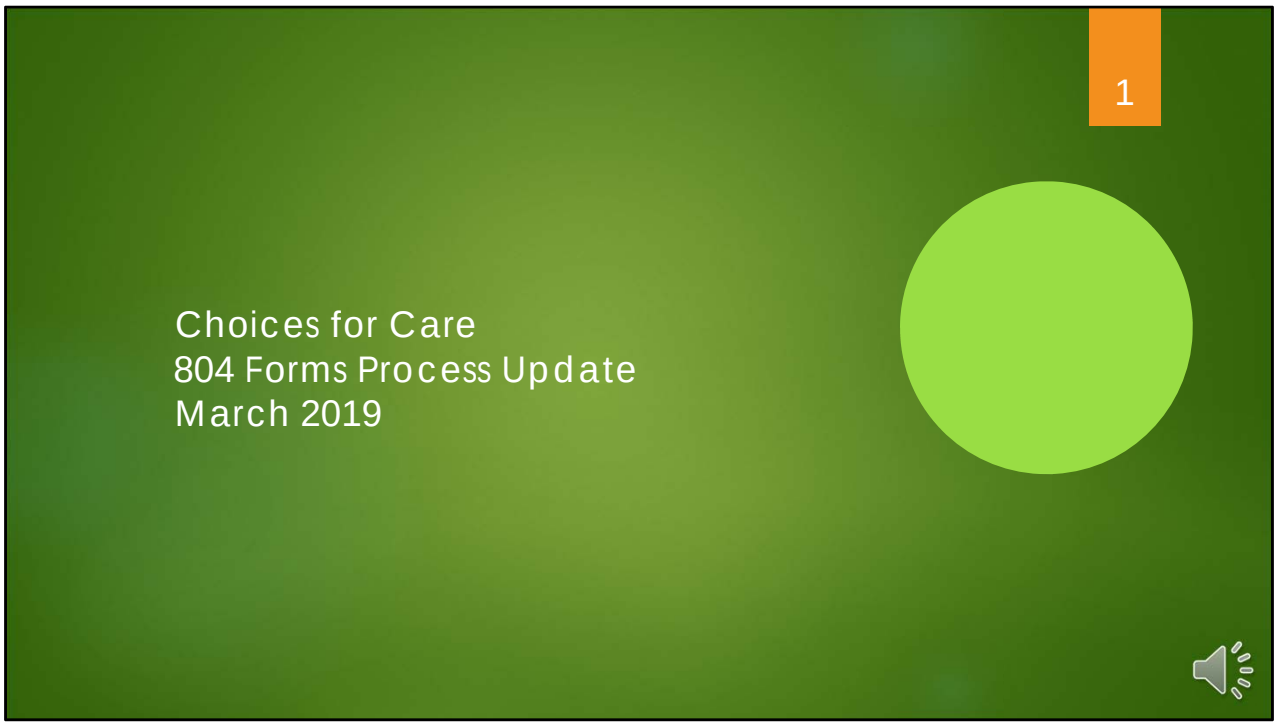
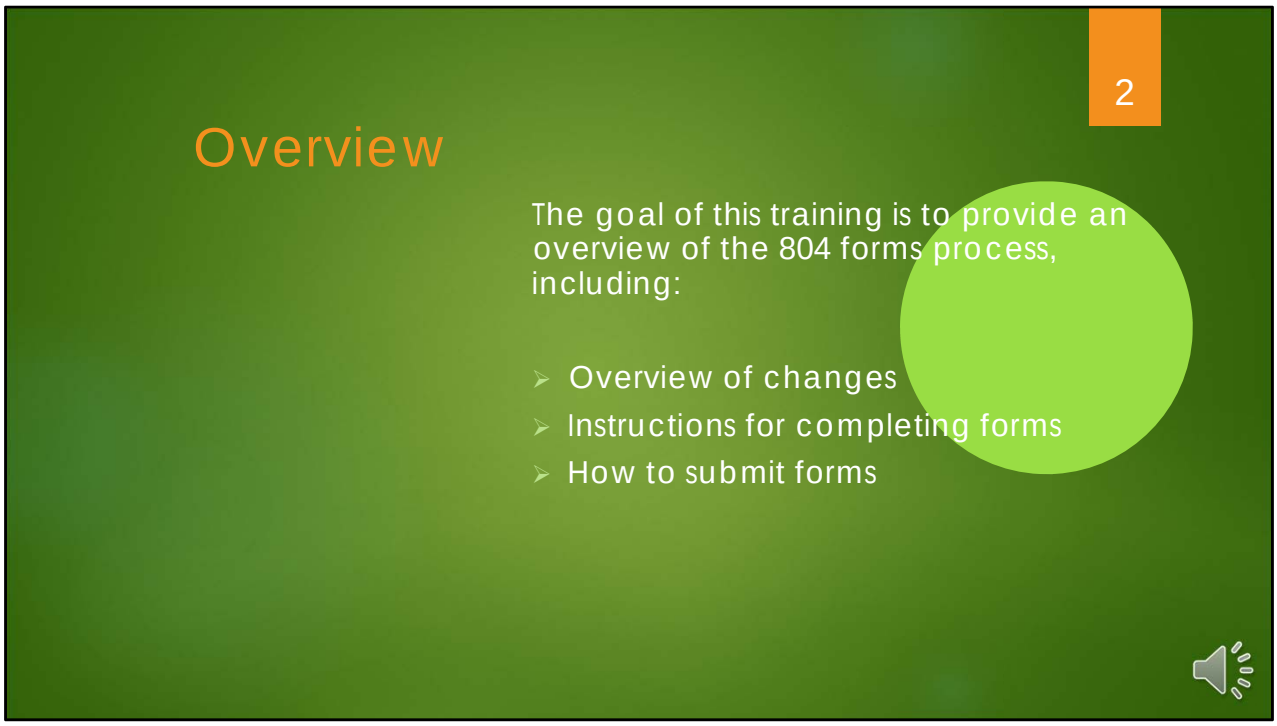
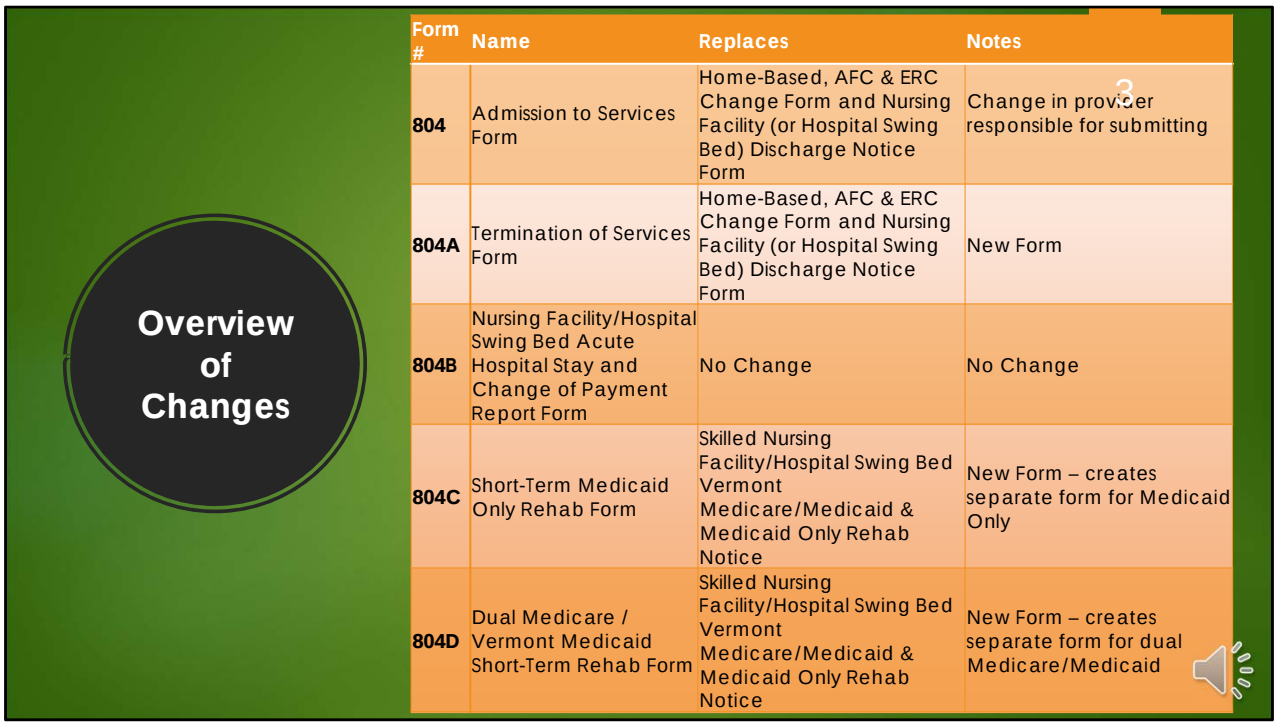


