or a kinship relative, but a plan to obtain the CPR certification must be identified within 30 days.

When a legally responsible person, live-in family member or a close kinship relative is approved to be the paid caregiver and there are criminal findings on the background check, criminal offenses occurring more than 10 years before the date of the criminal report may qualify for an exemption when the exemption does not violate Medicaid guidelines. The financial manager shall inform the CAP case manager when a legally responsible person, live-in family member or a close kinship relative is within the 10-year rule and the CAP beneficiary or the CAP case manager/NC Medicaid shall have the autonomy to approve the exemption. This exemption is consistent with the current criminal background policy guidelines.

The below assurances are implemented:

1. When a legally responsible person is authorized to receive payment for providing personal assistance services, the CAP/DA beneficiary is temporarily enrolled in the consumer-direction program. The enrollment in this service will provide quality assurance of the health, safety and well-being of the CAP/DA beneficiary and provides the controls to ensure that payments are made only for the services authorized to provide.
2. The assigned Case Management Entity (CME) shall monitor the CAP/DA beneficiary closely to ensure the services are provided according to the service plan and the waiver participation business requirements are met. Weekly monitoring visit will be conducted.
3. The COVID-19 Care Management Plan must be completed and fully describes the ability of the caregiver to function in that role.
4. A competency skill checklist must be completed on live-in family member, legally responsible person or close kinship to identify ability and any training needs.
5. A training will be provided in fraud, waste and abuse
6. A training will be provided on critical incident reporting and management
7. A training will be provided in abuse, neglect and exploitation

ii.___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. X Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

The initial level of care assessments may be performed telephonically in addition to the in-person assessments and must be completed within the established timelines. The annual reassessment and change of status assessments may be performed telephonically. The timelines to complete the annual reassessment may be extended for up to 365 calendar days of the previous assessment. Telephonic service plan approvals include an electronic signature when in accordance with HIPAA requirements.

f.___ Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

g.__X_ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

Service plans may be developed and approved telephonically which will be conducted in accordance with HIPAA requirements. Approved service plans shall be monitored telephonically which will be conducted in accordance with HIPAA requirements by the case manager, monthly. A quarterly telephonic contact which will be conducted in accordance with HIPAA requirements to service providers to monitor COVID-19 service plans and approved service modifications.
Telephonic service plan approvals include an electronic signature when in accordance with HIPAA requirements.

The approved services listed on the service plan in the amount, frequency and duration will continue to be approved through waiver service authorization updates. Prior approval segments will be transmitted to the MMIS for claims adjudication.

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.__X Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or

when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

Necessary supports including communication and personal care available through in-home aide, personal care assistance and congregate care may be provided in a hospital, rehabilitation facility, or short-term institution when the waiver participant is displaced from home because of COVID-19 and such supports are not otherwise available in these settings. Supplemental services provided in the hospital or other institutional placement can only be provided for up to 30 consecutive days. There may be more than one 30 consecutive day period.

j. X Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

Authorize payment to direct care workers (providers of personal care services) in the amount, frequency and duration as listed on the currently approved service plan when a waiver participant or hired worker is directly impacted by COVID-19. Retainer payments are time-limited and cannot exceed three (3), 30 billable day periods.

Retainer payments are for direct care providers who normally provide services that include habilitation and personal care, but are currently unable to due to complications experienced during the COVID-19 pandemic because the waiver participant is sick due to COVID-19; or the waiver participant is sequestered and/or quarantined based on local, state, federal and/or medical requirements/orders.

The state has a distinguishable process to monitor payments to avoid duplication of billing, which includes the following listed requirements:

- Individual workers are required to sign an attestation prior to claiming retainer payments in which they must attest to the items listed below:
- Individual workers are required to sign an attestation prior to claiming retainer payments in which they must attest to the items listed below:
  - Retain their availability to the specified waiver participant to assist with activities of daily living (ADLs) and instructional activities daily living (IADLs) that is consistent with an approved service plan when it is safe to return to the home.
  - To not file an unemployment claim while a retainer agreement is in progress.
  - To report to the waiver case manager the occurrence of a lay-off by an employer when a retainer payment is executed.
  - To receive the maximum reimbursement rate or wages per the planned pay period for approved hours/units in an active service plan approved before the retainer agreement was initiated.
  - To agree to receive a maximum of three retainer agreements for one specified waiver participant.
  - The retainer agreement is only authorized when the waiver participant is sequestrated and is not able to access needed services.
- Provider organizations that accept a retainer payment agreement for a specified worker cannot receive duplicative payments and must adhere to the following requirements list below:
  - The provider agency is not able to bill retainer payments on behalf of staff that are laid off.
  - The provider agency's retainer payment claims must be adjusted to account for any lay-offs, if staff is laid off.

