SUBCHAPTER 23C – APPLICATION FOR MEDICAID BENEFITS

SECTION .0100 - APPLICATION PROCESS

10A NCAC 23C .0101 ACCEPTANCE OF APPLICATION

(a) A client shall be allowed to apply without delay. Without delay is the same day the client appears at the county department of social services expressing a financial or medical need.

(b) The county department of social services shall not act to discourage any individual from applying for Medicaid. It shall be considered discouragement if any employee of the county department of social services:

(1) requires or suggests the individual wait to apply until he applies for other benefits or until an application for other benefits has been approved or denied; or

(2) incorrectly states or suggests the individual is ineligible for Medicaid; or

(3) gives incorrect or incomplete information about Medicaid programs; or

(4) requires the individual provide or obtain any information needed to establish eligibility prior to signing an application; or

(5) discourages a client from applying and this is proven by facts to the satisfaction of the county agency or a hearing officer; or

(6) suggests that the individual make an appointment to apply when he appears at the agency; or

(7) suggests that the individual complete a mail-in application when he appears at the agency; or

(8) fails to explain the date of application when he appears at the agency and requests a mail-in application; or

(9) fails to explain and offer Medicaid to individuals requesting Work First Employment Services.

(c) The client shall be informed verbally and in writing, that:

(1) he can apply without delay;

(2) a decision shall be made concerning his eligibility within 45 calendar days from the date of application for Medicaid, except for M-AD. For M-AD the application processing standard shall be 90 calendar days from the date of application; and

(3) he shall receive a written decision concerning his eligibility.

(d) The client shall apply in his county of residence.

(e) The date of the application shall be:

(1) The date the client or his representative signs the state application form for Medicaid, including Work First, under penalty of perjury at the county department of social services; or

(2) The date a signed complete state mail-in application form is received by the county department of social services in the county of residence. Complete is defined as information that is legible, signed, submitted to correct county of residence, and has identifying information for the person applying, including name, mailing address, date of birth and gender.

(f) If an individual requests assistance by mail, the letter shall be considered a request for information. Within three workdays following receipt of the request, the county agency shall mail follow-up information to the individual. The county agency shall advise the individual to come to the agency to apply and be interviewed, or if he is unable to come in person, to contact the agency so other arrangements can be made to take his application.

(g) If an individual requests assistance by telephone, he shall be advised to come to the county agency to sign an application and be interviewed; or, if he is unable to come to the agency in person other arrangements shall be made to take his application.

(h) If an individual sends in a complete state mail-in application form, the county department of social services shall use this application to determine eligibility for Medicaid. A mail-in application form may be picked up at a local county department of social services or other locations as determined by the State and county.

(i) An individual or his representative must request a determination for retroactive SSI Medicaid no later than 60 days from the date of the SSI Medicaid disposition notice or 90 days if good cause is established. Good cause exists when:

(1) the applicant does not receive the SSI Medicaid notice;

(2) the applicant or his representative dies;

(3) the applicant is incapacitated, incompetent, or unconscious and there is no representative acting on his behalf;

(4) the applicant or spouse, child, parent, or representative of applicant is hospitalized for an extended period of time; or

(5) the applicant's representative fails to meet the required time frame.

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.906; 42 C.F.R. 435.907; 42 C.F.R. 435.911; Alexander v. Flaherty, U.S.D.C., W.D.N.C., File No. C-C-74-183, Consent Order filed 15 December 1989; Alexander v. Flaherty Consent Order filed February 14, 1992; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. January 1, 1995; April 1, 1993; August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0201 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0102 FACE-TO-FACE INTERVIEW

(a) The county department of social services shall conduct a face-to-face interview with the client or his representative who appears at the agency requesting financial or medical assistance. The client may have any person or persons of his choice participate in the interview. During the interview, the Income Maintenance Caseworker shall explain the application process, the client's rights and responsibilities, the programs of public assistance and the eligibility conditions.

(b) The applicant shall be advised of his right to apply in more than one program category for which he qualifies and the advantages and disadvantages of the choices shall be explained.