Welcome to the Choices for Care 804 Forms Process Update. This training is designed for Choices for Care case managers, providers and service coordinators



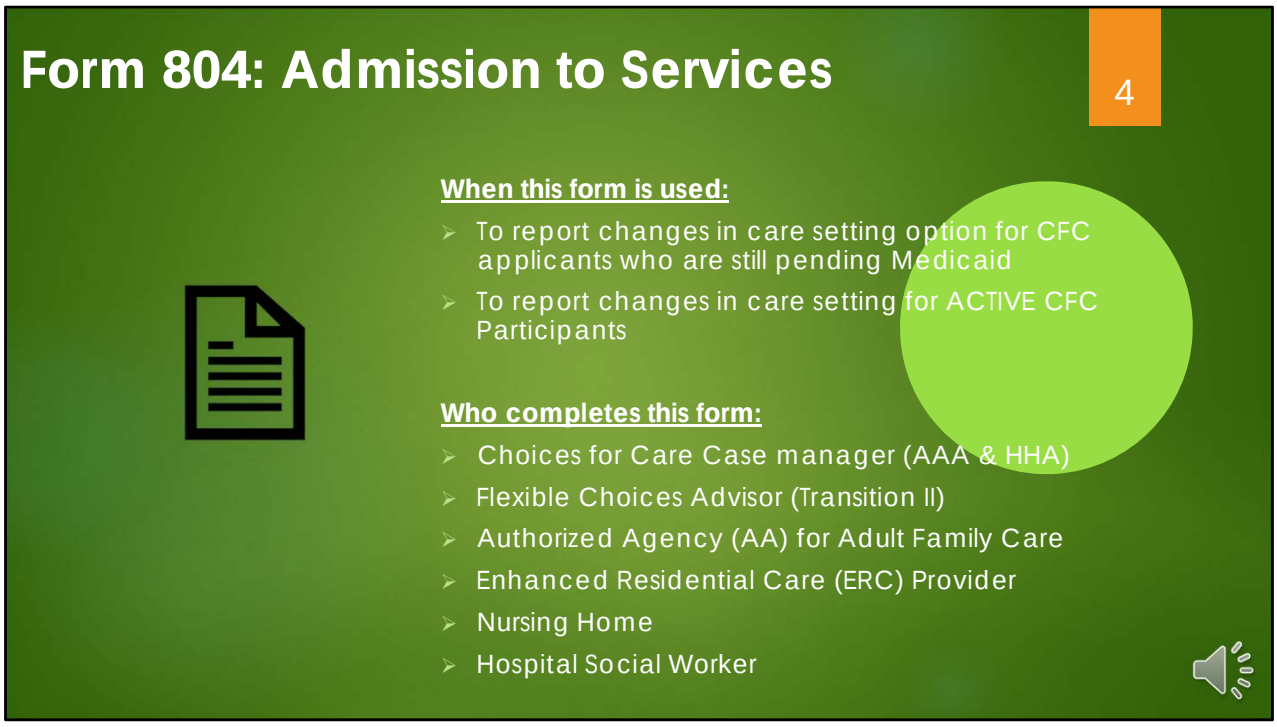
This training module is intended to provide you with an overview of the changes to the 804 forms process, including ***which*** *804 form must be completed,* ***who*** *completes the form,* ***how*** *it must be completed and* ***where*** *it must be submitted*.

