2018 North Carolina Medicaid
Community-Based Long Term Services and Supports

Program Eligibility and Benefits
Reference Guide
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NC Medicaid

Medicaid is a health insurance program for certain low-income individuals or families who are in need of medical care. It is governed by federal and state laws and regulations. Medicaid is administered by the North Carolina Division of Medical Assistance and monitored by the U.S. Centers for Medicare and Medicaid Services. There are two major program areas in Medicaid: 1) Aged (MAA), Blind (MAB), and Disabled (MAD) and 2) Families and Children. There are some other Medicaid programs that only provide limited services.

What does Medicaid Cover?

The Medicaid State Plan must cover:
- Ambulance
- Durable Medical Equipment
- Family Planning
- Federally Qualified Health Centers
- Health Check
- Home Health
- Hospitalizations - Inpatient/Outpatient
- Nurse Midwife/Nurse Practitioner
- Nursing Facility
- Labs and X-rays
- Physicians
- Rural Health Clinics

For Children Only:
- Dental Services
- Hearing Aids
- Routine Eye Exams and Visual Aids
- Early and Periodic Screening

A State may also elect to cover:
- Case Management
- Chiropractor Services
- Dental Services/Dentures for Adults
- Eye Care for Adults
- Home Infusion Therapy
- Hospice
- Intermediate Care Facilities
- Mental Health Services
- Non-Emergency Transportation
- Orthotics and Prosthetics
- Personal Care Services
- Physical, Occupational and Speech Therapy
- Podiatry
- Prescription Drugs
- Private Duty Nursing
- Rehabilitative Services
- Respiratory Care

Important Considerations:
North Carolina Medicaid is constantly changing. It is very important to regularly check for changes to Medicaid programs. A good way to stay informed is by reading the Medicaid Provider Bulletins which can be found at: http://www.ncdhhs.gov/dma/bulletin/index.htm

For More Information About Medicaid:
Go to the N.C. Division of Medical Assistance Website: http://www.ncdhhs.gov/dma/
Call the N.C. Division of Medical Assistance at (919) 855-4000
Go to U.S. Centers for Medicare and Medicaid Services Website: http://www.medicaid.gov
Who is eligible for Medicaid?

Basic Medicaid Eligibility

Basic Eligibility Requirements include:

- Are age 65 or older
- Are blind or disabled
- Meet income criteria ([https://dma.ncdhhs.gov/medicaid/get-started/eligibility-for-medicaid-or-health-choice/medicaid-income-and-resources-requirements](https://dma.ncdhhs.gov/medicaid/get-started/eligibility-for-medicaid-or-health-choice/medicaid-income-and-resources-requirements))
- Be in need of long-term care
- Be a US citizen or provide proof of eligible immigration status (individuals only applying for emergency services are not required to provide documentation of immigration status);
- Live in North Carolina, and provide proof of residency
- Have a Social Security number or have applied for one

Automatic Eligibility for Medicaid if receiving any of the following:

- Supplemental Security Income (SSI)
- Work First Cash Assistance
- State/County Special Assistance for the Aged or Disabled

How to Apply:

- Online using ePASS ([https://epass.nc.gov/CitizenPortal/application.do](https://epass.nc.gov/CitizenPortal/application.do))
- In person at the local Division of Social Services (DSS) in the county where the individual resides ([http://www.ncdhhs.gov/dss/local/](http://www.ncdhhs.gov/dss/local/)).
- By mail or fax ([www.ncdhhs.gov/dma/medicaid/applications.htm](http://www.ncdhhs.gov/dma/medicaid/applications.htm))
- By telephone through your local DSS ([http://www.ncdhhs.gov/dss/local/](http://www.ncdhhs.gov/dss/local/))

Representatives may apply on behalf of individuals unable to apply for themselves.

What information may be needed to determine eligibility?

- Social Security Card
- Proof of Identity
- Bank Statements
- Medical Bills
- Health Insurance Information
- Guardianship or Power of Attorney Papers (if acting on someone else’s behalf)
- Medicare Card
- Proof of N.C. State Residency
- Life Insurance Policies
- Proof of Income
- Proof of Citizenship or immigration status

Important Consideration:

Even when an individual qualifies for Medicaid, it does not always mean they qualify for a specific Medicaid program. Most Community-Based Long-Term Services and Supports programs have criteria in addition to the requirements for basic eligibility.

