



Welcome to the Choices for Care 804 Forms Process Update. This training is designed for Choices for Care case managers, providers and service coordinators

Overview

The goal of this training is to provide an overview of the 804 forms process, including:

- Overview of changes
- Instructions for completing forms
- How to submit forms



This training module is intended to provide you with an overview of the changes to the 804 forms process, including ***which 804 form must be completed, who completes the form, how it must be completed and where it must be submitted.***

This process will take effect on April 1, 2019

Overview
of
Changes

Form #	Name	Replaces	Notes
804	Admission to Services Form	Home-Based, AFC & ERC Change Form and Nursing Facility (or Hospital Swing Bed) Discharge Notice Form	Change in provider responsible for submitting ³
804A	Termination of Services Form	Home-Based, AFC & ERC Change Form and Nursing Facility (or Hospital Swing Bed) Discharge Notice Form	New Form
804B	Nursing Facility/Hospital Swing Bed Acute Hospital Stay and Change of Payment Report Form	No Change	No Change
804C	Short-Term Medicaid Only Rehab Form	Skilled Nursing Facility/Hospital Swing Bed Vermont Medicare/Medicaid & Medicaid Only Rehab Notice	New Form – creates separate form for Medicaid Only
804D	Dual Medicare / Vermont Medicaid Short-Term Rehab Form	Skilled Nursing Facility/Hospital Swing Bed Vermont Medicare/Medicaid & Medicaid Only Rehab Notice	New Form – creates separate form for dual Medicare/Medicaid

This table summarizes the changes to the 804 process.

Please note that the form names have changed, Several new forms have been created, and in some cases the provider responsible for submitting the form has been changed. We will review each of these forms individually

Some Additional changes

Fillable forms on ASD website

Updated Mailing addresses

Form 804: Admission to Services

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When this form is used:

- To report changes in care setting option for CFC applicants who are still pending Medicaid
- To report changes in care setting for ACTIVE CFC Participants

Who completes this form:

- Choices for Care Case manager (AAA & HHA)
- Flexible Choices Advisor (Transition II)
- Authorized Agency (AA) for Adult Family Care
- Enhanced Residential Care (ERC) Provider
- Nursing Home
- Hospital Social Worker



804 FORM: (ADMISSION TO SERVICES)

Previously, it was the responsibility of the provider who was discharging the client to complete this form. In many cases, the form was not completed timely, which prevented the “new” provider from billing for services. The 804 form will now be completed by the provider “admitting” a program participant to their service. This change allows the provider to bill for services upon admission. When this form is submitted, the Long Panel for long term care will be changed in the ACCESS system to reflect the **admitting provider name**. *If your provider name is not in the system as the current provider of service, then **you will not be paid when a claim is submitted**.*

Please note: For *traditional home-based services* the Long Panel must reflect the name of the “Highest Paid Provider”. This is usually the Home Health Agency, Adult Day Provider, ARIS Solutions or the Authorized Agency for Adult Family Care.

Form 804: Admission to Services

CFC 804

Choices For Care
Admission to Services Form

Complete when admitting a CFC applicant pending Medicaid or an active CFC participant.

Individual Name: _____
 Address: _____
 DOB: _____ SSN: _____

A. Previous Setting

<input type="checkbox"/> Home-Based (Traditional)	<input type="checkbox"/> Enhanced Residential Care
<input type="checkbox"/> Flexible Choices	<input type="checkbox"/> Nursing Facility
<input type="checkbox"/> Adult Family Care	<input type="checkbox"/> Hospital Swing Bed

B. Admission *(Check the service option and write in the name of the service provider)*

Date: _____

<input type="checkbox"/> Home-Based (Traditional)	_____ Provider ID # _____
<input type="checkbox"/> ARIS	_____ Provider ID # _____
<input type="checkbox"/> Home Health Agency:	_____ Provider ID # _____
<input type="checkbox"/> Flexible Choices, Transition II	_____ Provider ID # _____
<input type="checkbox"/> Adult Family Care	_____ Provider ID # _____
<input type="checkbox"/> Authorized Agency:	_____ Provider ID # _____
<input type="checkbox"/> Enhanced Residential Care:	_____ Provider ID # _____
<input type="checkbox"/> Nursing Facility:	_____ Provider ID # _____
<input type="checkbox"/> Hospital Swing Bed:	_____ Provider ID # _____

C. Case Management Agency *(For Home Based or Flexible Choices only)*

<input type="checkbox"/> Area Agency on Aging:	_____
<input type="checkbox"/> Home Health Agency:	_____