(c) The client shall be informed of the following:

(1) The client shall be told what information that he is required to provide, and what third party sources the agency shall contact to check the information. Third party sources are entities, other than the client, that can provide verification of information to determine eligibility.

(2) The client has the right to:

(A) Receive assistance if found eligible;

(B) Be protected against discrimination on the grounds of race, creed, or national origin by Title VI of the Civil Rights Act of 1964. He may appeal such discrimination;

(C) Have any information given to the agency kept in confidence;

(D) Appeal, if he believes the agency's action to deny, change, or terminate assistance is incorrect, or his request is not acted on with reasonable promptness;

(E) Reapply at any time, if found ineligible;

(F) Withdraw from the program at any time;

(G) Request the agency's help in obtaining third party information that he is responsible to provide;

(H) Be informed of all information he must provide and all alternative sources for obtaining the information.

(3) The client shall:

(A) Provide the county department, state and federal officials, the necessary sources from which to locate and obtain information needed to determine eligibility;

(B) Report to the county department of social services any change in situation that may affect eligibility within 10 calendar days after it happens. The Income Maintenance Caseworker shall explain the meaning of fraud and shall inform the applicant that he may be suspected of fraud if he fails to report a change in situation and that in such situations, he may have to repay assistance received in error and that he may also be tried by the courts for fraud;

(C) Inform the county department of social services of any persons or organization against whom he has a right to recover medical expenses. When he accepts medical assistance, the applicant shall assign his rights to third party insurance benefits to the state. The Income Maintenance Caseworker shall inform the applicant that it is a misdemeanor to fail to disclose the identity of any person or organization against whom he has a right to recover medical expenses;

(D) Immediately report to the county department the receipt of an I.D. card that he knows to be erroneous. If he does not report such and uses the I.D. card, he shall repay any medical expenses paid in error.

History Note: *Authority G.S. 108A-25(b); 108A-57; 42 C.F.R. 435.908; Alexander v. Flaherty, U.S.D.C., W.D.N.C., File No. C-C-74-183, Consent Order Filed 15 December 1989; Alexander v. Flaherty Consent Order filed February 14, 1992; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002; Eff. September 1, 1984;*
Amended Eff. April 1, 1993; August 1, 1990; March 1, 1986;
Temporary Amendment Eff. August 22, 1996;
Amended Eff. August 1, 1998;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0202 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0103 RECOMMENDATION FOR DISPOSITION

(a) When all information necessary to determine eligibility has been obtained, the Income Maintenance Caseworker shall recommend whether to approve or to deny assistance. The recommendation shall be based on all reliable, relevant information.

(b) The authority to approve or deny assistance rests with the county board of social services. The county board may, by appropriate resolution recorded in the board minutes, delegate to the county director of social services the authority to process applications, to determine eligibility, or to terminate assistance.

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.913;*
Eff. September 1, 1984;
Amended Eff. August 1, 1990;
Transferred from 10A NCAC 21B .0205 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0104 DISPOSITION

(a) Disposition of the application shall complete the application process and shall consist of one of the following actions:

(1) Approval of assistance;

(2) Denial of assistance;

(3) Denial of assistance for ineligible month or months of the certification period and approval for eligible month or months of the certification period; or

(4) Voluntary withdrawal of the application by the client. The Income Maintenance Caseworker shall not suggest to the client that he withdraw his application and shall explain alternatives to withdrawal. The Income Maintenance Caseworker shall explain the client's right to reapply at anytime.