For More Information About Medicaid Eligibility, Call DHHS Customer Service (800) 662–7030
Adult Medicaid Eligibility Requirements

Financial Eligibility

When applying for Medicaid, monthly income is calculated by subtracting certain deductions from the household’s gross income. Social Security, veteran’s benefits, wages, pensions and other retirement income are counted. Deductions vary with each Medicaid program. For the countable monthly income and resource limits, go to: https://dma.ncdhhs.gov/medicaid-income-limits

Resources include cash, bank accounts, retirement accounts, stocks and bonds, cash value of life insurance policies, and other investments.

Medicaid Deductible:
If your family income and resources are over the limit and you have high medical bills, you may still qualify for Medicaid and have a Medicaid deductible (https://dma.ncdhhs.gov/medicaid/get-started/eligibility-for-medicaid-or-health-choice/medicaid-deductible)

Unpaid medical bills and current medical expenses count toward meeting your deductible. For the most recent criteria of what can qualify refer to the link above. Individuals with deductibles who live in the community will have to spend down to meet eligibility. Go to https://dma.ncdhhs.gov/medicaid-income-limits and see criteria under deductible/spend down column.

Important Considerations:

- **Spousal Impoverishment:** Under the Medicaid spousal impoverishment provisions, a certain amount of the couple’s combined resources is protected for the spouse living in the community. Depending on how much of his or her own income the community spouse actually has, a certain amount of income belonging to the spouse in the institution can also be set aside for the community spouse’s use. For spouse income and resource allowance amounts go to: https://www.medicaid.gov/medicaid/eligibility/spousal-impoverishment/index.html

- **Asset Transfers:** If you or your representative give away assets or sell them for less than market value, you may be ineligible to receive Medicaid for 3 - 5 years. The sanction period is based upon the value of the assets transferred out of your name. There are certain circumstances where assets may be given away without penalty.

- **Estate Recovery:** When a Medicaid recipient receiving certain long-term care services (https://dma.ncdhhs.gov/medicaid/get-started/eligibility-for-medicaid-or-health-choice/medicaid-for-long-term-care) dies, Medicaid seeks to recover certain expenses. There will be a claim filed against the estate. Under certain circumstances, estate recovery may not apply.
What is CAP/DA? This program, authorized under the 1915 (c) Home and Community-Based Services Waiver is designed to provide an alternative to institutionalization for eligible individuals who prefer to be in their homes and who would be at risk of nursing facility placement without services. CAP/DA supplements rather than replaces the formal and informal services and supports already available to an individual. These services are intended for situations where no household member, relative, caregiver, landlord, community/volunteer agency, or third party payer is able or willing to meet the complete needs of the individual. Examples of benefits include Adult Day Health, personal care aide, home accessibility and adaptation, meal preparation and delivery, respite services, etc. For a more comprehensive list please visit the CAP/DA website at https://dma.ncdhhs.gov/providers/programs-services/long-term-care/community-alternatives-program-for-disabled-adults.

Important Considerations:

- The CAP/DA Lead Agency completes a needs assessment to identify the appropriate service and funding level for each applicant. The cost for LTSS Medicaid services cannot exceed the monthly cost limit.
- Recipients may live in an institutional setting at the time of application and screening, but must be discharged to a private residence before receiving services from the program.
- If the individual has a Medicaid deductible, medical expenses that meet the deductible must be incurred before CAP/DA will pay for services.
- Services suspended during a short-term nursing facility or rehab center stay lasting no more than 90 days are eligible to be reinstated into the program upon discharge.
- For most Adult Care Home residents, CAP/DA is not a good consideration to support a transition because they do not meet the Nursing Facility Level of Care criteria.

For more about CAP/DA services and eligibility, go to:


Or

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4340

Who Qualifies for CAP/DA?

