VT Choices for Care & Brain Injury Program 804 Change Report Form Process

This document is intended to provide you with instructions for reporting changes in care settings/services for individuals who are **pending** Long Term Care (LTC) Medicaid eligibility or have LTC Medicaid in place. *The instructions will indicate **which** 804 form must be completed, **who** completes the form, **how** it must be completed and **where** it needs to be submitted*.

It is the responsibility of the admitting provider of service to submit the appropriate 804 form. The 804 forms are what notifies the Department of Disabilities, Aging and Independent Living (DAIL) and the Department of VT Health Access (DVHA) that the provider of services will start providing services, if there is a change in the service or a termination of services.

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 below for information on how to find the forms, and where to submit each form.

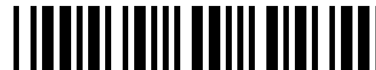
Form#	DAIL	ADPC	Where can I find the form?
804	☑	☑	SAMS or: https://asd.vermont.gov/resources/forms
804A	☑	☑	SAMS or: https://asd.vermont.gov/resources/forms
804B		☑	http://www.vtmedicaid.com/#/forms
804C		☑	https://asd.vermont.gov/resources/forms
804D		☑	https://asd.vermont.gov/resources/forms

Send all completed forms when indicated:

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

DVHA – Long Term Care Medicaid or
DCF – Economic Services Division by Mail or Fax to the following:
ADPC (Application and Document Processing Center): 280 State Drive
Waterbury, VT 05671-1500
Fax (802) 241-0514

VERMONT
Agency of Human Services
Department of Disabilities, Aging & Independent Living



804

Choices For Care – Admission to Services & Change Report Form

*Complete when **admitting** a Choices for Care (CFC) or Brain Injury Program (BIP) applicant pending Medicaid or an active program participant. Complete this form for an address change or change in Legal Guardian.*

Individual Name:________________________ DOB:____________ SSN:______________

Address Change:____

Legal Guardian Change:______________________ Legal Guardian Phone:________________

A. Previous Setting

☐ Home-Based *(CFC Traditional)*
☐ Flexible Choices
☐ Adult Family Care
☐ Brain Injury Program (*Home Based*)
☐ Enhanced Residential Care
☐ Nursing Facility
☐ Hospital Swing Bed
☐ Brain Injury Program (*Shared Living)*

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 #:____________
- ☐ Brain Injury Program Agency:______________ Provider ID #:____________

☐ Flexible Choices, Transition II

☐ Adult Family Care

Authorized Agency:______________________ Provider ID #:____________

☐ Enhanced Residential Care:__________________ Provider ID #:____________

☐ Nursing Facility:________________________ Provider ID #:____________

- ☐ Long Term Stay ☐ Short Term Stay

☐ 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:____________________ Phone:____________ Email:______________

Agency:________________________________ Provider ID#:__________________

SEND TO: ☐ ADPC: *280 State Drive Waterbury, VT 05671-1500*; Fax *(802) 241-0514*

AND

☐ DAIL: Local Nurse (DAIL Database or Email) or Fax (802) 241-0385

804 – ADMISSION TO SERVICES & CHANGE REPORT FORM INSTRUCTIONS

The 804 form is completed by the provider "admitting" a program participant to their service. 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 or Brain Injury Program provider.

When this form is used:

- To report changes in care setting option for CFC applicants who are still pending LTC Medicaid or to report changes in care setting for active CFC Participants
- To report a change of address
- To report a change of Legal Guardian

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
- Brain Injury Program Case Manager/Provider Agency

How to complete the 804 form:

1. Complete the Individual's name, Address, SS# or MID, Date of Birth and Legal Guardian (if changing)
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

Where to submit the 804 form:

DAIL Database Users: Send DAIL Database Alert to Local Nurse when form is completed. To request a contact list, call DAIL-Adult Services Division (802) 241-0294. Email or Fax completed form to (802)-241-0385

AND

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

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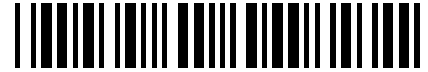
Department of Disabilities, Aging & Independent Living


804A

Termination of Services

*Completed by provider reporting the Program **termination** of Choices for Care (CFC) or Brain Injury Program (BIP) services.*

Individual Name:____

Address *(only if changed)*:____

DOB:____________________ SSN:____________________

Current Setting

- ☐ Home-Based (Traditional)
- ☐ Flexible Choices
- ☐ Nursing Home
- ☐ Brain Injury Program Home Based
- ☐ Enhanced Residential Care
- ☐ Adult Family Care
- ☐ Hospital Swing Bed
- ☐ Brain Injury Program Shared Living

Termination Date:____________________

- ☐ Died
- ☐ Permanent move out of State
- ☐ Brain Injury Program – Graduation
- ☐ 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 or the Brain Injury Program. I understand that I may reapply at any time.***

____ Date:____________________
Signature of Participant or Authorized Representative

Completed by:______________________________ Agency:____________________

Phone:____________________ Email:____________________ Provider ID#:____________________

Send to:
- ☐ ADPC – 280 State Drive Waterbury, VT 05671-1500; Fax (802) 241-0514 **AND**
- ☐ DAIL: Local Nurse (DAIL Database or Email) or Fax (802) 241-0385 **AND**
- ☐ ARIS – *Only For home-based consumer/surrogate directed, or Flexible Choices*

Revised 03/2024

804A – PROGRAMTERMINATION OF ENROLLMENT INSTRUCTIONS

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

When this form is used:

- ❖ To report Program termination of CFC or BIP for active CFC or BIP participants receiving Traditional Home- Based, ERC, Hospital Swing Bed, Nursing Facility, Adult Family Care, BIP Shared Living or Flexible Choices
- ❖ DO NOT USE this form for when a participant moves/transitions from one setting to another within the program.

