

Vermont Department of Disabilities, Aging and Independent Living

**Home-Based Service Plan**

Participant Name: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

(Please Print)

\*Address: \_\_\_\_\_

(If mailing is different-write on back of form) (Street/Box)

(Town) (State) (zip)

Phone Number : \_\_\_\_\_

Initial Assessment  Reassessment  Change

Start Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-9 CODE: \_\_\_\_\_ ICD-10 \_\_\_\_\_

DAIL UR \_\_\_\_\_

Service (√ box)	Provider (write in provider name)	Hours of Service	Rates	Cost/Month
<input checked="" type="checkbox"/> <b>Case Management</b>	<input type="checkbox"/> AAA:	Up to: <b>48hrs/yr</b>	\$69.42/hr	\$277.68
	<input type="checkbox"/> Home Health:			
<input type="checkbox"/> <b>Personal Care</b>	<input type="checkbox"/> Home Health:	Up to: hrs/*2 weeks	\$27.70/hr.	
	<input type="checkbox"/> Consumer: Payroll Agent ARIS	Up to: hrs/*2 weeks	\$12.80/hr.	
	<input type="checkbox"/> Surrogate: Payroll Agent ARIS	Up to: hrs/*2 weeks	\$12.80/hr.	
<input type="checkbox"/> <b>Adult Day</b>	Provider:	Up to: hrs/*2 weeks	\$15.40/hr.	
<input type="checkbox"/> <b>Respite Care</b> Not to exceed <b>720 hrs/calendar year</b> (combined with Companion).	<input type="checkbox"/> Home Health:	Up to: hrs/year	\$22.12/hr.	
	<input type="checkbox"/> Consumer: Payroll Agent ARIS	Up to: hrs/year	\$12.24/hr.	
	<input type="checkbox"/> Surrogate: Payroll Agent ARIS	Up to: hrs/year	\$12.24/hr.	
	<input type="checkbox"/> Adult Day:	Up to: hrs/year	\$15.43/hr.	
	<input type="checkbox"/> Res. Care Home:	Up to: days /year	\$94.00/day	
<input type="checkbox"/> <b>Companion</b> <b>NOTE:</b> See respite above.	<input type="checkbox"/> Home Health:	Up to: hrs/year	\$22.12/hr.	
	<input type="checkbox"/> Senior Comp. Program	Up to: hrs/year	\$7.98/hr.	
	<input type="checkbox"/> Consumer: Payroll Agent ARIS	Up to: hrs/year	\$12.24/hr.	
	<input type="checkbox"/> Surrogate: Payroll Agent ARIS	Up to: hrs/year	\$12.24/hr.	
<input type="checkbox"/> <b>Personal Emergency Response</b>	<input type="checkbox"/> Installation/First Month:		Up to \$56.61 one-time	
	<input type="checkbox"/> Ongoing:		Up to \$30.89/month	
<input type="checkbox"/> <b>Assistive Device/Home Mod.</b>	Item/Service: ( <b>\$777 calendar year max /attach addendum</b> )		Total: \$	
<input type="checkbox"/> <b>ISO Employer Support Services</b>	Payroll Agent ARIS: For all Consumer and Surrogate Directed		\$54.00 mo.	

\*Multiply bi-weekly hours by the hourly rate, then by 2.15 to determine monthly cost.

**Total Monthly Cost:**

➔ Spouse paid by CFC for Personal Care?  No \*\*\*  Yes – (see back for more information)

*Check other Services below and include any applicable frequency*

<input type="checkbox"/> RN Skilled Nursing	<input type="checkbox"/> PT	<input type="checkbox"/> High Tech	<input type="checkbox"/> Hospice Admit Date:
<input type="checkbox"/> H.H. Aide (LNA)	<input type="checkbox"/> OT	<input type="checkbox"/> MFP Transition	

**Department of Disabilities, Aging and Independent Living Authorization/Official Use Only**

Services are authorized effective: Start Date: \_\_\_\_\_ through End Date: \_\_\_\_\_  
(A full reassessment must be completed prior to the end date in order for Waiver services to continue.)

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 Enhanced Residential Care or Nursing Home setting.

▶ \_\_\_\_\_ Date: \_\_\_\_\_  
**Signature of applicant/participant or legal representative**

\_\_\_\_\_  
Surrogate Name/Print (when applicable) Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

▶ \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Surrogate

▶ \_\_\_\_\_ Surrogate  
Address

\_\_\_\_\_  
Case Manager Name/Print Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

▶ \_\_\_\_\_ Date: \_\_\_\_\_  
Case Manager Signature

**NOTE: All Plans must be signed by applicant/participant or legal representative (Power of Attorney or legal guardian), CFC Case Manager, and Surrogate (when applicable) in order for services to be authorized.**

**Service Plan Changes:** Complete a new Service Plan and briefly describe the reason for change here.

**\*Mailing Address if different from physical:**

### Important Information

**Appeal Rights:** Decisions made by the Department may be appealed to the DAIL Commissioner or the Human Services Board. See attached letter for detailed appeal rights.

**Changes:** The individual or legal representative must report all changes in status to the case manager.

**Consumer/Surrogate Directed Services:** Contact ARIS at (800) 798-1658 to enroll certified employers and employees for consumer/surrogate waiver services. Refer to the Employer Handbook for more information.

**Patient Share:** Refer to the Department for Children and Families (DCF) Notice of Decision for patient share amount (if any) and for the agency that the patient share is to be paid each month.

**Provider Billing:** Providers must retain a copy of the current approved Service Plan as authorization to bill for services. Providers may only bill for services provided within the limits indicated on the Service Plan.

**Reassessments:** Annual reassessments will start on the date after the previous Service Plan ends.

**Service Plan Changes:** Approved service changes (except consumer/surrogate directed services) will start no earlier than the date the Service Plan is received at the DAIL regional office. Consumer and surrogate directed service changes will start on the next full payroll period after the Service Plan is received at the DAIL regional office.

**\*\*\*Spouse as Paid Caregiver:** If the individual's spouse is approved to be a paid caregiver through Choices for Care, they may only be paid to provider assistance with Activities of Daily Living (ADL). They may not be paid for IADL's including meal preparation, medication management or companion/respite time.

Forms are available online at: <http://www.ddas.vermont.gov/ddas-forms>