NORTH CAROLINA DIVISION OF SOCIAL SERVICES
STATE/COUNTY SPECIAL ASSISTANCE

DOCUMENTATION REGARDING CONTINUATION OF SPECIAL ASSISTANCE WHEN THE LEVEL OF CARE IS UPGRADED, BUT NO BED AVAILABLE

Case Name: ______________________________ Date: ____________________________

County Case: ______________________________ Case ID: ____________________________

Ind. ID: ____________________________

Received: ____________________________

1. **Upgraded** FL-2/MR-2 dated: _________________________
2. Recommended level of care: ____
3. Date you or services staff notified of the upgraded FL-2/MR-2: ________________________________
4. Is a bed available at the upgraded level of care? ☐ yes ☐ no

   If **yes**, terminate SA benefits. Transfer the case to M-AABD if appropriate.
   If **no**, go to the next step.

5. Monthly Placement Progress Notes

DATE OF CONTACT WITH SERVICES STAFF	NAME OF SERVICES STAFF	PLACEMENT NOTES	CASEWORKER'S INITIALS