

**Admission to Services & Change Report Form**

*Complete when **admitting** a CFC or Brain Injury program 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 Number: \_\_\_\_\_

**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: \_\_\_\_\_ ProviderID# \_\_\_\_\_
  - 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: \_\_\_\_\_
- Brain Injury Program Agency: \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Agency: \_\_\_\_\_ Provider ID#: \_\_\_\_\_

Send to: ADPC, 280 State Drive Waterbury, VT 05671-1500; Fax (802) 241-0514 **AND**  
DAIL: Local Nurse (SAMS or Email/Fax) CALL 802-241-0294 For Contact List

## 804 FORM: (ADMISSION TO SERVICES & CHANGE REPORT FORM)

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 (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*

**and**

#### **ADPC (Application and Document Processing Center):**

Fax (802) 241-0514

280 State Drive Waterbury, VT 05671-1500