MEMORANDUM of CAP WAIVER ENROLLMENT STATUS

DATE: _____

FROM: _____ TO: _____

_____ _____

_____ _____

(Case Manager Contact Information) (County Department of Social Services)

RE: _____ _____

(CAP Beneficiary's Name/MID) (Date of Birth)

Notification Type (please note additional document(s) to be submitted with each notification type)**:**

☐ **Referral to apply for Medicaid (Potential CAP Beneficiary)**:

Date CAP Services Requested*: _____.

☐ Beneficiary assigned for assessment. ☐ Beneficiary Denied for Waiver Enrollment

☐ Beneficiary approved for CAP participation:

CAP Effective Date*: _____ **Service Plan/Plan of Care Effective Date***: _____

The approval for CAP in the following waiver type:	**Level of Care Effective Date*:** _____
☐ CAP/C- Community Alternatives Program for Children	☐SC ☐ CI
☐ CAP/DA-Community Alternatives Program of Adults	☐ ID ☐ SD
☐ CAP/CD-Community Alternatives Program for Consumer Direction (Adults)	☐ HC ☐ CS

Reassessment of Active CAP Beneficiary **Assessment Effective Date:** _____

☐ **CNR**

☐ **Change in Status**:

☐**Changes in Level of Care:** **Service Plan Effective Date:**_____

☐SC ☐ CI ☐ HC

☐ ID ☐ SD ☐ CS ☐ No Change

☐ **Hospitalized** **Date of Hospitalization:** _____ **Discharge Date:**_____

☐ **Returned to CAP after hospital stay 30 days or less.**

☐ **Returned to CAP after hospital stay greater than 30 days.**

☐ Nursing Facility Placement **Date of Nursing Facility Placement**: _____

Nursing Facility Discharge Date: _____

☐ **Returned to CAP after nursing facility stay 30 days or less**

☐ **Returned to CAP after Nursing facility stay 31-90 days**

☐ **Disenrollment from the Waiver** Waiver Enrollment Termination Date: _____

☐ **Transfer Between Counties:** Name of County transferring to: _____ Date of Transfer: _____

Address of new residence: _____

_____

(Section below to be completed by County DSS Staff & returned to CAP Case manager via fax or encrypted email)

☐**Eligible: Medicaid Number:** _____

Medicaid Eligibility Category: Date approved: _____	Certification period: _____	Level of Care Code: _____	☐ Assessed to have a monthly deductible in the amount of: _____

☐**Ineligible:**

☐ Application withdrawn by applicant	☐ Chooses Special Assistance In-Home instead of CAP.
☐ Ineligible due to Sanction. Length of Sanction period: _____.	☐ Ineligible due to Resources.
☐ Other: _____	
Date IMC returned to CAP Case Manager: _____	IMC Contact Information (include phone#, email & fax) _____ _____ _____

***See next page**

DEFINTION OF TERMS

Date CAP Services Requested: The date applicant/beneficiary requests CAP services.

CAP Effective Date: The date all eligibility requirements are met, and the beneficiary was assigned a slot for CAP participation.
This is used for the *CAP Effective Date* for Medical Institution Evidence.

Service Plan/Plan of Care Date: The date the Service Plan/Plan of Care is approved to start.
For CAP deductible beneficiaries, apply medical expenses toward the monthly deductible.
Cost of Care cannot be applied prior to the effective date of the Service Plan/Plan of Care Date.

Level of Care Effective Date: The date Level of Care is approved.
This is used as the *Entered Date* for Medical Institution Evidence and the *FL-2/MR-2 Approved Date* for Level of Care Evidence.

CAP CODES

CI: CAP/DA INTERMEDIATE CARE FACILITY

CS: CAP/DA SKILLED NURSING CARE

ID: CAP CONSUMER-DIRECTION INTERMEDIATE CARE FACILITY (ADULTS)

SD: CAP CONSUMER-DIRECTION SKILLED NURSING CARE (ADULTS)

SC: CAP/C SKILLED NURSING CARE

HC: CAP/C HOSPITAL LEVEL OF CARE