k.___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

l.___ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Melanie
Last Name	Bush
Title:	Deputy Director
Agency:	DHHS-Division of Health Benefits
Address 1:	1985 Umstead Drive
Address 2:	2501 Mail Service Center
City	Raleigh
State	NC
Zip Code	27609-2501
Telephone:	919 855-4182
E-mail	Melanie.bush@dhhs.nc.gov
Fax Number	919 733-6608

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Dave
Last Name	Richard
Title:	Deputy Secretary
Agency:	DHHS – Division of Health Benefits
Address 1:	1985 Umstead Drive 2501 Mail Service Center
Address 2:	
City	Raleigh
State	NC
Zip Code	27609-2501
Telephone:	919-855-4101
E-mail	Dave.richard@dhhs.nc.gov
Fax Number	

8. Authorizing Signature

Signature:
_____/S/_____
State Medicaid Director or Designee

Date:	**8/26/2020**

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Participant Goods and Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

The following language is additive to the state's current approved waiver definition for this service:

Specific supplies, when not available in the state plan, are coverable to assist in preventing the spread of COVID-19. These supplies are:

- Sanitation (disinfectant) wipes; hand sanitizer and disinfectant spray for CNAs or personal assistants who can continue to render in-home, pediatric and nurse care to waiver participant; facial tissue; thermometer; specific colored trash liners to distinguish dirty linen of infected household member to prevent spread; cloth face covering, and the coverage of a tablet or smartphone for identified waiver participants to promote telephonic/electronic engagements with service providers for telehealth, monitoring, and linkage and is restricted to individuals who do not have access to tablets or smartphones through the state plan. The approval of a smart device does not include minutes or data above and beyond what is included in the initial device purchase.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following language is additive to the state's current approved waiver definition for this service:
As authorized by the state, participant goods and services may exceed $800.00 during the pandemic period.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				DME
				Business retail

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DME	DME licensure		
Business retail	Commercial licensure		
Commercial	Commercial licensure		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
DME	**Case Management entity; DHHS Fiscal Agent; State Medicaid Agency**	**Initially and every five years thereafter**
Business retail	**Case Management entity; DHHS Fiscal Agent; State Medicaid Agency**	**Initially and every five years thereafter**

Commercial	**Case Management entity; DHHS Fiscal Agent; State Medicaid Agency**		**Initially and every five years thereafter**	
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

[i] Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

Service Specification	
Service Title:	Individual Directed Goods and Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

The following language is additive to the state's current approved waiver definition for this service:

Specific supplies, when not available in the state plan, are coverable to assist in preventing the spread of COVID-19. These supplies are:

- Sanitation (disinfectant) wipes; hand sanitizer and disinfectant spray for CNAs or personal assistants who can continue to render in-home, pediatric and nurse care to waiver participant; facial tissue; thermometer; specific colored trash liners to distinguish dirty linen of infected household member to prevent spread; and cloth face covering, and the coverage of a tablet or smartphone for identified waiver participants to promote telephonic/electronic engagements with service providers for telehealth, monitoring, and linkage and is restricted to individuals who do not have access to tablets or smartphones through the state plan. The approval of a smart device does not include minutes or data above and beyond what is included in the initial device purchase.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following language is additive to the state's current approved waiver definition for this service:

As authorized by the state, individual directed goods and services may exceed $800.00 during the pandemic period.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				DME
				Business retail

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DME	DME licensure		
Business retail	Commercial licensure		
Commercial	Commercial licensure		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
DME	**Case Management entity; DHHS Fiscal Agent; State Medicaid Agency**	**Initially and every five years thereafter**
Business retail	**Case Management entity; DHHS Fiscal Agent; State Medicaid Agency**	**Initially and every five years thereafter**

