Verification of Relative/Legal Guardian as Direct Support Employee

RAP for Adults (18 and over)

Effective March 1, 2024, and forward, RAPs for adults can provide up to 84 hours, pending approval from LME/MCO.

Per DHHS policy, relatives of adults are allowed to provide more than 56 hours and not exceeding 84 hours.

Relatives providing more than 56 hours must submit a RAP application for review by the LME/MCO. Should you have a relative who is living in the home and providing more than 56 hours, please submit the application provided below to Alliance Health. Hours up to 56 should be noted in the ISP and do not require approval from the MCO. The relative who provides this service must meet the same standards as providers who are unrelated to the individual.

For those requests over 56 hours, please remember a RAP application request form must be submitted to the LME/MCO. The RAP application must have a clear, employment-based justification as to why there are no other direct care staff who can provide the service. Additionally, this justification must be clearly noted in the ISP.

RAP for a Children (under the age of 18)

Effective March 1, 2024, and forward, RAP for a child can provide up to 40 hours without LME/MCO approval. Hours up to 40 should be noted in the ISP. The relative who provides this service must meet the same standards as providers who are unrelated to the individual.

RAPs for children, providing more than 40 hours not to exceed 56, must submit a RAP application for review by the LME/MCO.

For requests over 40 hours for children, there needs to be documentation of the member's extraordinary needs* and a clear employment-based justification as to why there are no other direct care staff who can provide the service and clearly noted in the ISP.

*Extraordinary needs means exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization.

Employers of record and managing employers participating in the individual family directed option (IFDS) may not be employed to provide waiver services. Therefore, another relative living in the home can provide CLS only.

Please choose one *

- ○ This is a new employee (including employees changing provider agencies)
- ○ This is an annual certification

Relative/ legal guardian information

1

Does the relative or legal guardian live in the same home as the member?* (Adults 18+ years of age may live outside the relative's or legal guardian's home.) ◉ Yes ○ No

Is the relative or legal guardian the beneficiary's parent or adoptive parent or relative by blood or marriage?* ○ Yes ○ No

NOTE: If the answer to either of these questions is no, this request is not eligible for review.

General contact information

2

Date of submission (mm/dd/yyyy)* _____

Network provider agency name or employer of record* _____

Contact name:* _____

Contact title:* _____

Physical address

Address line 1* _____ (Street, P.O. Box, etc.) Address line 2 _____ (Suite, Building, etc.)

City* _____ State* _____ ZIP Code* _____

Email* _____ Phone* _____

Beneficiary information

3

Beneficiary's name* _____

Beneficiary's DOB (mm/dd/yyyy)* _____

Please include a full list of the beneficiary's diagnoses:*

County from which beneficiary's Medicaid originates:*

○ Cumberland ○ Durham ○ Harnett ○ Johnston

○ Mecklenburg ○ Orange ○ Wake

Beneficiary information

Continued

3

Care manager's name* _____

Care manager's email* _____

Is the member living in their natural home?* ○ Yes ○ No

Employee / prospective employee information

4

Employee / prospective employee's name* _____

Relationship to beneficiary:*

○ Mother ○ Father ○ Other (describe) _____

Legal guardian?* ○ Yes ○ No

Is the guardian legally able to provide the service as defined in HB 543?* ○ Yes ○ No

Service type and hours*

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How many total hours of community living and support are requested per week?* _____

Will the relative or legal guardian be providing*

○ Primary or ○ Backup service?

Who will provide required backup staffing?* _____

Reason for application*

Please complete each of the associated long-form questions.

If additional documentation is needed, please submit it along with your application.

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As the provider agency, I am attesting that no other qualified provider (who is not a relative or legal guardian) is available to provide the **authorized** service. **Provide a detailed employment-based justification**.

Does the individual live in a remote area unserved or underserved by other providers? ○ Yes ○ No

Does the individual have documented complex medical or behavioral needs, which do not require skilled nursing services, and are best met by the family member? ○ Yes ○ No

Reason for application*

Continued

6

Does the individual who requires services have hard-to-staff hours? ○ Yes ○ No

Have numerous providers been unsuccessful at appropriately supporting this individual? ○ Yes ○ No

Have numerous providers assessed the situation and responded in writing that they cannot provide services? ○ Yes ○ No

Explain how you plan to assure provider choice for the member:

Explain how you plan to protect the member from isolation from the community. For example: What is the plan to introduce additional staff to provide some of the services that are needed by the member?

Beneficiary's current authorized services*

Please list all services that appear in the beneficiary's service plan.

If additional documentation is needed, please submit it along with your application.

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Service Name	Service Code	Service Amount Authorized Weekly

Annual certification

A qualified provider who is not a relative or legal guardian is not available to provide the service.

8

Month and year that the relative/legal guardian was hired by your agency (mm/dd/yyyy) _____

Did the relative/legal guardian work for another provider agency prior to employment with your agency? ○ Yes ○ No

If yes, which agency? _____

Does your agency employ other staff to provide services to this member? ○ Yes ○ No

If yes, what other services? _____

Attestations of compliance and understanding*

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The NC Innovations Waiver requires that justification be provided as to why there is no other qualified provider to provide community living and support, assurances of provider choice, and that the individual will not be isolated from their community.

- ☐ The prospective employee understands that the provider agency/employer of record will monitor the service that a relative or legal guardian provides each month on-site, at a minimum of one time per month.
- ☐ The prospective employee understands that a care manager will monitor the relative/legal guardian's provision of service on-site, at a minimum of one time per month.
- ☐ The prospective employee will provide community living and support. Payments are only made for service in the individual support plan authorized by the Utilization Management Department.
- ☐ The relative or legal guardian must meet the provider qualifications for the service. If applicable, the provider certifies that there is documented training for the specific medical task(s) by a professional appropriately qualified in the task or equipment and that the employee receives nursing supervision to carry out this function as specified by the NC Nursing Practice Act. Provider will train all staff, including parents/guardians, who are providing medical tasks.

Signatures certify that all information on the form is true and accurate.

Provider agency qualified professional, employers of record, managing employers signature

x	*Type name or print and sign*

Date (mm/dd/yyyy)

MCO approval*

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☐ Approval ☐ Denial ☐ Reduction

Alliance staff _____

Title _____ Date (mm/dd/yyyy) _____

Comments:

Submission instructions

PAPER: Please save and/or scan the completed form and email it to relativeasprovider@AllianceHealthPlan.org. Incomplete forms will be returned.