(b) The county department of social services shall not deny an application prior to 45 days, or for M-AD, 90 days, except when:

(1) It is established the applicant will not be able to meet the deductible;

(2) The applicant cannot be located; or

(3) The applicant refuses to cooperate or provide information to establish eligibility;

History Note: *Authority G.S. 108A-54; 42 C.F.R. 435.912; 42 C.F.R. 435.913; Alexander v. Flaherty, U.S.D.C., W.D.N.C., File No. C-C-74-183, Consent Order filed 15 December 1989; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. April 1, 1993; August 1, 1990;
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Amended Eff. August 1, 2004;
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Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0105 REFERRALS AT A FACE-TO-FACE INTERVIEW

For all Medicaid applicants who have a face-to-face interview at the county department of social services, the Income Maintenance Caseworker shall explain and make referrals for:

(1) Health Check;

(2) Family planning services;
(3) Food stamps;
(4) Governmental benefits including RSDI, SSI, VA;
(5) Women, Infants and Children Program (WIC);
(6) Carolina ACCESS;
(7) Medicaid Transportation;
(8) Life Line/Link-up;
(9) Health Insurance Premium Payment program; and
(10) Voter Registration.

History Note: *Authority G.S. 108A-54; 42 C.F.R. 441.56; 42 U.S.C. 1396a(a); Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. January 1, 1995; August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0207 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0106 MANDATORY USE OF OUTREACH LOCATIONS

The county department of social services shall provide for the acceptance of applications and initial interviews for M-PW and M-IC coverage groups at certain outreach locations as follows:

(1) disproportionate share acute care hospitals which serve the coverage groups listed; and
(2) Medicaid enrolled federally qualified health centers.

History Note: *Authority G.S. 108A-43; 108A-54; P.L. 101-508;*
Temporary Adoption Eff. July 1, 1991, for a period of 180 days to expire
Eff. January 1, 1992;
Transferred from 10A NCAC 21B .0208 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

10A NCAC 23C .0107 HOURS FOR ACCEPTING FINANCIAL AND MEDICAL ASSISTANCE APPLICATIONS

The county department of social services must maintain the same number of operating hours as in February of 2002. Provisions must be made for acceptance of financial and medical assistance applications if the agency elects to close for lunch or for other reasons during the week.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Temporary Adoption Eff. March 1, 2003;
Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0209 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016.

SECTION .0200 – APPLICATION PROCESSING, MONITORING AND CORRECTIVE ACTION

10A NCAC 23C .0201 APPLICATION PROCESSING STANDARDS

(a) The county department of social services shall comply with the following standards in processing applications:

(1) A decision shall be made within the timeframes set out in G.S. 108A-70.37;
(2) Only require information or verification to establish eligibility for assistance;
(3) Make a minimum of two requests for all information from the applicant or third party;
(4) Allow a minimum of 12 calendar days between the initial request and a follow-up request and at least 12 calendar days between the follow-up request and denial of the application;
(5) Inform the client in writing of the right to request help in obtaining information requested from the client. The county department of social services shall not discourage any client from requesting such help;

(6) An application may pend up to six months for verification that the deductible, as defined in 10A NCAC 23A .0102 has been met or disability established; and

(7) When a hearing decision reverses the decision of the county department of social services on an application, pursuant to 10A NCAC 21A .0303, the application shall be reopened within five business days from the date the final appeal decision is received by the county department of social services. If the county department of social services has all of the information needed to process the application, the application shall be processed within five additional business days. If additional information is needed pursuant to the final decision, the county shall make such requests in accordance with this Rule. The first request for the additional information shall be made within five business days of receipt of the final appeal decision. The application shall be processed within five business of receipt of the last piece of required information.

(b) The county department of social services shall obtain verification, as defined by 10A NCAC 23A .0102, other than the applicant's statement for the following:

(1) Any element requiring medical verification. This includes verification of disability, incapacity, emergency dates for aliens referenced in the Medicaid State Plan, incompetence, and approval of institutional care;

(2) Proof a deductible has been met;

(3) Legal alien status;

(4) Proof of the rebuttal value for resources and of the rebuttal of intent to transfer resources to become eligible for Medicaid. When a client disagrees with the determination of the county department of social services on the value of an asset, then the client must provide proof of what the value of the asset is;

(5) Proof of designation of liquid assets for burial;

(6) Proof of legally binding agreement limiting resource availability;

(7) Proof of valid social security number or application for a social security number;

(8) Proof of reserve reduction when resources exceed the allowable reserve limit for Medicaid;

(9) Proof of earned and unearned income, including deductions, exclusions, and operational expenses when the applicant or caseworker has or can obtain the verification; and

(10) Any other information for which the applicant does not know or cannot give an estimate.