Commercial	**Case Management entity; DHHS Fiscal Agent; State Medicaid Agency**		**Initially and every five years thereafter**	
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Equipment, Modification and Technology
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
The following language is additive to the state's current approved waiver definition for this service: To manage the spread of the COVID-19, germicidal air filters are coverable, when not available in the state plan.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The following language is additive to the state's current approved waiver definition for this service: As authorized by the state, coverage for Equipment, Modification and Technology may exceed $13,000 over the 5-year cycle of the waiver to assist with the management of the spread of COVID-19.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
DME	DME licensure		
Business retail	Commercial licensure		
Commercial	Commercial licensure		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
DME	Case Management entity; DHHS Fiscal Agent; State Medicaid Agency	Initially and every five years thereafter
Business retail	Case Management entity; DHHS Fiscal Agent; State Medicaid Agency	Initially and every five years thereafter
Commercial	Case Management entity; DHHS Fiscal Agent; State Medicaid Agency	Initially and every five years thereafter

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Coordination of care - case management and care advisement

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

The following language is additive to the state's current approved waiver definition for this service:
Coverage of a less than 90-day institutionalized Medicaid beneficiary experiencing COVID-19 symptoms who can safely transition to a home and community-based placement using HCBS services can receive case management services.

Case management activities may be performed telephonically on a monthly basis with the waiver participant and quarterly telephonic contact with service providers to monitor the service plan, which will be conducted in accordance with HIPAA requirements. The initial and annual level of care assessments and a reasonable indication of need may be performed telephonically, which will be conducted in accordance with HIPAA requirements. The annual LOC assessment may be delayed by 365 days of the original assessment when the waiver participant is sequestrated or not able to participate in the recertification process. A change in status assessment may be performed telephonically. To ensure access to needed services as identified in an approved service plan, the case manager will develop a one-time purchase order process for each approved service through this Appendix K to promote an on-demand quick procurement when PPE items are readily available in retail. The purchase order may include the participant being given a check made out directly to the provider (that the provider has to sign), a purchase account at the retailer where the participant and the provider must sign, (the invoice is submitted to the case manager for verification), or the designation of a VISA card number assigned specifically to a waiver participant for on-line procurement of approved services, arranged by the case manager. The VISA card will not be given to the individual. The case manager will document the VISA card number and the associated pin. When the need for the goods and services, training, and germicidal filters are identified, the case manager will revise the POC and seek approval. Upon the approval of the POC, the case manager will identify the most efficient purchase order process to ensure quick access to the approved services.
The case manager may seek a telephonic service plan approval which includes an electronic signature when in accordance with HIPAA requirements. Electronic signatures will have disclaimer/attestation for approval of the plan in the e-CAP system for new requests or revisions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following language is additive to the state's current approved waiver definition for this service:
As authorized by the state, case management services may exceed $377/month ($56.56/hr. X 80 hours) per calendar year (January 1-December 31) per waiver participant for combined use of both case management and care advisor services during this pandemic period, when determine necessary as evidence by excessive case management activities as described or documented in the case notes.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Case Management Entities

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
case management entity	N/A	N/A	a minimum a 4-year degree in social work or a human service profession or be a registered nurse at an RN or LPN level, licensed to practice in the state.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Case Management	NC Medicaid	Initially and every five years

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Training/Education/Consultative Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
The following language is additive to the state's current approved waiver definition for this service: This service will cover training to the paid workers on PPE specific to the care needs of waiver participant to assist to prevent the spread of COVID-19 when trainings are not provided in the state plan.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The following language is additive to the state's current approved waiver definition for this service: As authorized by the state, this service may exceed $500 per fiscal year during this pandemic period.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	Individual		Education settings	
			Home Health Agencies	

Specify whether the service may be provided by *(check each that applies):*	x	Legally Responsible Person	x	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual	N/A	N/A	Knowledge and competency
Educational setting		Certification	
Home Health Agency	License		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual	Case management entity	Upon approval
Educational setting	Case management entity	Upon approval
Home Health Agency	Case management entity	Upon approval

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	CAP In-Home Aide
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	

The following language is additive to the state's current approved waiver definition for this service:
During the pandemic, this service is not required to be used on a monthly basis and can be rendered in varying amounts, frequencies and duration as approved in the service plan to manage symptoms or the spread of COVID-19, but not less than what is approved in the service plan.

The person-centered service plan (PCSP) will be modified to meet the needs of the individual during the pandemic, which the state refers to as a short-term intensive service plan. This is a modification to the annual plan and the state will adhere to all PCPS annual requirements. Short-term intensive services are used for a significant change in the health, safety and well-being or acuity status of the CAP beneficiary but will extend no longer than one year without review. Short-term intensive services are listed in the annual person-centered service plan and is consistent with the needs identified in the COVID-19 care management plan. This service may be provided in an in-patient facility when waiver participant is institutionalized because of COVID-19 symptoms. Necessary supports including communication and personal care available through in-home aide, pediatric nurse aide, congregate care, and personal care assistance may be provided in a hospital, rehabilitation facility, or short-term institution when the waiver participant is displaced from home because of COVID-19 and such supports are not otherwise available in these settings. Supplemental services provided in the hospital or other institutional placement can only be provided for up to 30 consecutive days. There may be more than one 30 consecutive day period.