To be eligible for CAP/DA, the individual must:

- Be 18 years of age or older.
- Reside in or intend to transition to a private residence.
- Be eligible for Long Term Services and Supports (LTSS) Medicaid under one of the Medically Needy Categories. This is determined by the county Department of Social Services where the individual resides.
- Be determined to need Nursing Facility Level of Care.
- Have a documented medical condition that supports the need for services provided under CAP/DA.
- Be at risk of institutionalization within 30 calendar days.
- Require two waiver services monthly (excluding incontinence supplies, personal emergency response services and meal preparation and delivery).
- Be compliant with the established Plan of Care. Non-compliance by the individual and the identified primary caregiver creates a health, safety and well-being risk.

The eligibility process begins with the completion of the Service Request Form (SRF) and a signed Physician’s Attestation form.

To Access CAP/DA services:

Contact the county CAP/DA Lead Agency: http://dma.ncdhhs.gov/document/capda-lead-agency-list

Contact the DSS in the county where the individual resides: http://www.ncdhhs.gov/dss/local

Last Updated April 2018
**CAP/CHOICE**

**What is CAP/CHOICE?** CAP/CHOICE, authorized under the 1915 (c) Home and Community-Based Services Waiver, is a consumer-directed care option for disabled adults who want to remain at their primary private residence and have increased control over their own services and supports. Customers and their caregivers direct their own services and supports, which are provided in their own primary private residence and community. It offers customers choice, flexibility and control over types of services they receive, when and where services are provided, and who delivers the services.

CAP/Choice supplements formal and informal services and supports already available to a beneficiary. Services are for situations where no household member, relative, caregiver, landlord, community, agency, volunteer agency or third-party payer is able or willing to meet all medical, psychosocial and functional needs of the beneficiary.

**Important Considerations**
- Individual must demonstrate ability and willingness to self-direct through a self-assessment questionnaire ([https://dma.ncdhhs.gov/providers/forms/community-alternatives-program-forms](https://dma.ncdhhs.gov/providers/forms/community-alternatives-program-forms)).
- Based on the outcome of the self-assessment, the individual may be encouraged to enroll in CAP/DA first.
- Self-direction is not for everyone. If the person is not appropriate for or comfortable with the responsibilities associated with CAP/CHOICE he/she will be re-enrolled in traditional CAP/DA services.

**Who Qualifies for CAP/CHOICE?**

In addition to meeting the eligibility requirements for CAP/DA, the individual must:

- Understand the rights and responsibilities of directing one’s own care.
- Be willing and capable of assuming the responsibilities for self-directed care, or select a representative who is willing and capable to assume the responsibilities to direct the recipient’s care.

The prospective recipient or their designated representative will be given a self-assessment questionnaire to determine the recipient’s ability to direct care or identify training opportunities to build competencies to aid in self-direction.

**Access to the CAP/CHOICE program occurs:**

Through the county CAP/DA Lead Agency- [http://dma.ncdhhs.gov/document/capda-lead-agency-list](http://dma.ncdhhs.gov/document/capda-lead-agency-list)

Through the DSS in the county where the individual resides- [http://www.ncdhhs.gov/dss/local/](http://www.ncdhhs.gov/dss/local/)

**For more about CAP/CHOICE services and eligibility, go to:**

**OR**

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4340
What is the Innovations Waiver? The North Carolina Innovations Waiver is a resource for funding services and supports for people with intellectual and other related developmental disabilities that are at risk for institutional care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Medicaid Innovations Waiver helps individuals with Intellectual or Developmental Disabilities (I/DD) live a more independent lifestyle. The local management entity/managed care organization (LME/MCO) receives a set amount of money (capitation) each year that is used to help people get I/DD services. The Innovations waiver is designed to provide an array of community-based services and supports to promote choice, control, and community membership.

A listing of services provided under the Innovations waiver can be found at: https://www2.ncdhhs.gov/ncinnovations/services.html.

Who Qualifies for Innovations? The individual must: 1) meet the requirements for ICF-IID level of care 2) live in an ICF-IID facility or be at high risk of placement in an ICF-IID facility; 3) be able to stay safe, healthy and well in the community while using NC Innovations Waiver services, 4) need and use NC Innovations services listed in the person-centered Individual Support Plan at least once a month; and 5) want to use NC Innovations Waiver services instead of living in an ICF-IID.

Eligibility for the Innovations waiver is managed through the Local Management Entity/Managed Care Organization (LME/MCO) networks (https://www.ncdhhs.gov/providers/lme-mco-directory).

