Vermont Department of Disabilities, Aging and Independent Living

Choices for Care - Enhanced Residential Care Service Plan

Participant Name:_______________________________ Soc. Sec. #_____-_____-_____
(Please Print)

Initial Assessment Reassessment Change

Address:_______________________________
(Street)

Start Date: _______________________

____
(Town) (Zip Code)

Date of Birth: _______________________

Phone Number: _______________________

Diagnosis: _______________________

ICD-10 CODE: _______________________

DAIL UR__________

Service	**Provider** (Write in provider name)	**Hours of Service**	**Rates** **(check one)**	**Cost per Month**
☒ **Enhanced Residential Care**	ERC Provider Name:	24 hrs./day 7 days/wk.	**TIER 1** ☐ $54.90/day **RCH** ☐ $60.74/day **ALR**	$1663.47/RCH $1840.42/ALR
		24 hrs./day 7 days/wk.	**TIER 2** ☐ $62.49/day **RCH** ☐ $68.31/day **ALR**	$1893.45/RCH $2069.79/ALR
		24 hrs./day 7 days/wk.	**TIER 3** ☐ $70.08/day **RCH** ☐ $75.92/day **ALR**	$2123.42/RCH $2300.38/ALR

Services not funded by Choices for Care – Formal Services (indicate funding source)

Services	**Service Provider**	**Funding Source**	**Frequency**	**Cost per Month**
☒ ACCS	$42.25/day	MEDICAID	DAILY	$1280.18
☒ Room & Board		SELF	MONTHLY	
☐ Hospice				
☐ Skilled Services				

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 ERC services to continue)

_______________________________ _______________
DAIL Authorized Signature Date

CONSENT TO PLAN OF CARE

The ERC Provider certifies that the service plan was developed with the participant /applicant or their legal representative and all parties fully understand the terms of the proposed plan and consent to the terms of the plan. The participant /applicant or their legal representative accept it as an alternative to the Home-Based or Nursing Home setting

❑ **Yes**

____ Date: ____________________
ERC Provider Signature

Service Plan Changes: Complete a new Service Plan and briefly describe the reason for change. (Attach supporting information.)

Important Information

Appeal Rights: See attached letter if services were reduced or denied by DAIL.

Changes: The individual or legal representative must report all changes in status to the ERC provider.

Patient Share: Refer to the Department of Vermont Health Access (DVHA) Notice of Decision for patient share amount (if any) and for the provider 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 Plan changes will start no earlier than the date the Service Plan is received at the DAIL regional office.

__Level of Care Variances for ERC:__ A request for a variance from section 5.1.a of the VT RCH Licensing Regulations to retain or admit a resident whose needs exceed that for which the home is licensed to provide must be made to the VT Division of Licensing and Protection (DLP). This must be done for all residents being admitted or retained who meet nursing home level of care to receive ERC services. See page 7 section III. Variances in the VT RCH Licensing Regulations for details of how to make the request. http://www.dlp.vermont.gov/ ***For new CFC/ERC participants, the start date for ERC services will be the date the Level of Care Variance is approved.