This process will take effect on April 1, 2019



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



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

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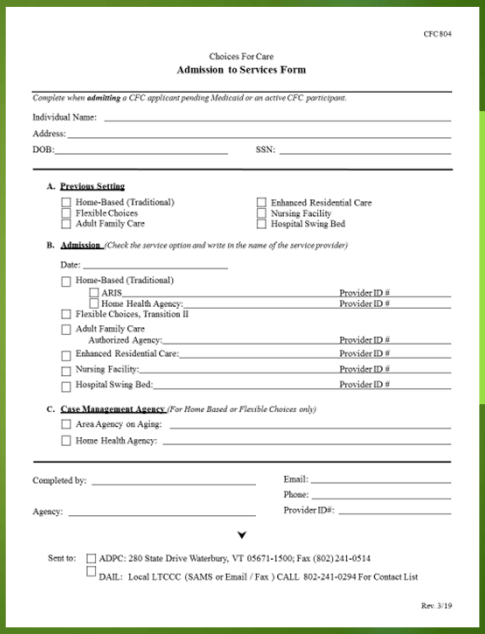


CFC 804

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

☐ Home-Based (Traditional) ☐ Enhanced Residential Care
☐ Flexible Choices ☐ Nursing Facility
☐ Adult Family Care ☐ Hospital Swing Bed

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

Date: _____

☐ Home-Based (Traditional)
☐ ARIS _____ Provider ID # _____
☐ Home Health Agency: _____ Provider ID # _____
☐ Flexible Choices, Transition II
☐ Adult Family Care
Authorized Agency: _____ Provider ID # _____
☐ Enhanced Residential Care: _____ Provider ID # _____
☐ Nursing Facility: _____ Provider ID # _____
☐ Hospital Swing Bed: _____ Provider ID # _____

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

☐ Area Agency on Aging: _____
☐ 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

Rev. 3/19

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)

