

**VERMONT CHOICES FOR CARE MEDICAID PROGRAM
ENHANCED RESIDENTIAL CARE SETTING
Provider Enrollment Application**

Facility Name: _____ Phone: _____

Mailing Address: _____

Street Address if different: _____

Owner: _____ Manager: _____

Administrator: _____ RN: _____

FAX: _____ Email: _____

Directions to the Facility: _____

Is this application for new RCH/ALR (no previous ownership/operatorship)? _____
OR

Is this application for a change in licensure (from previous owner or operatorship)? _____

And if so, has the facility changed its name? _____

Please provide the previous name: _____

If your facility has been assigned a pre-approved level of care variance number by the Division of Licensing and Protection indicate it here. _____

How many residents do you expect to serve through Choices for Care ERC? _____

Section A FACILITY DESCRIPTION.

1. Is the facility currently licensed as or applying to become (Check all that apply)?

- Vermont Level III Residential Care Home (RCH)
- Vermont Assisted Living Residence (ALR)
- Assistive Community Care Services (ACCS) provider

2. Total number of licensed beds? _____

3. Is the facility sprinklered? Yes No

4. Number of rooms that are private? _____ Semi-private? _____

5. ERC residents will be offered which type(s) of room? private semi-private

6. Current resident census? _____

7. Identify common areas (for socialization/meals and/or other spaces) _____

8. Check each accessibility feature the facility includes:
- | | | |
|---|--|--|
| <input type="checkbox"/> wheelchair ramps | <input type="checkbox"/> electronic door opened | <input type="checkbox"/> wandering alert system |
| <input type="checkbox"/> stair lift | <input type="checkbox"/> elevator | <input type="checkbox"/> call button system |
| <input type="checkbox"/> roll-in showers | <input type="checkbox"/> lift chairs in common rooms | <input type="checkbox"/> hallway rails/grab bars |
| <input type="checkbox"/> recreational gardening outdoor space | | |
| <input type="checkbox"/> other (describe) _____ | | |

Section B. ADMISSION & DISCHARGE & CENSUS

1. Please describe at what point an ERC resident’s functional status will result in discharge (i.e., two-person assist, wandering). _____

2. In the last year, how many persons served had a diagnosis of Alzheimer’s Disease or a related dementia? _____
3. Is the facility able to retain residents that wander? Yes No
4. How many residents is the facility willing to serve at the ACCS rate? (Non-ERC):

5. How many residents were discharged to a nursing facility or hospital in the last year? ____
Describe specific reason(s) why: _____

Section C. RN STAFFING & PERSONAL CARE SERVICES

1. How many hours a week is the RN scheduled in the facility? _____
2. What amount of personal care time per day is available to each ERC resident? _____

Section D. ACTIVITY INFORMATION

The activity requirement is daily social and recreational offerings either “in house” or in the community. How will you meet that need? Who will organize and conduct the activities? _____

Section E. FINANCIAL INFORMATION

1. Who will be responsible for ERC Medicaid billing? _____
2. Is the facility considering selling: () Yes () No

*****See page 3 for a list of required documentation to accompany the application*****

SECTION F. ATTACHMENTS

Attachment A: Admission policy that reflects ERC residents (nursing home level of care).

Attachment B: Discharge policy.

Attachment C: Revised resident admission agreement (*ERC providers must include the ERC/ACCS addendum as prescribed by the Department.*)

Attachment D: Uniform Disclosure with the admission agreement. (*ALR only*)

Attachment E: Most recent Department of Labor and Industry life safety inspection report.

Attachment F: Weekly or monthly staff schedule to included all staff positions.

Attachment G: Weekly or monthly activity schedule.

Attachment H: Certificate of insurance.

Completed by: _____ Title: _____

Signature: _____ Date: _____