Completed by: _____ Email: _____
 Phone: _____
 Agency: _____ Provider ID#: _____

▼

Sent to: ☐ ADPC: 280 State Drive Waterbury, VT 05671-1500; Fax: (802) 241-0514
☐ DAIL: Local LTCCC (SAMS or Email / Fax) CALL 802-241-0294 For Contact List

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How to complete the 804 form:

1. Complete the Individual's name, Address, SS# or MID, Date of Birth
2. **Previous setting:** Check the box of the individual's previous setting (if there is a change in care setting option)
3. **Admission**
 - a. Fill in the Admission Date
 - b. Check the admission service options and
 - c. fill in the name of the provider of services and Provider ID #
4. **Case Management Agency** (for Home Based and Flexible Choices only)
 - a. Check one of the Case Management boxes
 - b. Fill in the Provider name
5. Fill in the name of the Person filling out the 804 form and contact information

Form 804: Admission to Services

Form#	DAIL	ADPC	DVHA	Where Can I find the Form?
804	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<u>SAMS or:</u> https://asd.vermont.gov/resources/forms
804A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		SAMS or: https://asd.vermont.gov/resources/forms
804B		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	http://www.vtmedicaid.com/assets/forms/CF804B.pdf
804C		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms
804D		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms

DAIL (Disabilities, Aging and Independent Living) LTCCC Nurse: To request a contact list, call DAIL-Adult Services Division (802) 241-0294
SAMS Users: Send SAMS Alert to LTCCC Nurse when form is completed

ADPC (Application and Document Processing Center):
 Fax (802) 241-0514
 280 State Drive Waterbury, VT 05671-1500



The 804 form is submitted to DAIL and to ADPC. For SAMS users: Forms are available as an assessment form. When completed, send an alert to the LTCCC, print and send to ADPC

Form 804A: Termination of Services

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When this form is used:

- To report termination of CFC services for active CFC participants receiving Traditional Home-Based, ERC, Hospital Swing Bed, Nursing Facility Services, Adult Family Care, or Flexible Choices

Who completes this form:

- Choices for Care Case manager (AAA & HHA)
- Flexible Choices Advisor
- Authorized Agency (AA) for Adult Family Care
- Enhanced Residential Care (ERC) Provider
- Nursing Home
- Hospital Social Worker



This form is a new form used to report the **termination** of CFC services for active CFC participants receiving Home-Based, ERC, Adult Family Care, Flexible Choices, Hospital Swing Bed or Nursing Facility services. If an individual terminates services or voluntarily withdraws from CFC services, it is the responsibility of the current provider of services to notify the ADPC and the DAIL LTCCC Nurse.

Form 804A: Termination of Services

CFC 804A

Choices For Care
Termination of Services Form

Completed by provider reporting the termination of CFC services

Individual Name: _____
 Address (only if changed): _____
 DOB: _____ SSN: _____

Current Setting

<input type="checkbox"/> Home-Based (Traditional)	<input type="checkbox"/> Enhanced Residential Care
<input type="checkbox"/> Flexible Choices	<input type="checkbox"/> Adult Family Care
<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Hospital Swing Bed

Date: _____

Termination

☐ Died

☐ Permanent move out of state

☐ Other: _____

☐ Voluntary Withdrawal (A notice with appeal rights will be provided if signature of Participant or Authorized representative is not included)

I agree that I am voluntarily withdrawing from Choices for Care. I understand that I may reapply at any time.

Signature of Participant or Authorized Representative: _____ Date: _____

Completed by: _____ Email: _____
 Agency: _____ Phone: _____
 Provider ID#: _____

▼

Sent to: ☐ ADPC, 280 State Drive Waterbury, VT 05671-1500; Fax (802) 241-0514
☐ DAIL: Local LTCCC (SAMS or Email / Fax) CALL 802-241-0294 For Contact List
☐ ARIS: Only For home based; consumer/navigate directed, or Flexible Choices

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How to complete the 804A form:

1. Complete the Individual's name, Address, SS# or MID, Date of Birth
2. **Current Setting:** Check the box of where the individual is currently receiving services
3. **Termination:**
 - a. Fill in the effective Date of Termination of services
 - b. Check the box for the reason for the termination of services
 - c. Check the Voluntary Withdrawal box if the individual is withdrawing services by their choice
 - d. The individual must sign the form if Voluntarily withdrawing
4. Fill in the name of the Person filling out the 804 A form and contact information

Form 804A: Termination of Services

Form#	DAIL	ADPC	DVHA	Where Can I find the Form?
804	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		SAMS or: https://asd.vermont.gov/resources/forms
804A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		SAMS or: https://asd.vermont.gov/resources/forms
804B		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	http://www.vtmedicaid.com/assets/forms/CF804B.pdf
804C		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms
804D		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms

DAIL (Disabilities, Aging and Independent Living) LTCCC

Nurse: To request a contact list, call DAIL-Adult Services Division (802) 241-0294

SAMS Users: Send SAMS Alert to LTCCC Nurse when form is completed

ADPC (Application and Document Processing Center):

Fax (802) 241-0514

280 State Drive Waterbury, VT 05671-1500



The 804 form is submitted to DAIL and to ADPC. For SAMS users: Forms are available as an assessment form. When completed, send an alert to the LTCCC, print and send to ADPC

Form 804B: Hospital & Nursing Facility Admissions/Discharges

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When this form is used:

- To report Acute Hospital admissions and discharges
- To report a change in payment source
- To report Hospice admissions

Who completes this form:

- Nursing Home
- Hospital Social Worker



This form is used by Hospitals and Nursing Facilities to report *Acute hospital* admissions and discharges. This form is also used to *report a change in payment source* and *Hospice admission*. *This form is managed and updated by DVHA and can be found on <http://www.vtmedicaid.com/#/forms>*

This form has been recently updated with new fax numbers and current address.

**Form 804B:
Hospital & Nursing
Facility
Admissions/
Discharges**

Choices for Care
Nursing Facility/Hospital - Swing Bed
Acute Hospital Stay and Change of Payment Report Form
Complete all sections that apply for active and pending Choices for Care participants.

Individual Name: _____ Date of Birth: _____
SSN: _____
Facility Name/Provider #: _____ Phone: _____

A. Acute Hospital Admission/Discharges

☐ Admission to Hospital date: _____ Hospital: _____
☐ Re-admission from Hospital date: _____ #26 BED HOLD ☐ YES ☐ NO
Total # of days in hospital: _____

Payment source upon re-admission to facility:
☐ Medicare, ☐ VT Medicaid, ☐ Private Insurance: _____ ☐ Other: _____

B. Change in Payment Source

☐ Change from VT Medicaid coverage to the following payment source:
MEDI-CARE effective date: _____ / Insurance: _____
Other insurance effective date: _____ Private pay effective date: _____
☐ Return to VT Medicaid coverage (Choices for Care) date: _____
Total # of days at previous payment source: _____
☐ MEDICARE Co-insurance start date: _____ through end date: _____

C. Hospice
Hospice Start Date: _____
Home Health Hospice Provider: _____

Comments (if needed): _____

Person Completing Form (print): _____ Date: _____
Signature: _____
Send a Copy to: **Department for Children and Families, ADPC** Fax: 802-241-0514
103 S. Main Street, Waterbury, VT 05676-9990
AND
Department of Vermont Health Access, COB Fax: (802)241-9070
280 State Dr. - NOB 1 South Waterbury, VT 05671-4020 PHONE: (802)879-5957
Attn: LTC - RM

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How to complete the 804B form:

1. Complete the Individual's name, SS# or MID, Date of Birth, Facility Name and Phone

2. Acute Hospital Admissions/Discharge

- a. Check the appropriate box for
 - i. Admission to Hospital, Hospital Name
 - ii. Bed Hold – if appropriate
 - iii. Facility Admission to Nursing Home from the hospital
 - iv. Fill in admission/re-admission date
 - v. Payment Source upon re-admission to the facility

3. Change in Payment Source

- a. Check the appropriate box for:
 - i. Medicare Co-insurance Start Date and End Date
 - ii. Return to VT Medicaid Coverage (Choices for Care) with the start date and indicate total # of days covered by previous payor
 - iii. Change from VT Medicaid to a different payment source - indicate new payment source with the effective date and name if commercial insurance carrier

4. Hospice – complete all fields

5. Fill in the name of the Person completing this form with signature and date

Questions about this form should be directed to DVHA.