(c) The county department of social services shall be responsible for verifying or obtaining an item of information when:

(1) A fee must be paid to obtain the verification;

(2) It is available within the agency;

(3) The county department of social services is required by federal law to assist or to use interagency or intra-agency verification aids;

(4) The applicant requests assistance; or

(5) A representative has not agreed to obtain the information and the applicant is:

(A) physically or mentally incapable of obtaining the information;

(B) unable to speak English or read and write in English; or

(C) housebound, hospitalized, or institutionalized.

History Note: *Authority G.S. 108A-54; 108A-54.1B; 42 C.F.R. 435.911; 42 C.F.R 435.912; 42 C.F.R 435.952; Alexander v. Flaherty, V.S.D.C., W.D.N.C., File No. C-C-74-183, Consent Order Filed 15 December 1989; Alexander v. Flaherty Consent Order filed February 14, 1992; Alexander v. Bruton Consent Order dismissed Effective February 1, 2002;*
Eff. September 1, 1984;
Amended Eff. April 1, 1993; August 1, 1990;
Temporary Amendment Eff. March 1, 2003;
Amended Eff. August 1, 2004;
Transferred from 10A NCAC 21B .0203 Eff. May 1, 2012;
Readopted Eff. June 1, 2019.

10A NCAC 23C .0202 MONITORING THRESHOLDS AND CORRECTIVE ACTION

(a) Division of Health Benefits employees, known as application monitors, shall review a random sample of applications in all county departments of social services and the Disability Determination Section (DDS) of the Division of Vocational Rehabilitation to determine if counties are denying and withdrawing applications in accordance with federal/state rules.

The application monitors shall also review inquiries where a person comes to the agency and decides not to make an application to ensure person was given correct information under federal/state rules. A county and DDS must meet a monitoring threshold of 80 percent in each area of denials, withdrawals and inquiries in order to be found in compliance with federal/state rules.

(b) If the agency falls below the 80 percent threshold, the agency must analyze why it fell below 80 percent and implement a corrective action plan.

(c) The agency or DDS may dispute monitoring findings within 10 workdays of receipt of findings.

(d) Within 30 calendar days of the final monitoring results, the agency must take corrective action to reopen cases the application monitors determine were not handled pursuant to federal/state rules.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton, U.S.D.C., File No. C-C-74-183-M, Consent Order dismissed effective February 1, 2002;*
Temporary Adoption Eff. March 1, 2003;
Eff. August 1, 2004;
Transferred from 10A NCAC 21A .0605 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;
Amended Eff. March 1, 2020.

10A NCAC 23C .0203 TIMELINESS

(a) Every month, each county department of social services and the Disability Determination Section (DDS) of the Division of Vocational Rehabilitation shall process applications as follows:

(1) The average processing time (APT) for the county department of social services shall be 90 days for M-AD and 45 days for all other aid program categories.

(2) APT for DDS shall be 70 days.

(3) The percentage processed timely (PPT) standard for county departments of social services: Level I counties must process 85 percent of applications within the 45/90 day time standard. Level II and III counties must process 90 percent of applications within the 45/90 day time standard. Counties are classified as Levels I through III based on population of the county with Level I counties as the smallest in population while Level III counties are the largest in population size.

(4) PPT standard for DDS: DDS must render a decision within 70 days on 85 percent of cases for Level I counties and 90 percent of cases for Level II and III counties. For county levels refer to the table below.