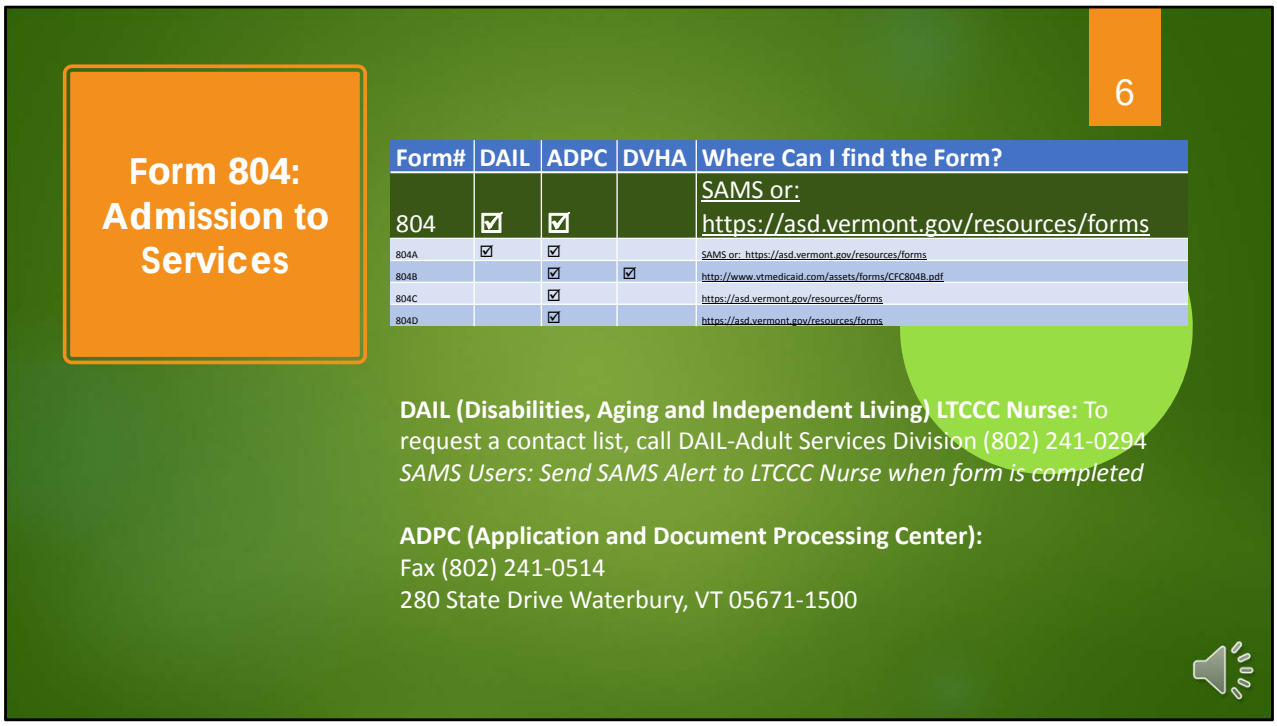
3.**Admission**

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



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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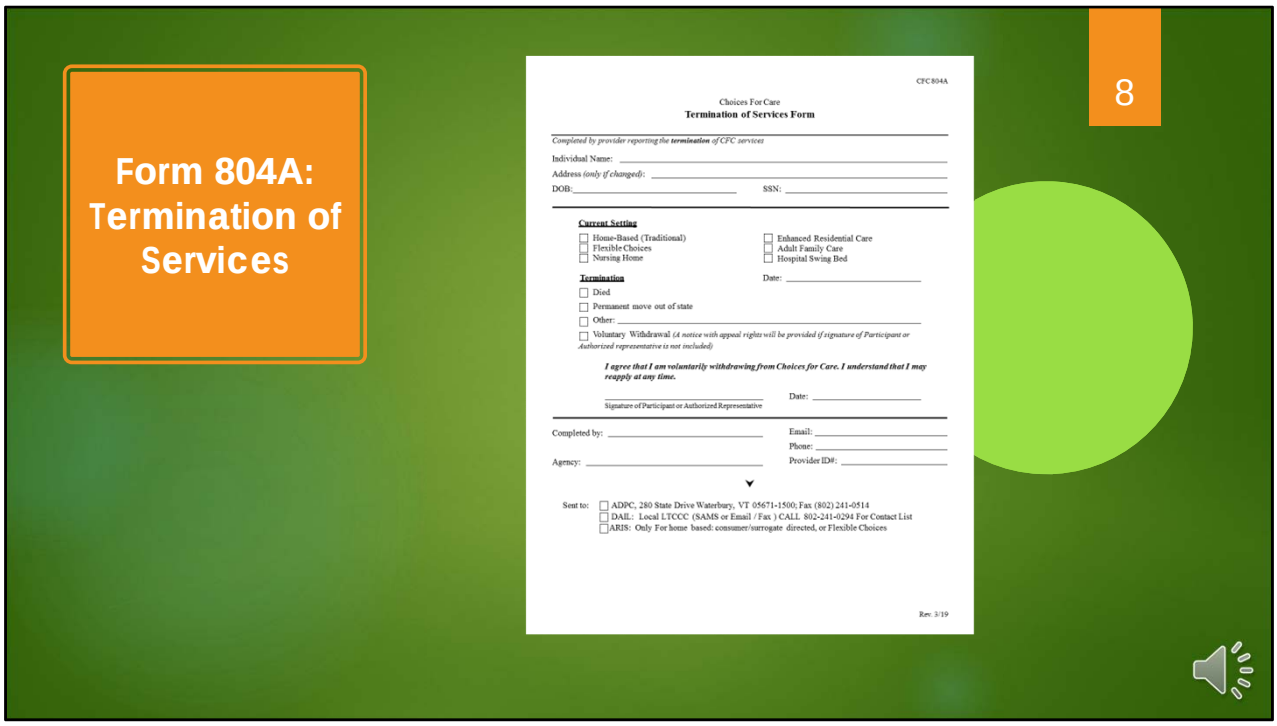
When this form is used:

- 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

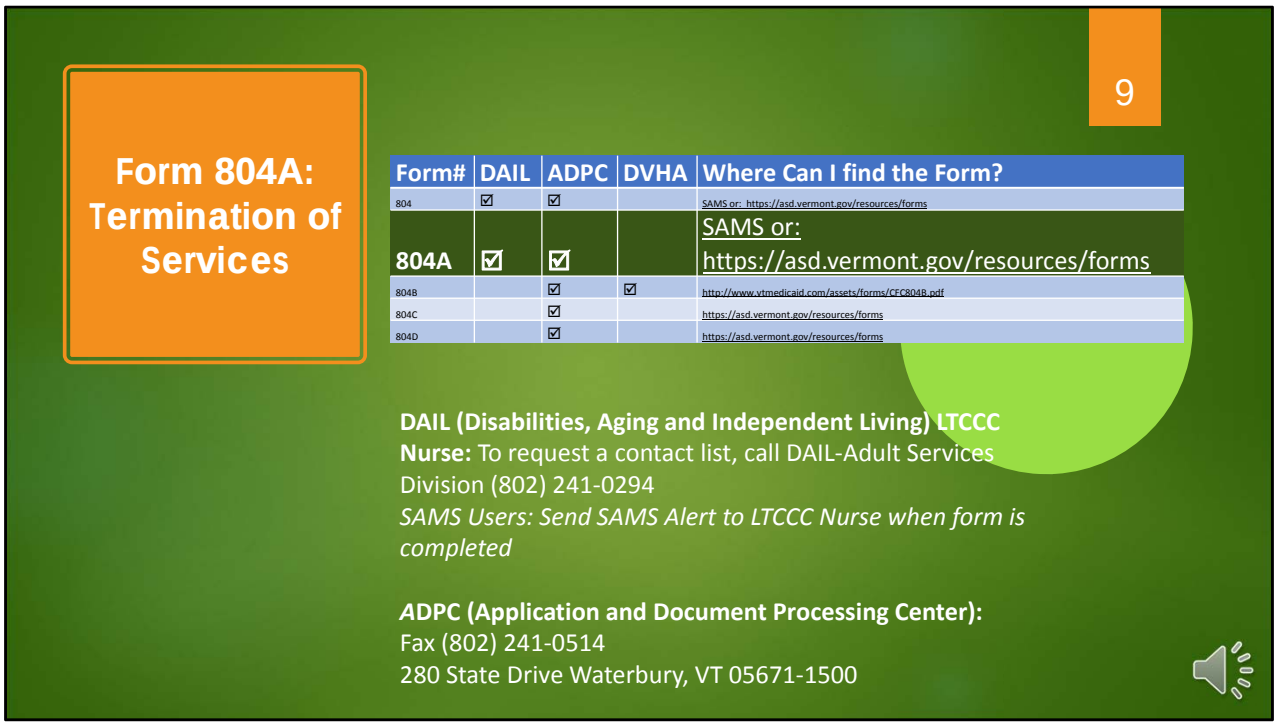
This form is a new form used to report the **termination** of CFC services for active CFC participants receiving Home-Based, ERC, Adult Family Care, Flexible Choices, Hospital Swing Bed or Nursing Facility services. If an individual terminates services or voluntarily withdraws from CFC services, it is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



