NAME: ______________________________________ SAR ID: ____________________
REVIEW START DATE: ______________________________________

1915 (b) (3) Services

Community Guide: Periodic – T2041-U1 U4; Monthly – T2041 U4

Met	Not Met	N/A	Required Elements to Approve Service
☐	☐	☐	Recipient is currently enrolled in Medicaid.
☐	☐	☐	Recipient is a child age 3-21 or an adult who is functionally eligible but not enrolled in the NC-Innovations 1915(c) waiver program.
☐	☐	☐	Requesting provider meets all NC Innovations waiver provider requirements and is an enrolled 1915(c) waiver provider.
☐	☐	☐	The service is requested to provide support and assistance to participants and planning teams in developing social networks and connections within local communities.
☐	☐	☐	The service is requested to provide support and assistance to participants throughout the service delivery process.
☐	☐	☐	The requested service does not replace existing natural and community resources.
☐	☐	☐	The service is requested to promote self-determination, increase independence and enhance the participant's ability to interact with and contribute to his/her local community.
☐	☐	☐	The service is used to emphasize, promote and coordinate of the use of natural and generic (unpaid) support to address the participant's needs in addition to paid services.
☐	☐	☐	The service will be intermittent and fade as community connections develop and skills increase in participant's direction.
☐	☐	☐	The requested service does not duplicate care coordination. Care coordination under managed care includes assisting the beneficiary in the development of the ISP, completing or gathering evaluations inclusive of the re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the beneficiary consistent with 42 CFR 438.208(c).
☐	☐	☐	Specific functions outlined in request include: o Assistance in forming and sustaining a full range of relationships with natural and community supports that allows the participant meaningful community integration and inclusion; o Support to develop social networks with community organizations to increase the participant's opportunity to expand valued social relationships and build connections within the participant's local community; o Assistance in locating and accessing non-Medicaid community supports and resources that are related to achieving ISP outcomes: this includes social and educational resources, as well as natural supports; o Instruction and counseling which guides the participant in problem solving and decision making; o Advocacy and collaborating with other individuals and organizations on behalf of the participant; o Supporting the person in preparing, participating in and implementing plans of any type (IEP, ISP, or service plan) o Informing and coordinating community resources including coordination among primary,

			preventative and chronic care providers; ○ Assistance in locating options for renting or purchasing a personal residence, assisting with purchasing furnishings for the personal residence.
☐	☐	☐	The units requested for this service does not exceed the Partners BHM Benefit Plan and is within the current treatment plan.

ALL CRITERIA MET: ☐ **YES** __________________ REVIEWER INITIALS / DATE ☐ **NO** Send to Licensed Reviewer

Clinical Review:

☐ **APPROVED** ☐ **SEND TO PEER REVIEW (sign & date)** ____

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