

Community Alternatives Program for Disabled Adults (CAP/DA) Program Summary

The Community Alternatives Program for Disabled Adults (CAP/DA) is a Medicaid Home and Community Based Services Waiver Program. CAP/DA supplements rather than replaces the formal and informal services and supports already available to an individual. North Carolina Medicaid beneficiaries 18 years of age and older who are disabled and who are at risk of institutionalization are eligible to participate in CAP/DA. The CAP/DA beneficiary must reside in a private residence but require nursing facility level of care. The beneficiary must choose CAP/DA services instead of institutional care and should be able to have his or her health, safety, and well-being maintained at home within the Medicaid cost limit. They must require services directly related to a documented medical diagnosis and identified medical care need in order to avoid institutional care in a nursing facility. A beneficiary being considered for CAP/DA services shall meet the North Carolina Medicaid's nursing facility level of care criteria. Medicaid's Fiscal Agent shall give prior approval for nursing facility level of care. A prior approved authorization and referral indicating nursing level of care is the first basic component of determining whether a beneficiary is appropriate for CAP/DA services.

The lead agency social worker and a registered nurse shall complete an assessment that is comprehensive and culturally appropriate to determine the beneficiary's needs, strengths, resources, preferences, and goals. The assessment will identify areas that pose a significant risk to health, safety, and well-being for each CAP/DA beneficiary. It addresses all basic aspects of the beneficiary's life, including medical, physical or functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational or educational, and other areas. The assessment involves consultation with other natural and paid supports such as family members, medical and behavioral health providers, to form a complete assessment. The social worker and RN shall identify diagnosis and symptoms. The beneficiary shall be reassessed annually to determine if a beneficiary's needs or preferences have changed.

The information collected through the needs assessment is documented in a Plan of Care. The Plan of Care specifies the goals and actions to address the medical diagnosis and identified medical and functional care needs of an approved CAP/DA participant. The Plan of Care is developed annually and periodically whenever the beneficiary's needs or preferences have changed.

The CAP/DA Lead Agency provides case management to the CAP/DA beneficiary. The CAP/DA case manager is responsible for assessing, care planning, referral or linkage and monitoring and follow-up. Case management services are necessary to identify needed medical, social, environmental, financial, and emotional needs. These services are provided to maintain the beneficiary's health, safety, and well-being in the community.

The services that CAP/DA can provide are case management and care advisement, in-home aide and personal assistant services, adult day health, home modifications and mobility aids, meal preparation and delivery, institutional and non-institutional respite care,

personal emergency response services, waiver supplies, participant goods and services, transition services, training and educational services, assistive technology, and financial management services.