Some eligibility requirements include meeting ICF-IID (Intermediate Care Facility) Level of Care, requiring active treatment and have a diagnosis of Intellectual Disability (ID) as characterized by significant limitations in both intellectual functioning and in adaptive behavior and the disability manifests before age 18 OR have a closely related condition. A closely related condition refers to individuals who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy and occurred before the age of 22, OR any condition, other than mental illness, found to be closely related to Intellectual Disability because the condition results in impairment of general functioning OR adaptive behavior similar to a person with ID and is manifested before the age of 22. This condition is likely to continue indefinitely and it results in functional limitations to three or more of the following: 1) self-care; 2) understanding/use of language; 3) learning; 4) mobility; 5) self-direction; or 6) capacity for independent living.

Access to the Innovations program occurs through: The Local Management Entity/Managed Care Organization (LME/MCO): https://www.ncdhhs.gov/providers/lme-mco-directory

Important Considerations:
- It is essential to get the LME/MCO involved as quickly as possible to determine eligibility for the waiver, as services can only be accessed through the LME/MCO network.
- At times it may not be clear if the individual is appropriate for services or if they will qualify. The LME/MCO must conduct assessments and make all mental health related eligibility determinations.

For more about the Innovations waiver:

Visit DMA’s Innovations Waiver Page: https://www2.ncdhhs.gov/ncinnovations/

Call DMA Recipient Services: 919-855-4000

OR


Clinical Policy https://dma.ncdhhs.gov/behavioral-health-clinical-coverage-policies

What is PACE?
The Program of All-Inclusive Care for the Elderly (PACE) is a managed care program for older adults. This program features a comprehensive service delivery system, and integrated Medicare and Medicaid financing. PACE can provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as safely possible. Medical care is provided by an Inter-Disciplinary Team (IDT) to case manage services provided or arranged by the PACE organization for each participant. PACE services include delivery of all needed medical and supportive services, medical specialists (e.g. cardiology, dentistry, optometry), adult day health care, physical, occupational, speech and recreational therapies, nutritional counseling by a registered dietician, social work and social services, hospital and nursing home care when necessary, home health care and personal care, all necessary prescription drugs and respite care.

Important Considerations:
- All services are provided directly by the program or through its provider network
- PACE will only pay for services which have been pre-approved by the Interdisciplinary Team (IDT)
- Individuals enrolled in PACE who move outside the service area will no longer be eligible for PACE services, unless the move is to another program’s service area.
- PACE IDT members can perform assessments while the individual is in the nursing facility

For more information about PACE services and eligibility go to:
North Carolina PACE Association
http://ncpace.org

NC PACE Programs List
https://dma.ncdhhs.gov/providers/programs-services/long-term-care/program-of-all-inclusive-care-for-the-elderly
National PACE Association site
http://www.npaonline.org
PACE Clinical Coverage Policy

Call the Home and Community Care Section of the NC Division of Medical Assistance: phone 919-855-4340

Who Qualifies for PACE?
To be eligible for PACE, the individual must:
- Be 55 years of age or older.
- Live in a PACE program service area.
- Be determined by a physician to need Nursing Facility Level of Care.
- Be able to live in a community setting when enrolled without jeopardizing health or safety

Only a small percentage of PACE participants reside in a nursing facility, even though all must be certified to need nursing facility level of care. If a PACE recipient needs nursing facility care, as determined by the IDT’s assessments, the PACE program will pay for it and continue to coordinate the individual’s care with the facility.

To Access PACE:
- A referral can be made to the PACE program that has a service area covering the address where the individual resides (https://dma.ncdhhs.gov/providers/programs-services/long-term-care/program-of-all-inclusive-care-for-the-elderly). The program will assess the individual and facilitate the enrollment process for those determined eligible.
- Medicaid recipients and individuals who are dually-eligible may request PACE services through their local DSS http://www.ncdhhs.gov/dss/local/
What is PCS? For eligible Medicaid beneficiaries, PCS provides hands-on assistance by paraprofessional aides in certain types of beneficiary living arrangements. Hands-on assistance is provided for the five qualifying activities of daily living (ADLs) which include eating, dressing, bathing, toileting, and mobility. The amount of approved service is based on an assessment conducted by an independent entity to determine the beneficiary’s ability to perform their ADLs.