CAP In-Home Aide provided in an acute care hospital are

(A) identified in an individual's person-centered service plan (or comparable plan of care);
(B) provided to meet needs of the individual that are not met through the provision of hospital services;
(C) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
(D) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

When determined appropriate per the CAP COVID-19 Care Management Plan payment for services rendered by a family caregivers or legally responsible person and guardian may be permissible for a 30 consecutive day approval period specifically to quarantine or the practice of social distancing mandated, according to the extraordinary policy outlined in the waiver. Monitoring requirements as described in the extraordinary criteria will be implemented.

During the pandemic, when family members are choosing to be the paid caregiver, waiving of the CPR certification upon enrollment is permitted for a live-in relative or a kinship relative for up to 30 days, but CPR certification must be obtained within 30 days of the employee agreement. A registry check and a statewide criminal background check, competency validation, consumer direction training overview in fraud, waste and abuse, abuse, neglect and exploitation and critical incident reporting and consumer direction enrollment are required before the hiring agreement is approved to work with the waiver participant.
This service may be provided in an alternative setting such as hotels, shelters, schools, churches when not duplicative to services regularly provided by facility-based settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following language is additive to the state's current approved waiver definition for this service:
The number of hours of CAP In-Home Aide service is authorized based on person-centered needs.
A legal guardian, Power of Attorney, Health Power of Attorney can be hired to provide CAP In-Home Aide to a waiver participant during the public health emergency due to the lack of a qualified provider who can furnish services and the sequestration or quarantine mandates executed through the Governor's Executive Orders or physician's medical order.

1. When a legally responsible person is authorized to receive payment for providing personal assistance services, the CAP/DA beneficiary is temporarily enrolled in the consumer-direction program. The enrollment in this service will provide quality assurance of the health, safety and well-being of the CAP/DA beneficiary and provides the controls to ensure that payments are made only for the services authorized to provide.
2. The assigned Case Management Entity (CME) shall monitor the CAP/DA beneficiary closely to ensure the services are provided according to the service plan and the waiver participation business requirements are met. Weekly monitoring visit will be conducted.
3. The COVID-19 Care Management Plan must be completed and fully describes the ability of the caregiver to function in that role.
4. A competency skill checklist must be completed on live-in family member, legally responsible person or close kinship to identify ability and any training needs, and the individual will only complete those functions that s/he has the ability to render as confirmed by the checklist and/or by the additional training.
5. A training will be provided in fraud, waste and abuse
6. A training will be provided on critical incident reporting and management
7. A training will be provided in abuse, neglect and exploitation

Time-limited retainer payments (cannot exceed three (3), 30 billable day periods) are for direct care providers who normally provide services that include habilitation and personal care, but are currently unable to due to complications experienced during the COVID-19 pandemic because the waiver participant is sick due to COVID-19; or the waiver participant is sequestered and/or quarantined based on local, state, federal and/or medical requirements/orders. The state has a distinguishable process to monitor payments to avoid duplication of billing for the employee and the provider organization, refer to K-2j.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	x	Agency. List the types of agencies:
				In-home Aide Agencies
				Home Health Agencies

Specify whether the service may be provided by *(check each that applies):*	x	Legally Responsible Person	x	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
In-home Aide Agencies		CNA	Personal assistant
Home Health Agencies		CNA	Personal assistant

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
In-home Aide Agencies	NC Medicaid and case management entity	initially and annually
Home Health Agencies	NC Medicaid and case management entity	initially and annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	Personal Assistant Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	

The following language is additive to the state's current approved waiver definition for this service:
During the pandemic, this service is not required to be used on a monthly basis and can be rendered in varying amounts, frequencies and duration as approved in the service plan to manage symptoms or the spread of COVID-19, but not less than the approved service plan.