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

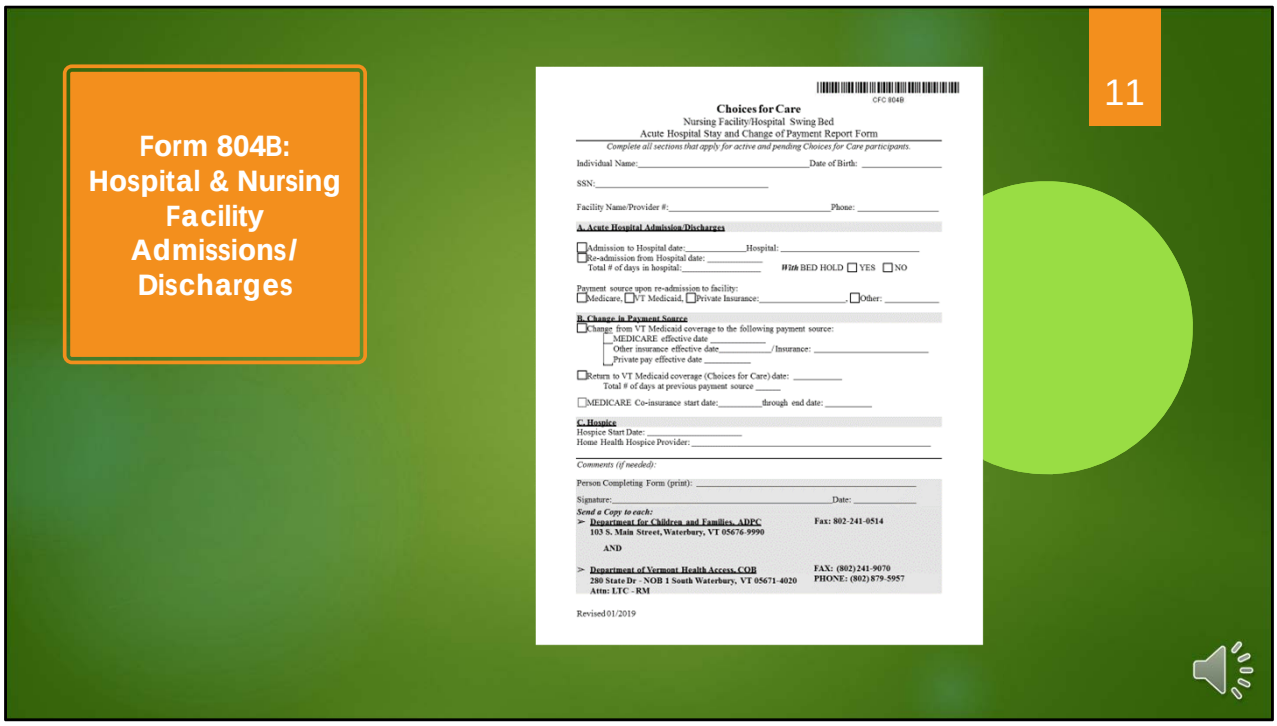
4. Fill in the name of the Person filling out the 804 A form and contact information



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

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.



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

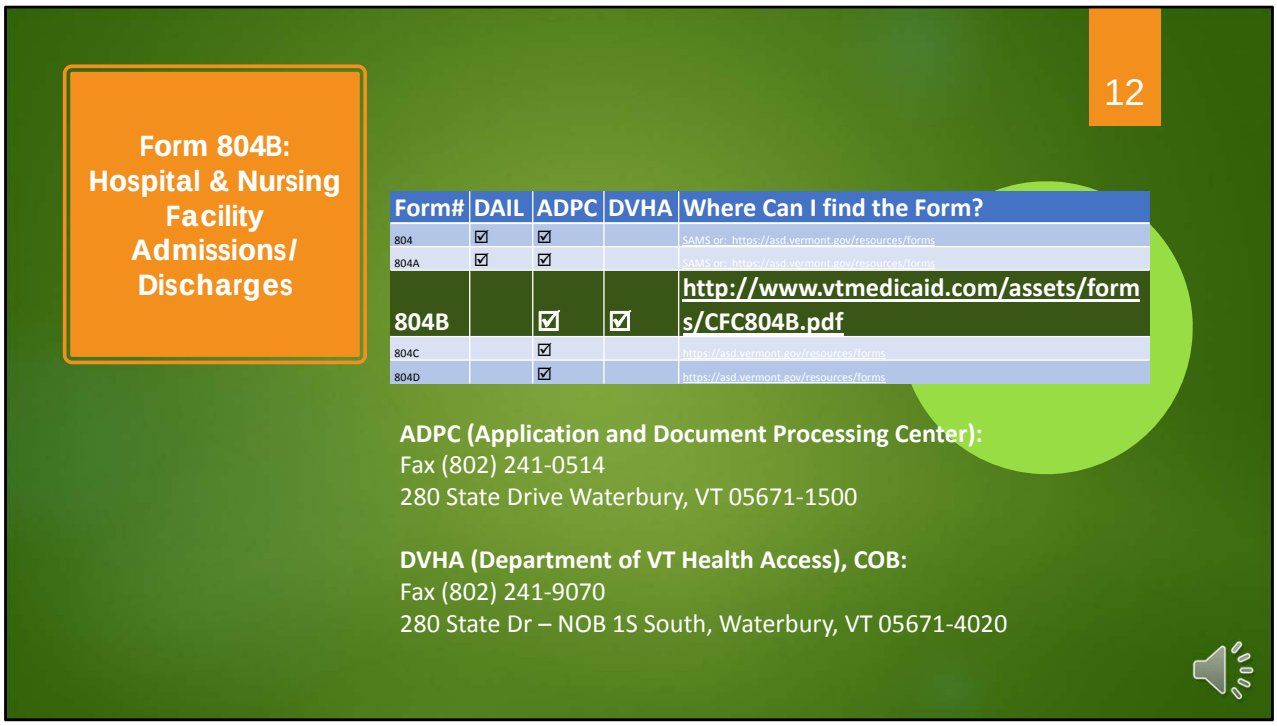
ii. Return to VT Medicaid Coverage (Choices for Care) with the start date and indicate total # of days covered by previous payor

