CAP INDICATOR LETTER

MEMORANDUM

To: DSS Eligibility Specialist

_____

Name of county

From:

_____

MCO or LME Name

Date: _____

RE: Request for CAP I/DD Waiver Indicator

_____has approved_____ to participate in
MCO or LME Name **Recipient name and MID**
the CAP I/DD Waiver.

Please enter the appropriate indicator checked below which reflects the current waiver status for this recipient:

_____IN - NC Innovations Waiver
_____C2 - CAP I/DD Supports Waiver
_____CM - CAP I/DD Comprehensive Waiver

The effective date for CAP I/DD Waiver participation is _____.
Date

Attached, you will find a copy of the Plan of Care with the approved Medicaid waiver services and budget for this person. If this person has a Medicaid deductible/spend down please notify our office.

Please call our office if you have any questions at _____
MCO or LME phone number