The person-centered service plan (PCSP) will be modified to meet the needs of the individual during the pandemic, which the state refers to as a short-term intensive service plan. This is a modification to the annual plan and the state will adhere to all PCPS annual requirements. Short-term intensive services are used for a significant change in the health, safety and well-being or acuity status of the CAP beneficiary but will extend no longer than one year without review. Short-term intensive services are listed in the annual person-centered service plan and is consistent with the needs identified in the COVID-19 care management plan. This service may be provided in an in-patient facility when waiver participant is institutionalized because of COVID-19 symptoms. Necessary supports including communication and personal care available through in-home aide, congregate care, and personal care assistance may be provided in a hospital, rehabilitation facility, or short-term institution when the waiver participant is displaced from home because of COVID-19 and such supports are not otherwise available in these settings. Supplemental services provided in the hospital or other institutional placement can only be provided for up to 30 consecutive days. There may be more than one 30 consecutive day period.
Personal Assistant Service provided in an acute care hospital are

> (A) identified in an individual's person-centered service plan (or comparable plan of care);
> (B) provided to meet needs of the individual that are not met through the provision of hospital services;
> (C) not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and
> (D) designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

When determined appropriate per the CAP COVID-19 Care Management Plan payment for services rendered by a family caregivers or legally responsible person and guardian may be permissible for a 30 consecutive day approval period specifically to quarantine or the practice of social distancing mandated, when extraordinary requirements are met. Monitoring requirements as described in the extraordinary criteria will be implemented.

During the pandemic, when family members are choosing to be the paid caregiver, waiving of the CPR certification upon enrollment is permitted for a live-in relative or a kinship relative for up to 30 days, but CPR certification must be obtained within 30 days of the employee agreement. A registry check and a statewide criminal background check, competency validation, consumer direction training overview in fraud, waste and abuse, abuse, neglect and exploitation and critical incident reporting and consumer direction enrollment are required before the hiring agreement is approved to work with the waiver participant.

1. When a legally responsible person is authorized to receive payment for providing personal assistance services, the CAP/DA beneficiary is temporarily enrolled in the consumer-direction program. The enrollment in this service will provide quality assurance of the health, safety and well-being of the CAP/DA beneficiary and provides the controls to ensure that payments are made only for the services authorized to provide.
2. The assigned Case Management Entity (CME) shall monitor the CAP/DA beneficiary closely to ensure the services are provided according to the service plan and the waiver participation business requirements are met. Weekly monitoring visit will be conducted.

3. The COVID-19 Care Management Plan must be completed and fully describes the ability of the caregiver to function in that role.
4. A competency skill checklist must be completed on live-in family member, legally responsible person or close kinship to identify ability and any training needs.
5. A training will be provided in fraud, waste and abuse
6. A training will be provided on critical incident reporting and management
7. A training will be provided in abuse, neglect and exploitation

When a legally responsible person, live-in family member or a close kinship relative is approved to be the paid caregiver and there are criminal findings on the background check, criminal offenses occurring more than 10 years before the date of the criminal report may qualify for an exemption when the exemption does not violate Medicaid guidelines. The financial manager shall inform the CAP case manager when a legally responsible person, live-in family member or a close kinship relative is within the 10-year rule and the CAP beneficiary or the CAP case manager/NC Medicaid shall have the autonomy to approve the exemption. This exemption is consistent with the current criminal background policy guidelines.

Legally responsible person, live-in family member or a close kinship relative who are granted an employee agreement shall comply with the U.S. Department of Labor Fair Labor Standards Act.

Time-limited retainer payments (cannot exceed three (3), 30 billable day periods) are for direct care providers who normally provide services that include habilitation and personal care, but are currently unable to due to complications experienced during the COVID-19 pandemic because the waiver participant is sick due to COVID-19; or the waiver participant is sequestered and/or quarantined based on local, state, federal and/or medical requirements/orders. The state has a distinguishable process to monitor payments to avoid duplication of billing for both the employee and provider organization, refer to K-2j.

This service may be provided in an alternative setting such as hotels, shelters, schools, churches when not duplicative to services regularly provided by facility-based settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	x	Individual. List types:	☐	Agency. List the types of agencies:
	Personal Assistants			

Specify whether the service may be provided by *(check each that applies):*	x	Legally Responsible Person	x	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Assistant			Pass competency assessment

Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:			Frequency of Verification	
Personal assistant	NC Medicaid and case management entity			initially and annually	
Service Delivery Method					
Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E		☐	Provider managed

Service Specification	
Service Title:	Community Transition
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
The following language is additive to the state's current approved waiver definition for this service. The coverage of this service is extended to individuals with a less than 90-day institutional stay who are experiencing COVID-19 symptoms and can safely transition to a home and community-based placement using HCBS services.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The following language is additive to the state's current approved waiver definition for this service: As authorized by the state, the waiver year cost limit may be exceeded.	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Business/Commercial

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Business	Commercial license		
Commercial	Commercial license		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Business	Case management entity and NC Medicaid	prior to service provision
Commercial	Case management entity and NC Medicaid	prior to service provision

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Title:	Respite Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

The following language is additive to the state's current approved waiver definition for this service:
This service may be provided in an alternative setting such as hotels, shelters, schools, churches and adult day health agencies. Institutional Respite may not exceed 30 consecutive days in the authorization period, but there may be more than one 30 consecutive day period.

