NORTH CAROLINA COMMUNITY ALTERNATIVES PROGRAM FOR CHILDREN PARTICIPATION NOTICE

DATE:__/__/____

TO:	**Provider**	FROM:	**Case Manager**
	Agency: _____		Agency: _____
	Address: _____		Address: _____
	Address: _____		Address: _____
	Phone: _____		Phone: _____
	Fax: _____		Fax: _____
	Contact Person: _____		E-mail: _____

RE: RECIPIENT'S NAME: _____ **MID: ___-__-____ _**

Parent/Responsible Party Name: _____
Phone: (___) ___-____ Address: _____

This recipient have insurance other than Medicaid.

This recipient have a monthly deductible that has to be met before being authorized for Medicaid coverage.

Please begin these services on __/__/____ and continue until A) __/__/____, B) otherwise notified, or C) the recipient's Medicaid is terminated, whichever occurs first.

The following services/supplies/equipment from your agency are included on this recipient's CAP/C Plan of Care.
If there are any changes in the type, amount, frequency or funding source of any of these services, or if any items are added or deleted, please notify me. My contact information is above.

CODE	ITEM	AMOUNT/FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Attach additional page if necessary.)

IMPORTANT: This is not an authorization for or approval of services from your agency. The purpose of this notice is to coordinate the recipient's home and community care services. Your services are provided and paid according to Medicaid policies and procedures. You are responsible for verifying Medicaid eligibility and the recipient's eligibility for the service.

Thank You, ___________________________________ _____ CAP/C Case Manager