COUNTY LEVELS			
ALAMANCE (II)	CUMBERLAND (III)	JOHNSTON (II)	RANDOLPH (II)
ALEXANDER (I)	CURRITUCK (I)	JONES (I)	RICHMOND (I)
ALLEGHANY (I)	DARE (I)	LEE (I)	ROBESON (II)
ANSON (I)	DAVIDSON (II)	LENOIR (II)	ROCKINGHAM (II)
ASHE (I)	DAVIE (I)	LINCOLN (I)	ROWAN (II)
AVERY (I)	DUPLIN (II)	MACON (I)	RUTHERFORD (II)
BEAUFORT (II)	DURHAM (III)	MADISON (I)	SAMPSON (II)
BERTIE (I)	EDGECOMBE (II)	MARTIN (I)	SCOTLAND (II)
BLADEN (I)	FORSYTH (III)	MCDOWELL (I)	STANLY (I)

BRUNSWICK (II)	FRANKLIN (I)	MECKLENBURG (III)	STOKES (I)
BUNCOMBE (III)	GASTON (III)	MITCHELL (I)	SURRY (II)
BURKE (II)	GATES (I)	MONTGOMERY (I)	SWAIN (I)
CABARRUS (II)	GRAHAM (I)	MOORE (II)	TRANSYLVANIA (I)
CALDWELL (II)	GRANVILLE (I)	NASH (II)	TYRRELL (I)
CAMDEN (I)	GREENE (I)	NEW HANOVER (III)	UNION (II)
CARTERET (II)	GUILFORD (III)	NORTHAMPTON (I)	VANCE (II)
CASWELL (I)	HALIFAX (II)	ONSLOW (II)	WAKE (III)
CATAWBA (III)	HARNETT(II)	ORANGE (II)	WARREN (I)
CHATHAM (I)	HAYWOOD (II)	PAMLICO (I)	WASHINGTON (I)
CHEROKEE (I)	HENDERSON (II)	PASQUOTANK (I)	WATAUGA (I)
CHOWAN (I)	HERTFORD (I)	PENDER (I)	WAYNE (II)
CLAY (I)	HOKE (I)	PERQUIMANS (I)	WILKES (II)
CLEVELAND (II)	HYDE (I)	PERSON (I)	WILSON (II)
COLUMBUS (II)	IREDELL (II)	PITT (II)	YADKIN (I)
CRAVEN (II)	JACKSON (I)	POLK (I)	YANCEY (I)

(b) If a county department of social services fails to meet the standards in Paragraph (a) of this Rule, the county shall analyze the reason for failure, document findings and work with the Medicaid Program Representative (MPR) to achieve corrective action. The MPR is a Division of Health Benefits employee.

(c) Failure to meet the time standards in Paragraph (a) of this Rule, monthly shall result in corrective action to alleviate problems as outlined in Rules .0204 and .0205 of this Section. Once eligibility is determined except for the following requirements:

(1) sufficient medical expenses to meet a deductible; or

(2) the determination of need for institutionalization; or

(3) the plan of care for the home and community-based waivers; or

(4) the disability decision made by the Disability Determination Section; or

(5) medical records needed to determine emergency dates for non-qualified aliens; days shall be excluded from the time standard of 45 or 90 days. Days in the time standard are again included when the items in Subparagraph (c)(1) through (5) are received until the application is completed with a written notice to the applicant. When the 45/90th day falls on a weekend or holiday, the next workday in the month is considered the 45/90th day.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton, U.S.D.C., File No. C-C-74-183-M, Consent Order dismissed effective February 1, 2002;*
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10A NCAC 23C .0204 LOCAL CORRECTIVE ACTION TEAM

(a) The Assistant Director for Recipient and Provider Services (R&PS) in the Division of Health Benefits shall determine that a Local Corrective Action Team is needed when the county department of social services (DSS) is out of compliance with the monitoring or APT or PPT processing thresholds in any category for 3 consecutive months, or, 5 months out of any 12 consecutive months. The Local Corrective Action Team shall include the Medicaid Program Representative and any additional state staff identified by the Assistant Director for R&PS, the county department of social services director and any county staff the county director designates, the county manager or the chair of the county board of commissioners as selected by the county director, a member of the general public as selected by the county director, the social services board chairman or other board member for the county as selected by the county director, and an independent management consultant at the option and expense of the county.