iii. Change from VT Medicaid to a different payment source - indicate new payment source with the effective date and name if commercial insurance carrier

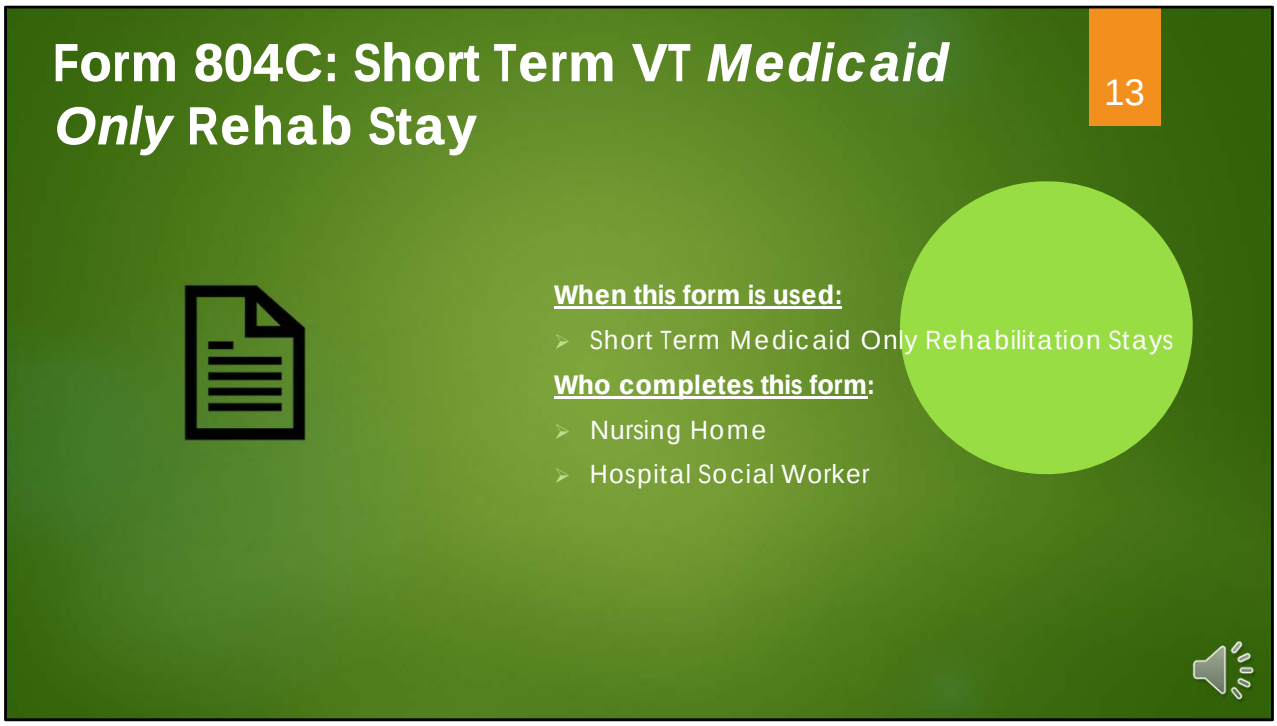
4. **Hospice – complete all fields**

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

Questions about this form should be directed to DVHA.

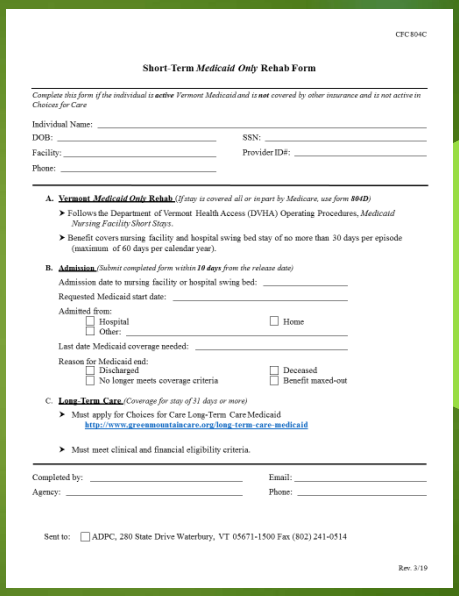


The 804B form is submitted to BOTH ADPC and DVHA



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



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: _____

DOB: _____ SSN: _____

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.greenmountaincare.org/long-term-care-medicaid
- 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