**Form 804B:
Hospital & Nursing
Facility
Admissions/
Discharges**

Form#	DAIL	ADPC	DVHA	Where Can I find the Form?
804	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		SAMS or: https://asd.vermont.gov/resources/forms
804A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		SAMS or: https://asd.vermont.gov/resources/forms
804B		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	http://www.vtmedicaid.com/assets/forms/CFC804B.pdf
804C		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms
804D		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms

ADPC (Application and Document Processing Center):

Fax (802) 241-0514

280 State Drive Waterbury, VT 05671-1500

DVHA (Department of VT Health Access), COB:

Fax (802) 241-9070

280 State Dr – NOB 1S South, Waterbury, VT 05671-4020



The 804B form is submitted to BOTH ADPC and DVHA

Form 804C: Short Term VT *Medicaid Only* Rehab Stay

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When this form is used:

- Short Term Medicaid Only Rehabilitation Stays

Who completes this form:

- Nursing Home
- Hospital Social Worker



This form is used by Skilled Nursing Facilities and Hospitals that have Swing Bed status. This form is used to report Short Term *Medicaid Only* Rehabilitation Stays. Please use this form if the beneficiary currently has active Medicaid. The VT Medicaid Rehab benefit covers stays less than 30 days per episode/60 days per calendar year following the Department of VT Health Access (DVHA) Operating Procedures, *Medicaid Nursing Facility Short Stays*. **If Medicare is covering part of the stay, use form 804D.**

Form 804C: Short Term VT Medicaid Only Rehab Stay

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CFC 804C

Short-Term Medicaid Only Rehab Form

Complete this form if the individual is active Vermont Medicaid and is not covered by other insurance and is not active in Choices for Care

Individual Name: _____ SSN: _____
 DOB: _____ Facility: _____ Provider ID#: _____
 Phone: _____

A. Vermont Medicaid Only Rehab: *(If stay is covered all or in part by Medicare, use form 804D)*

- Follows the Department of Vermont Health Access (DVHA) Operating Procedures, Medicaid Nursing Facility Short Stays.
- Benefit covers nursing facility and hospital swing bed stay of no more than 30 days per episode (maximum of 60 days per calendar year).

B. Admission: *(Submit completed form within 10 days from the release date)*

Admission date to nursing facility or hospital swing bed: _____
 Requested Medicaid start date: _____

Admitted from: _____
☐ Hospital ☐ Home
☐ Other: _____

Last date Medicaid coverage needed: _____
 Reason for Medicaid end: _____
☐ Discharged ☐ Deceased
☐ No longer meets coverage criteria ☐ Benefit maxed-out

C. Long-Term Care: *(Coverage for stay of 31 days or more)*

- Must apply for Choices for Care Long-Term Care-Medicaid
<http://www.governorshouse.org/long-term-care-medicare>
- Must meet clinical and financial eligibility criteria.

Completed by: _____ Email: _____
 Agency: _____ Phone: _____

Sent to: ☐ ADPC, 280 State Drive Waterbury, VT 05671-1500 Fax (802) 241-0514

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How to complete the 804C form:

1. Complete the Individual's name, Address, SS# or MID, Date of Birth

2. Admission:

- a. Complete this form within 10 days after the coverage was needed
- b. Fill in the Admission Date
- c. Fill in Requested Start Date of Medicaid Coverage
- d. Check the box to indicate where the beneficiary was admitted from
- e. Fill in the last date that Medicaid coverage was needed
- f. Check the reason for no longer needing Medicaid coverage

3. Provide the Name of the Nursing Facility/Hospital and Person Completing the form

**Form 804C:
Short Term VT
Medicaid Only
Rehab Stay**

Form#	DAIL	ADPC	DVHA	Where Can I find the Form?
804	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		SAMS or: https://asd.vermont.gov/resources/forms
804A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		SAMS or: https://asd.vermont.gov/resources/forms
804B		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	http://www.vtmedicaid.com/assets/forms/CF804B.pdf
804C		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms
804D		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms

ADPC (Application and Document Processing Center):

Fax (802) 241-0514

280 State Drive Waterbury, VT 05671-1500



Form 804D: VT Medicaid/Medicare Stays

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When this form is used:

- To report dual Medicaid/Medicare Rehabilitation Stays
- Beneficiary has Active Medicare/Medicaid eligibility and needs short term coverage

Who completes this form:

- Nursing Home
- Hospital Social Worker



This form is used by Skilled Nursing Facilities and Hospitals that have Swing Bed status. This form is used to report dual Medicare/Medicaid Rehabilitation Stays. Please use this form if the beneficiary currently has an active Medicare/Medicaid eligibility and is in need of short-term coverage. Medicare is always the primary payor for individuals with both Medicare and Medicaid. VT Medicaid co-insurance coverage is day 21 to day 100 of the Medicare stay, following all Medicare standards, including a qualifying 3 – day hospital stay. Other private insurance must be billed prior to VT Medicaid. **If the beneficiary does not have Medicare, use form 804C.**

Form 804D: VT Medicaid/Medicare Stays

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CFC 804D

Dual Medicare / Vermont Medicaid Short-Term Rehab Form

Complete this form if the individual is active Medicare and Vermont Medicaid. Do not complete if individual is active on Choices for Care

Individual Name: _____
 DOB: _____ SSN: _____
 Facility: _____ Provider ID#: _____
 Phone: _____

A. Dual Medicare / Vermont Medicaid Rehab *(If stay is not covered by Medicare, use form 804 or 804C)*

- Follows Medicare standards, including 3-day qualifying hospital stay. Medicare standards found at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/sp102c08.pdf>
- Vermont Medicaid co-pay covers days 21 – 100 of the Medicare stay.
- Medicare is always the primary payer for individuals with both Medicare and Medicaid.
- Private long-term care insurance must be billed prior to Vermont Medicaid.