(b) A Local Corrective Action Team shall not convene when:

(1) All failures are attributable to DDS.

(2) It is determined by DHB Assistant Director for Recipient and Provider Services that the reasons for non-compliance have been or are being corrected.

(3) Budgetary constraints decided by DHB Assistant Director for R&PS do not allow travel for the purpose of convening a corrective action team. Conference calls shall be held by the DHB Assistant Director for R&PS when travel is not allowed as determined by State officials due to fiscal constraints.

(c) The Local Corrective Action Team may design any remedy reasonable and necessary to bring the DSS into compliance with application processing requirements as in 10A NCAC 21B .0204 and this Subchapter.

(d) The Team shall establish a corrective action plan within 40 calendar days of notice from the Assistant Director of Recipient and Provider Services to the county director of social services that a local corrective action team was required, and a date for compliance with the plan shall be set. The corrective action plan must be submitted to the Assistant Director for R&PS. The county must meet the thresholds in 10A NCAC 23C .0203(a) within three months after the date the compliance plan was required to be established.

(e) Failure of a county to take corrective action, or meet compliance thresholds shall result in a referral by the Division of Health Benefits a State Corrective Action Team, unless the State Corrective Action Team grants an extension, not to exceed three months, for the county to meet the thresholds. In determining if an extension shall be granted, the State Corrective Action Team shall receive a recommendation from the Division of Health Benefits to grant an extension based on the Division's assessment that the county is taking action to comply with the corrective action plan. The State Corrective Action Team shall be formed by the Secretary for the Department of Health and Human Services based on a request from the Division of Health Benefits. The State Corrective Action Team shall consist of a representative from the Department of Health and Human Services appointed by the Secretary, a representative of the NC Association of County Commissioners, two representatives from county departments of social services, excluding the county in question, appointed by the presidents of the following associations: NC Social Services Association, NC Association of County Directors of Social Services, and the NC Association of County Boards of Social Services, the chairman of the Board of Legal Services of North Carolina or his designee, a recipient of Medicaid appointed by the Secretary, and a representative of the UNC School of Government.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton, U.S.D.C., File No. C-C-74-183-M, Consent Order dismissed effective February 1, 2002;*
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Eff. August 1, 2004;
Transferred from 10A NCAC 21A .0607 Eff. May 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 23, 2016;
Amended Eff. March 1, 2020.

10A NCAC 23C .0205 STATE CORRECTIVE ACTION TEAM

(a) A State Corrective Action Team shall be convened by the Chairperson within 10 days when:

(1) The county department of social services (DSS) has failed to meet the compliance thresholds by the date established by the local corrective action team.

(2) A local corrective action team requests an extension of time, not to exceed three months, to meet the compliance thresholds.

(3) DDS fails to meet its compliance thresholds for 3 consecutive months or 5 out of 12 consecutive months.

(b) The State Corrective Action Team may design any remedy reasonable and necessary to bring the DSS or DDS into compliance with application processing requirements in 10A NCAC 21B .0204 and this Subchapter. This includes employing additional staff, altering office procedures (such procedures must be consistent with federal and state regulations, laws and Departmental rules), purchasing office equipment, retaining private consultants, reopening of cases, ordering retroactive relief to applicants harmed by violation of application processing requirements, and ordering the State to assist in the operation of a county department.

(c) The State Corrective Action Team shall establish a corrective action plan for the DSS or DDS within 45 calendar days of convening. A date for compliance shall be established. The county or DDS must meet the thresholds in 10A NCAC 23C .0203(a) within three months after the date the team was convened.

(d) Failure to achieve compliance shall result in a request from the Division of Health Benefits to the Local Government Commission to assess and determine the capacity of the county to expend resources to bring the county into compliance.

History Note: *Authority G.S. 108A-54; Alexander v. Bruton, U.S.D.C., File No. C-C-74-183-M, Consent Order dismissed effective February 1, 2002;*
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