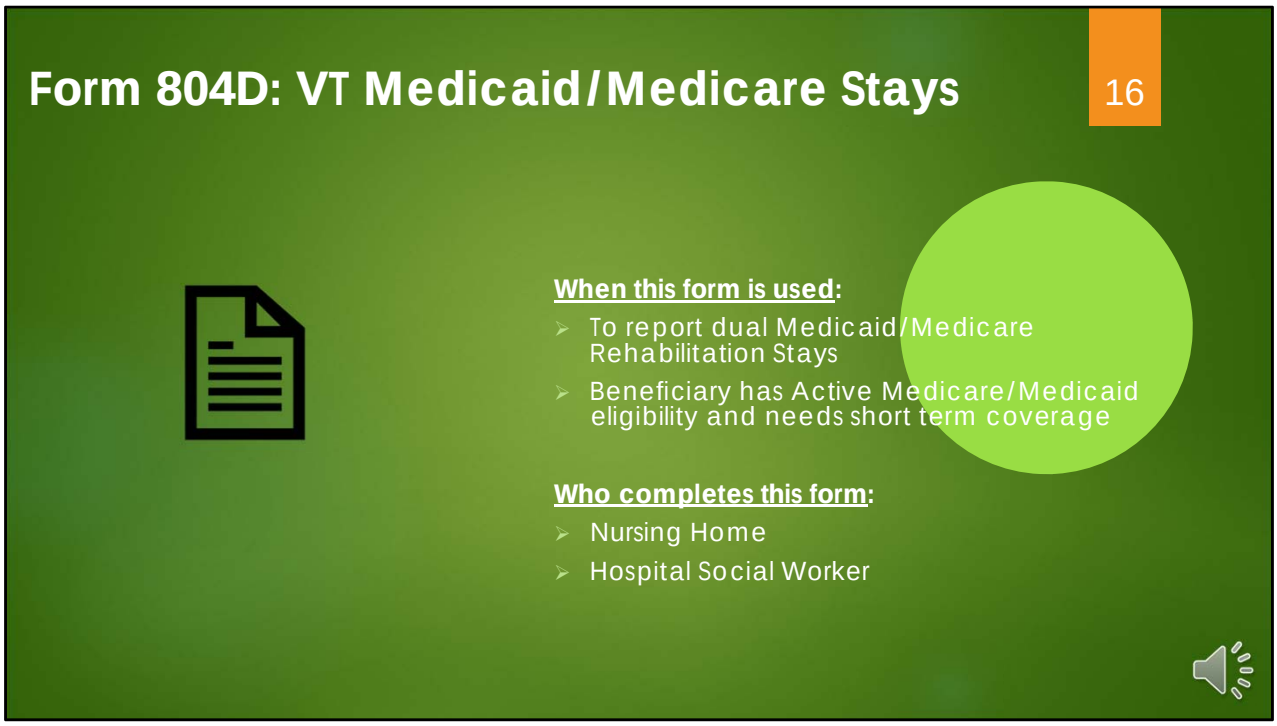
f. Check the reason for no longer needing Medicaid coverage

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	☑	☑		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

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



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.**

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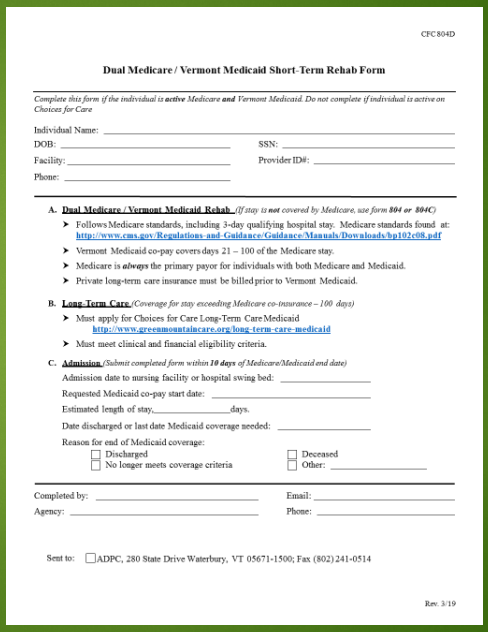
Form 804D: VT Medicaid/Medicare Stays



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/bp102c08.pdf
- Vermont Medicaid co-pay covers days 21 – 100 of the Medicare stay.
- Medicare is **always** the primary payor 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.greenmountaincare.org/long-term-care-medicaid
- 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:

☐ Discharged ☐ Deceased

☐ No longer meets coverage criteria ☐ Other: _____

Completed by: _____ Email: _____

Agency: _____ Phone: _____

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

Rev. 3/19

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

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Form 804D: VT Medicaid/Medicare Stays