Who Qualifies for PCS?

Medicaid covers the cost of PCS if:

- The individual qualifies for Medicaid
- The individual has either 1) three of five ADLs which require limited hands-on assistance; 2) two ADLs, one of which requires extensive assistance; or 3) two ADLs, one of which requires complete assistance
- PCS is linked to a documented physical or developmental disability, cognitive impairment, or chronic health condition.
- The individual is under the ongoing direct care of a physician for the medical condition(s) causing the functional limitations.
- The individual is medically stable and does not require continuous monitoring by a licensed nurse or other licensed health care professional.
- The home or residential setting is safe for the beneficiary and the PCS provider(s) and is adequately equipped to implement needed services.
- There is no available, willing, or able family, household member or other informal caregiver to provide ADL assistance at the time when services are provided.
- There is no other third-party payer responsible for covering PCS.

Eligible individuals must live in an approved residence including private living arrangement, residential facility licensed by North Carolina as an adult care home, a combination home as defined in G.S. 131E-101(1a), G.S. 131E-101(1a), or a group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G.5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability or substance abuse dependency.

To Access PCS:

The individual’s primary care or attending physician, physician assistant, or nurse practitioner must make the referral for the individual to be assessed for PCS.
**What is Private Duty Nursing?** Private Duty Nursing (PDN) is substantial, complex, and continuous skilled nursing care provided in the home for medically fragile Medicaid beneficiaries. PDN is based upon a written individualized plan of care approved by an attending physician. Case Management is not provided with this service. PDN must be provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) employed by a licensed home care agency. Eligible individuals may receive up to 112 hours per week.

**Important Considerations**
- PDN services may be used outside the home for normal life activities, such as supported or sheltered work settings, licensed child care, school, school related activities, and religious services/activities.
- This service is considered supplemental to the care provided by a beneficiary's family or designated caregivers, and allows the beneficiary to remain in their residence rather than an institution.
- Prior approval (PA) is required for PDN services, and is granted based on the beneficiary's medical necessity and fragility.
- It is recommended that there be a second trained informal caregiver for instances when the primary informal caregiver is unavailable due to illness, emergency, or need for respite.

For more about PDN services and eligibility go to:

PDN Home Page: [https://dma.ncdhhs.gov/private-duty-nursing-pdn](https://dma.ncdhhs.gov/private-duty-nursing-pdn)


Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4380

**Who Qualifies for PDN?**

To be eligible for PDN standard nursing services, the individual must:
- Be eligible for Medicaid under one of the Medically Needy Categories as determined by the local county Department of Social Services where the individual resides.
- Reside in a qualified private residence.
- Have a documented medical need for skilled nursing care in the home, with a prior approval from the individual’s attending physician.
- Have at least one trained, informal caregiver to provide direct care to the beneficiary during planned or unplanned absences of PDN staff.
- Be ventilator-dependent for at least eight hours per day, or meet four of the following criteria: 1) unable to wean from a tracheostomy; 2) require nebulizer treatments at least two scheduled times per day and one as needed; 3) require pulse oximetry readings every nursing shift; 4) require skilled nursing or respiratory assessments every shift due to a respiratory insufficiency; 5) require oxygen as needed or rate adjustments at least two times per week; 6) require daily tracheal care; 7) require PRN tracheal suctioning requiring a suction machine and a flexible catheter; or 8) at risk for requiring ventilator support.

**To Access PDN Services:**

The individual must ask a primary care or attending physician to make a referral for PDN.

Nurse Consultants at the North Carolina Division of Medical Assistance provide prior approval determinations for PDN.
What is DME? Durable medical equipment (DME) refers to the following categories of equipment and related supplies for use in a Medicaid recipient’s home:

- Inexpensive or routinely purchased items
- Equipment requiring frequent and substantial servicing
- Related medical supplies
- Other individually priced items
- Capped rental/purchased equipment
- Oxygen and oxygen equipment
- Service and repair
- Enteral nutrition equipment

DMA has designated Roche Diagnostics Corporation Diabetes Care as the preferred manufacturer for glucose meters, test strips, control solutions, lancets and lancing devices. Diabetic supply questions to ACCU-CHEK Customer Care at 877-906-8969.

