Vermont Department of Disabilities, Aging and Independent Living

Choices for Care
Adult Family Care Home – Service Plan Authorization

Participant Name: _____ **Soc. Sec. #** _____
(Please Print)

Home Provider Name: _____ ☐ Initial Assessment ☐ Reassessment ☐ Change

_____ **Address:**
(Street)

_____ **Requested Start Date**: _____
(Town) (Zip Code)

Date of Birth: _____

Phone Number: _____

Diagnosis:
_____
_____

ICD-10 Code: _____

DAIL UR_____

Choices for Care Service	Agency Name	Volume	Billed Rate	Planned Costs
☒ **Adult Family Care** (revenue code 086) ☐		**Tier #:** _____ *(Tier table on back)*	$_____/day	**$ /mo.** **($/day X 30.3 days)**
Adult Day Services (revenue code 078)		_____hrs./wk.	$15.76 /hr.	
			Total Monthly Costs:	**$ /mo.**

Other Services / Frequency	Payment Source	Other Services / Frequency	Payment Source
☐ **Skilled Nursing**:		☐ **MFP Transition**	
☐ **H.H. Aide (LNA):**		☐ **Other:**	
☐ **CRT**		☐ **Other:**	

Department of Disabilities, Aging and Independent Living Authorization

Services are authorized effective:

Start Date: _____through End Date: _____

A full reassessment must be completed & authorized prior to the service plan expiration in order for Waiver services to continue and to avoid an interruption in Medicaid claims submissions.

_____ _____

DAIL Authorized Signature Date

CONSENT TO PLAN OF CARE

I, have been fully informed of the proposed **SERVICE PLAN** and understand the terms as described in this **Service Plan**. I consent to this plan and accept it as an alternative to the other Choices for Care setting options.

_____ Date: _____

Signature of applicant/participant or legal representative

_____Agency:_____Phone #: _____

Authorized Agency AFC Coordinator (Print)

_____ Date: _____

Authorized Agency AFC Coordinator Signature

NOTE: All Plans must be signed by applicant/participant or legal representative (Power of Attorney or legal guardian) and Authorized Agency in order for services to be authorized.

Important Information

Changes: The individual or legal representative must report all changes in status to the Authorized Agency (AA).

Patient Share: The Department for Children and Families (DCF) Notice of Decision includes the patient share amount (if any) that is to be paid to the Authorized Agency (AA) each month.

Provider Billing: Case Management and Authorized Agencies (AA) must retain a copy of the current approved Service Plan as authorization to bill for services. ***The AFC tier rate while admitted in a hospital is 94% of the approved daily tier rate.*** An in-hospital day is determined by where the participant is at midnight on the date of service.

Adult Day Services: People may choose to voluntarily participate in Adult Day Services. The Adult Day provider will bill Medicaid directly for the services identified on this Service Plan. Payment for Adult Day will not be deducted from the AFC Tier Rate.

Reassessments: Annual reassessments will start on the date after the previous service plan ends.

Service Plan Changes: Approved service plan changes will start no earlier than the date the service plan and supporting information is received at the DAIL regional office.

AFC Tier Rate Table

Tier	Tier **Score**	**Daily Rate**	**94% Daily Rate** *(rate while in hospital)*
1	Less than 52	$78.54	$73.83
2	52 to 66	$89.76	$84.37
3	67 to 75	$95.88	$90.13
4	76 to 86	$100.98	$94.92
5	87 to 96	$106.08	$99.72
6	97 to 106	$112.20	$105.47
7	107 to 119	$118.32	$111.22
8	120 to 135	$125.46	$117.93
9	136 to 168	$137.70	$129.44
10	Greater than 168	$159.12	$149.57

CFC Forms can be found at:
http://asd.vermont.gov/sites/asd/files/documents/CFC_805D_Adult_Family_Care_Service_Plan.pdf