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
- Brain Injury Program Case Manager/Provider Agency

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

Where to submit the 804A form:

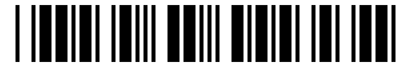
DAIL Database Users: Send DAIL Database Alert to Local Nurse when form is completed. To request a contact list, call DAIL-Adult Services Division (802) 241-0294. Email or Fax completed form to (802)-241-0385

AND

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

VERMONT

Agency of Human Services
Department of Vermont Health Access



804B

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 or Brain Injury Program participants.

Individual Name:______________________ DOB:__________ Last 4 SSN:__________

Facility Name:____________________ Provider #:____________ Phone:____________

A. Acute Hospital Admission/Discharges

☐ Admission to Hospital Date:____________ Hospital:______________________

☐ Re-admission from Hospital Date:______________

Total Number of Days in Hospital:____________ → ***WITH*** BED HOLD? ☐ YES ☐ NO

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:

☐ Medicare – Effective Date:______________

☐ Other Insurance - Effective Date:__________ Insurance Company Name:____________

☐ Private pay - Effective Date:________________

☐ Return to VT Medicaid Coverage (*Choices for Care or Brain Injury Program*):

Date:________________

Total Number of days at previous payment source:______________________________

☐ Medicare Co-Insurance Start Date:____________ through End Date:________________

C: Hospice

Hospice Start Date:______________ Hospice End Date:________________

Home Health Hospice Provider:____

LTC Patient Share Responsible Party Billing Contact:______________________________

Responsible Party Address & Phone:______________________________________

Comments *(if needed)*:____

____

Name of Person Completing Form (*print*):______________________ Signature: ________________

Agency:____ Date:________________

Email:____ Phone:________________

Send this form to: Department of Vermont Health Access
Application & Document Processing Center
280 State Drive, Waterbury, VT 05671-1500
Fax: 802-241-0514

Document Uploader:
VT Agency of Human Services Document Uploader

https://dvha.vermont.gov/members/vermont-medicaid-programs/medicaid/medicaid-aged-blind-or-disabled-mabd/instructions-0

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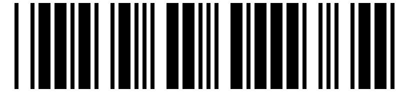
Department of Vermont Health Access



804C

Vermont Medicaid Only Short-term Rehab

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

Individual Name:______________________________DOB:_____________Last 4 SSN:____________

Facility Name:_______________________Provider #:________________Phone:_________________

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

Benefit covers nursing facility and hospital swing bed stay of no more than 30 days per episode (*Maximum od 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:_____________________________

Admission form: ☐ Hospital ☐ Home ☐ Other:____

Last date Medicaid coverage needed:__________________________

Reason for end of Medicaid coverage:

☐ Discharged Date:__________________ ☐ Deceased Date:__________________

☐ No longer meets coverage criteria ☐ Benefit maxed out *(Maximum of 60 days per calendar year)*

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

- Must apply for Choices for Care Long-Term Care Medicaid: https://dvha.vermont.gov/members/long-term-care.
- Must meet clinical and financial eligibility criteria.

Name of Person Completing Form (*print*):_____________________________ Signature: _________________________

Agency:____ Date:_________________________

Email:____ Phone:____________________________

Send this form to: Department of Vermont Health Access
Application & Document Processing Center
280 State Drive, Waterbury, VT 05671-1500
Fax: 802-241-0514

Document Uploader:
VT Agency of Human Services Document Uploader
https://dvha.vermont.gov/members/vermont-medicaid-programs/medicaid/medicaid-aged-blind-or-disabled-mabd/instructions-0

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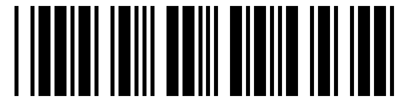
Department of Vermont Health Access


804D

Dual Medicare / Vermont Medicaid Short-Term Rehab

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

Individual Name:____________________________________DOB:____________Last 4 SSN:__________

Facility Name:________________________Provider #:________________Phone:___________________

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

- ☐ Follows Medicare standards, including 3-day qualifying hospital stay. Medicare standards found at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c08pdf.pdf
- ☐ Vermont Medicaid co-pay covers 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: https://dvha.vermont.gov/members/long-term-care
- ☐ 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:___________________________________

Last date Medicaid coverage needed:_____________________________

Reason for end of Medicaid coverage:

☐ Discharge Date:__________________ ☐ Deceased Date:_______________

☐ No longer meets coverage criteria ☐ Other:____

Name of Person Completing Form (*print*):______________________________ Signature: __________________________

Agency:____ Date:__________________________

Email:____ Phone:____________________________

Send this form to: Department of Vermont Health Access
Application & Document Processing Center
280 State Drive, Waterbury, VT 05671-1500
Fax: 802-241-0514

Document Uploader:
VT Agency of Human Services Document Uploader

https://dvha.vermont.gov/members/vermont-medicaid-programs/medicaid/medicaid-aged-blind-or-disabled-mabd/instructions-0