Form#	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**

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

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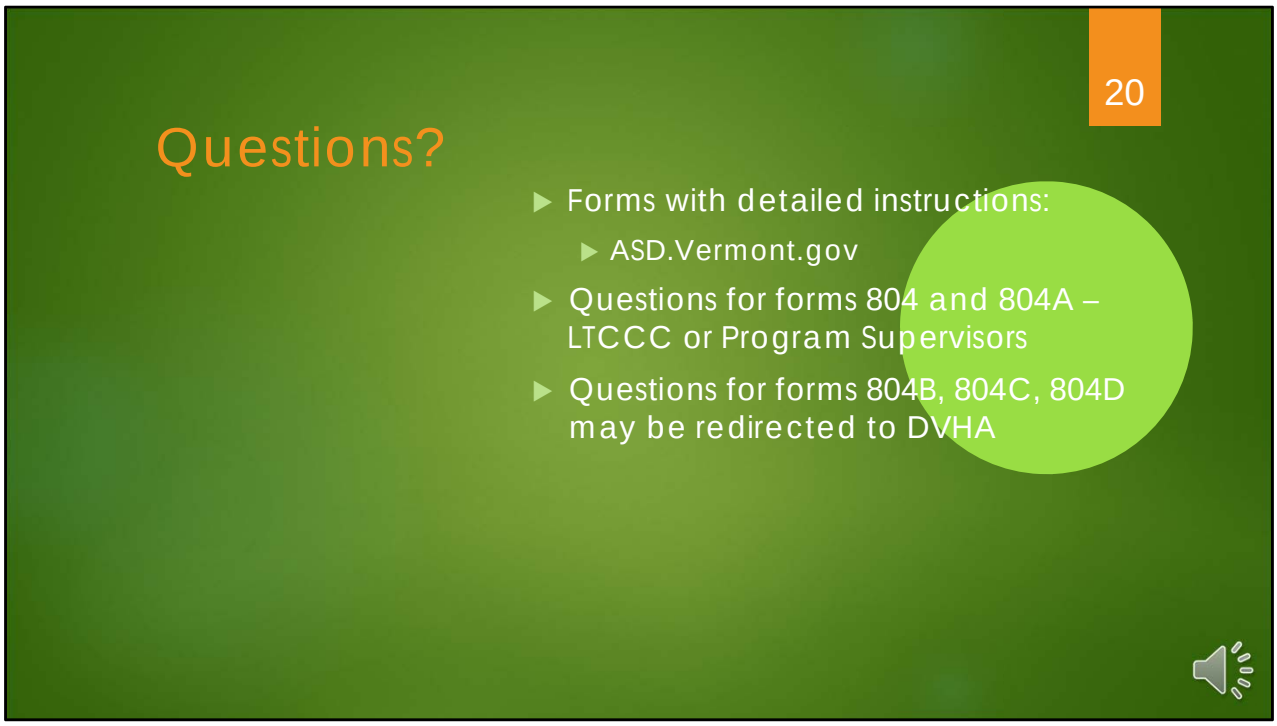
Where to submit forms

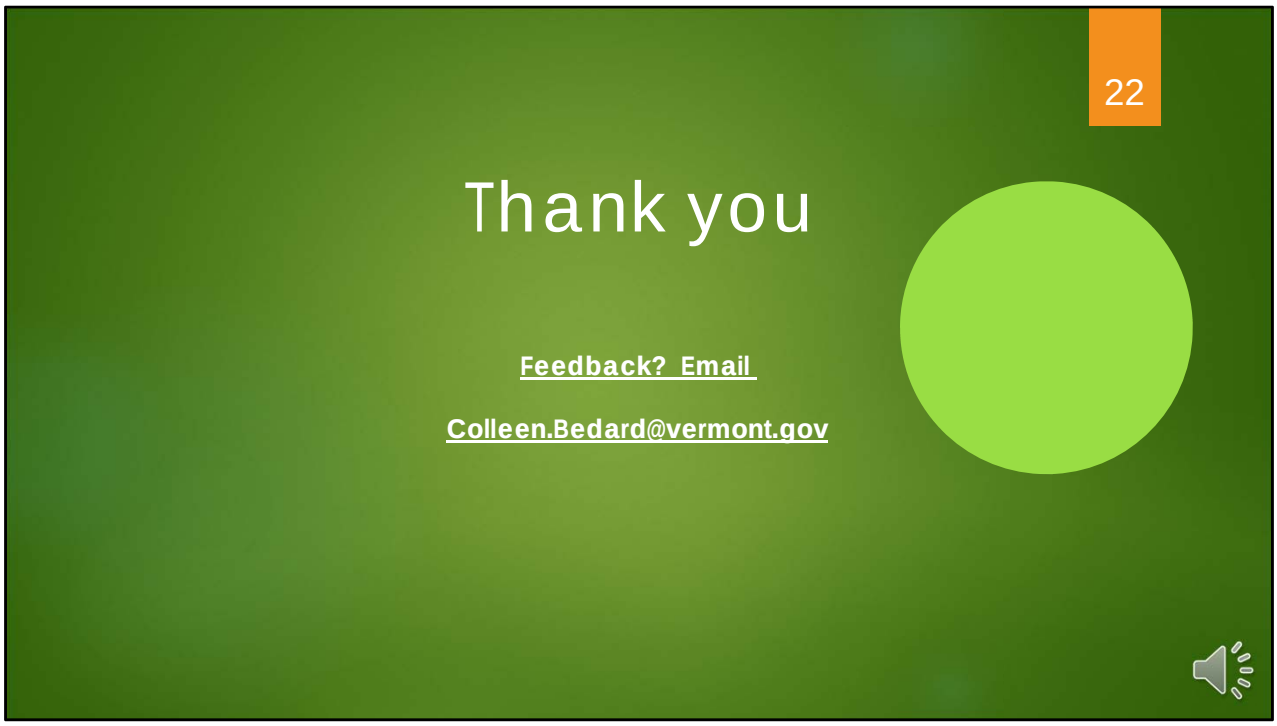
	DAIL	ADPC	DVHA	Where Can I find the Form?
804	☑	☑		SAMS or: https://asd.vermont.gov/resources/forms
804A	☑	☑		SAMS or: https://asd.vermont.gov/resources/forms
804B		☑	☑	http://www.vtmedicaid.com/assets/forms/CFC804B.pdf
804C		☑		https://asd.vermont.gov/resources/forms
804D		☑		https://asd.vermont.gov/resources/forms

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.



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.

- 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”.



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

Colleen.Bedard@vermont.gov