CFC 804B

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: _____ Phone: _____

A. Acute Hospital Admission/Discharges

☐Admission to Hospital date: _____ Hospital: _____
☐Re-admission from Hospital date: _____
Total # of days in hospital: _____With BED HOLD

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:_____
☐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): _____

Signature: _____ Date: _____

Copy to:
➢ **Department for Children and Families, ADPC, 280 State St. Waterbury, VT 05671-1500 or Fax: 802-241-0514**
and
➢ **Department of Vermont Health Access**
312 Hurricane Lane, Suite 201, Williston, VT 05495 **DO NOT SEND TO DAIL**
PHONE: (802) 879-5957 FAX: (802) 879-5959

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