B. Long-Term Care *(Coverage for stay exceeding Medicare co-insurance – 100 days)*

- Must apply for Choices for Care Long-Term Care Medicaid <http://www.vermontmedicaid.org/long-term-care-medicare>
- Must meet clinical and financial eligibility criteria.

C. Admission *(Submit completed form within 10 days of Medicare/Medicaid end date)*

Admission date to nursing facility or hospital swing bed: _____
 Requested Medicaid co-pay start date: _____
 Estimated length of stay, _____ days.
 Date discharged or last date Medicaid coverage needed: _____

Reason for end of Medicaid coverage:

<input type="checkbox"/> Discharged	<input type="checkbox"/> Deceased
<input type="checkbox"/> No longer meets coverage criteria	<input type="checkbox"/> Other: _____

Completed by: _____ Email: _____
 Agency: _____ Phone: _____

Sent to: ☐ ADPC, 280 State Drive Waterbury, VT 05671-1500; Fax (802) 241-0514

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How to complete the 804D form:

1. Complete the Individual's name, Address, SS# or MID, Date of Birth
2. Provide the Name of the Nursing Facility/Hospital and Person Completing the form
3. Complete Section C of this form within 10 days of the need for Medicaid to pay the Medicare co-payment and within 10 days after the end of coverage for both Medicare/Medicaid.
 - a. Fill in the Admission Date,
 - b. Requested Start Date of Medicaid co-insurance
 - c. Check the box where the beneficiary was admitted from
 - d. Fill in the last date that Medicaid coverage was needed
 - e. Check the reason for no longer needing Medicaid coverage

Form 804D: VT Medicaid/Medicare Stays

Form#	DAIL	ADPC	DVHA	Where Can I find the Form?
804	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		SAMS or: https://asd.vermont.gov/resources/forms
804A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		SAMS or: https://asd.vermont.gov/resources/forms
804B		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	http://www.vtmedicaid.com/assets/forms/CFC804B.pdf
804C		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms
804D		<input checked="" type="checkbox"/>		https://asd.vermont.gov/resources/forms

ADPC (Application and Document Processing Center):

Fax (802) 241-0514

280 State Drive Waterbury, VT 05671-1500



Where to submit forms

	DAIL	ADPC	DVHA	Where Can I find the Form?
804	☑	☑		SAMS or: https://asd.vermont.gov/resources/forms
804A	☑	☑		SAMS or: https://asd.vermont.gov/resources/forms
804B		☑	☑	http://www.vtmedicaid.com/assets/forms/CFC804B.pdf
804C		☑		https://asd.vermont.gov/resources/forms
804D		☑		https://asd.vermont.gov/resources/forms



If the appropriate 804 form is not submitted to the correct agency promptly, this will affect the payment to the provider of services. See table for summary information on how to find the forms, and where to submit each form.

Questions?

- ▶ Forms with detailed instructions:
 - ▶ ASD.Vermont.gov
- ▶ Questions for forms 804 and 804A – LTCCC or Program Supervisors
- ▶ Questions for forms 804B, 804C, 804D may be redirected to DVHA



Please feel free to reach out to your local LTCCC or program supervisors for support with filling out these forms. For the forms that are submitted to DVHA and ADPC, the LTCCC may recommend that you contact DVHA for support.

Contacts



DAIL: 802 241-2401

DAIL Online Contact Information:
<http://dail.vermont.gov/contact-us>

ASD: 802 241-0294

ASD Online Contact Information:
http://asd.vermont.gov/contact_us



- To contact the Department of Disabilities, Aging & Independent Living, call 802 241-2401 or go online at dail.Vermont.gov and click “Contact Us”.
- To contact the Adult Services Division, call 802 241-0294 or go online at asd.Vermont.gov and click “Contact Us”.

Thank you

Feedback? Email

Colleen.Bedard@vermont.gov



I welcome your feedback on how to improve this training. Feel free to provide feedback via email:

Colleen.Bedard@vermont.gov