Respite hours may exceed more than that total to 720 hours/fiscal year when identified in the COVID-19 Care Management Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following language is additive to the state's current approved waiver definition for this service:
As authorized by the state, Institutional and In-home Respite Services may exceed more than one 30 calendar days authorization period during the pandemic or more than 720 hours in one fiscal year (July 1-June 30) for combined use of Institutional Respite Care and In-Home respite care.

Respite cannot be provided by a legally responsible party or a live-in family member.

Provider Specifications

Provider Category(s) *(check one or both)***:**	x	Individual. List types:	x	Agency. List the types of agencies:
	Personal assistant		In-home Aide Agencies	
			Home Health Agencies	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Assistant			Pass competency assessment
In-home Aide Agencies		CNA	Personal assistant
Home Health Agencies		CNA	Personal assistant
Adult Day Health		ADH certification	The Division of Health Services Regulation approval

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
In-home Aide Agencies	NC Medicaid and case management entity	initially and annually
Home Health Agencies	NC Medicaid and case management entity	initially and annually
Personal assistant	NC Medicaid and case management entity	initially and annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Title:	Adult Day Health
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
The following language is additive to the state's current approved waiver definition for this service: This service may be used for a period less than 4 hours per day or may be used up to seven days per week.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
The following language is additive to the state's current approved waiver definition for this service: Services are organized and provided at varying durations during the pandemic period to manage symptoms and to prevent spread, but not less than what is approved in the service plan.	

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Adult Day Health
				Federally Recognized Tribes

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Health		ADH certification	
Federally Recognized Tribes		ADH certification	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Health	**NC Medicaid and DAAS**	**Initially and annually**
Federally Recognized Tribes	**NC Medicaid and case management entity**	**Initially and annually**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	

Service Title:	Meal Preparation and Delivery
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	

The following language is additive to the state's current approved waiver definition for this service: When home delivered meals are suspended during the pandemic, or when a waiver participant is assessed to need a meal during the pandemic, this service shall cover up to one home delivered meal for seven days per week. This coverage ensures the waiver participant get at least one meal per day. Nutritionally balanced frozen meals will be provided during the pandemic as another food source for meal preparation or delivery The daily reimbursement rate for the meal may be exceeded during the pandemic.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)*:	☐	Individual. List types:	x	Agency. List the types of agencies:
				Food Industry/commercial
				Uber Eats, DoorDash, Grub Hub, Frozen Meals or a similar meal delivery service.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Food Industry or commercial	Commercial license		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Food Industry or commercial	NC Medicaid and case management entity	initially and annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Title:	Financial Management Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

The following language is additive to the state's current approved waiver definition for this service:
The financial management services may be conducted telephonically when new waiver participants are choosing to direct care for the first time, a CPR certification can be waived during the pandemic, but certification must be obtained within 30-days of when the individual begins rendering services. A registry check and a statewide criminal background check, competency validation, and consumer direction training overview in fraud, waste and abuse, abuse, neglect and exploitation, critical incident reporting, and consumer direction enrollment are mandatory requirements before the hiring agreement is approved to work with the waiver participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Financial management agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Financial management services		Yes	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Financial management	NC Medicaid and case management entity	initially and annually

Service Delivery Method

Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification					
Service Title:	Non-medical transportation services				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Definition (Scope)**:**					
The following language is additive to the state's current approved waiver definition for this service. The coverage of this service is extended to individuals who are attending an Adult Day Health program and need assistance with transportation.					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	x	Agency. List the types of agencies:
				Business/Commercial
				Adult Day Health

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Business	Commercial license		
Commercial	Commercial license		
Adult Day Health		ADH certification	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Business	Case management entity and NC Medicaid	prior to service provision
Commercial	Case management entity and NC Medicaid	prior to service provision
Adult Day Health	Case management entity and NC Medicaid	Prior to the service provision

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	x	Participant-directed as specified in Appendix E	x	Provider managed