North Carolina
Community Alternatives Program (CAP)
Case Worker Monthly Deductible Attestation

I, _____, (Case Worker Name) have verified that client _____, has met part or all their monthly deductible for the Community Alternatives Program (CAP) with Medicaid approved expenses. I am aware of my responsibility to accurately inform Acumen Fiscal Agent and understand my client's employer could be held financially responsible if the information reported is inaccurate.

I understand the client's monthly deductible has been determined by NC Medicaid and must be met for Acumen Fiscal Agent of North Carolina pay employee(s) for services rendered under the Community Alternatives Program.

I understand following:

- I understand payroll will be suspended for non-payment of the full monthly deductible and the employee(s) of the above client will not be paid until the pay cycle after the entire deductible has been met. If work was performed for the client, and the full monthly deductible is not met in a timely manner the employer will be held responsible for paying employee(s) for the month(s) the client is suspended regardless of the remaining monthly deductible amount.

_____ _____
Deductible Month Deductible Year

_____
Clients Monthly Deductible ($)

_____
Monthly Deductible Amount Met ($)

I understand the above statements and conditions:

_____ _____
Case Worker Signature Date

Return form to:

- Mailing Address: 5416 E Baseline Road, Ste. 200, Mesa, AZ 85206
- Fax: 866-463-7589
- Email: Caseworker@Outreachfiscalagent.com