What Qualifies as DME? There are two DME categories for equipment and related supplies for use in a beneficiary’s home: 1) Inexpensive or Routinely Purchased are items purchased for a beneficiary and 2) Capped Rental or Purchased Equipment are rented or purchased as follows:

- The item is rented if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six months or less.
- The item may be rented or purchased if the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months. Once rental is initiated on an item, a subsequent request for prior approval of purchase of that item will be denied. The item becomes the property of the beneficiary when the accrued rental payments reach NC Medicaid (Medicaid) allowable purchase price.

The following requirements must be met before an item can be considered DME:

1. It can withstand repeated use;
2. It is primarily and customarily used to serve a medical purpose;
3. It is not useful to a beneficiary in the absence of a disability, illness, or injury;
4. It is suitable for use in any non-institutional setting in which normal life activities take place;
5. It is reusable or removable.

All requirements above must be met before an item can be considered medical equipment. The item becomes the property of the beneficiary when the accrued rental payments reach the NC Medicaid allowable purchase price.

Medical supplies are non-durable supplies that:
1. are consumable or disposable, or cannot withstand repeated use by more than one individual;
2. are required to address an individual medical disability, illness, or injury;
3. are ordered or prescribed by a physician, physician assistant, or nurse practitioner.

For a list of covered Durable Medical Equipment, reference the most recent DME Fee Schedule: https://dma.ncdhhs.gov/documents/durable-medical-equipment-dme

Please note that items listed with an asterisk require prior approval.

For more information - DME Clinical Coverage Policy https://dma.ncdhhs.gov/documents/medical-equipment-clinical-coverage-policies or call (919) 855-4310
What is Community Care of North Carolina/Carolina Access? Community Care of North Carolina/Carolina Access (CCNC/CA) is a primary care case management (PCCM) health care plan for a majority of Medicaid & Health Choice (NCHC) beneficiaries in North Carolina. The mission is to improve the health and quality of life of all North Carolinians by building and supporting better community-based health care delivery systems. CCNC is a statewide program that serves 1.7 million Medicaid beneficiaries through local, on-the-ground clinical teams that know their communities and local resources intimately. CCNC combines state-of-the-art predictive analytics with long-term relationships with patients, clinicians and a wide range of providers that together make up the medical neighborhood. Community Care of North Carolina works in concert with agencies, non-profits, and other organizations to better serve the needs of the Medicaid and other vulnerable populations in North Carolina.

Important Considerations:
- If a medical home is not chosen by the enrollee, one may be assigned.
- CCNC has care managers (nurses and social workers) who can assist enrollees with understanding a physician’s instructions, making appointments, explaining how to take medications and teaching the recipient how to manage chronic care needs.
- The PCP will make referrals to specialists as needed.

Who Qualifies For CCNC?
The Medicaid program aid category determines if a beneficiary is mandatory, optional or ineligible for CCNC/CA enrollment.

Beneficiaries have freedom of choice when selecting his/her preferred primary care provider. If a beneficiary is enrolled with another provider but wants to join a CCNC/CA practice, they must fill out a CCNC/CA Enrollment Form for Medicaid Recipients.

CCNC works to provide cooperative, coordinated care through the Patient-centered Medical Home model. This approach matches each patient with a primary care physician who leads a health care team that addresses the patient’s health needs.

CCNC Health Homes: These doctors’ offices provide medical care and have a place you can call anytime (24 hours a day/7 days a week) for medical advice. These offices also have access to care managers. If needed care managers can offer extra help with your health problems or medicines.

Access to CCNC can occur through:
The Departments of Social Services (DSS) in the county where the individual resides- http://www.ncdhhs.gov/dss/local/. Local DSS offices have a complete list of participating primary care physicians.

For More Information About CCNC/CA go to:
Division of Medical Assistance CCNC/CA website: https://dma.ncdhhs.gov/providers/programs-and-services/community-care-north-carolinacarolina-access-ccncca

CCNC Website: https://www.communitycarenc.org/

Contact a CCNC Regional Managed Care Consultant : https://dma.ncdhhs.gov/regional-managed-care-consultant

Call the N.C. Division of Medical Assistance: 919-855-4100