BENEFICIARY RESPONSIBILITIES NORTH CAROLINA INNOVATIONS WAIVER

Beneficiary:_____ Record Number: _____

I understand that enrollment in the North Carolina (NC) Innovations waiver is voluntary. I also understand that if enrolled I will be receiving Waiver services instead of services in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). My Medicaid eligibility must continue in North Carolina for me to continue to be eligible for the NC Innovations waiver and I must continue to meet all other waiver eligibility criteria.

- I understand that by accepting NC Innovations waiver funding that I am in need of waiver services to prevent an immediate need for ICF-IID facility services.
- I understand that to maintain my eligibility for this waiver I require the provision of at least one waiver service monthly and that failure to use a waiver service monthly will jeopardize my continued eligibility for the NC Innovations waiver. The services approved in my Individual Support Plan have been determined necessary to improve/support my disability.
- I understand that beneficiaries in the NC Innovations waiver live in private homes or in residential facilities which meet waiver requirements and services must also meet the home and community characteristics defined in the waiver
- I understand if I choose to move to a facility during my participation in the waiver that is larger than 6 beds or does not meet the home and community characteristics defined in the waiver, I will no longer be eligible for the waiver.
- I understand that the total of my waiver services cannot exceed $184,000 when I enter the waiver (unless I am utilizing Supported Living Level 3).
- I understand that at any time during my plan year, the total of my waiver services cannot exceed $184,000 or I will no longer be eligible for the waiver. The only exception is that individuals utilizing Supported Living Level 3 may request medically necessary services that exceed the typical $184,000 Waiver limit.

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- I understand if I select the NC Innovations waiver, I will have an Individual Support Plan (ISP) developed that reflects services to meet my needs. My Care Coordinator will explain the planning process and the establishment of my Individual Budget Guideline to me. My ISP will be re-developed annually prior to my birth month. I understand the NC Innovations waiver will deliver services according to my ISP.

- I understand that I may be required to pay a monthly Medicaid deductible if that is part of my financial eligibility for waiver services. My Care Coordinator can assist me in obtaining information on Medicaid deductibles from my local Department of Social Services.

- I understand that I will cooperate in the assessment process to include but not be limited to Supports Intensity Scale (SIS®) no less frequently than every 2 years; NC Innovations Risk/Support Needs Assessment; and Level of Care. I understand that the SIS assessment is a requirement and failure to comply may result in termination of Innovations Waiver services.

- I understand that my ISP will be monitored and reviewed by my Care Coordinator, and that I can contact my Care Coordinator at any time if I have questions about my ISP, Individual Budget or the services that I receive.

- I understand that I have the right to choose a provider within Trillium Provider Network.

- I understand that I am required to meet with my Care Coordinator for care coordination activities in the home and/or all settings where services are provided. The Care Coordinator will schedule meetings as often as needed in order to ensure appropriate service implementation and beneficiary's needs are met. I may also request meetings.

- I understand that I am required to notify the Care Coordinator of any concerns regarding services provided.

- I understand that I am required to give adequate notice to the Care Coordinator of any change in address, phone number, insurance status, and/or financial situation prior to or immediately following the change.

- I understand that I am required to give adequate notice to the Care Coordinator of any behavior or medication changes as well as any change in health condition.

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- I understand that I am required to attend appointments set by the Department of Social Services (DSS) to determine Medicaid renewals to ensure my continued Medicaid eligibility.
- I understand that I will be provided a copy of educational information about the NC Innovations waiver to assist with my understanding the services available through the NC Innovations waiver and guidelines that needs to be followed to ensure continued eligibility.
- I understand that Trillium is responsible for ensuring an adequate network of provider agencies is available to promote choice for the beneficiary.
- I understand that Trillium will make a Care Coordinator available to provide care coordination supports which include:

1. Assessment to determine service needs to include but not be limited to the, NC Innovations Risk/Support Needs Assessment.
2. Working with the Individual Support Planning Team to coordinate and document the Individual Support Plan (ISP).
3. Requesting services that are requested by the beneficiary.
4. Making the beneficiaries aware of the amount of their Individual Budget and the process used to establish this budget and make any needed changes as well as the right to request services in excess of his/her budget.
5. Monitoring all authorized services to ensure that they are provided as described in the ISP and that meet the beneficiary's needs.
6. Assisting the beneficiary with the coordination of benefits through Medicaid and other sources to include, if needed, linkage with the local Department of Social Services regarding coordination of Medicaid deductibles.
7. Responding to any complaints or concerns and reach resolution within 30 days of the complaint regarding NC Innovations services.
8. Promoting the empowerment of the beneficiary to lead as much of his/ her Individual Support Planning, decision making regarding the use of waiver dollars and oversight of waiver services as they choose.

9. Obtaining an order from the beneficiary's physician for all needed medical supplies and specialized equipment.

10. Supporting the beneficiary in obtaining all needed information to make an informed choice of provider within the Trillium network, inclusive of notifying the Trillium Network Management Department if providers are needed outside of the current Trillium Network.

Name of Beneficiary	Date
Signature of Beneficiary (or Authorized Representative)	Date