Choices for Care
Flexible Choices Allowance

CFC 836 June 2020

Participant Information

Name: _____
Last *First* *MI*

Mailing Address: _____
Street/RFD/Box *City/Town* *State* *Zip*

Physical Address: _____
Street *City/Town* *State* *Zip*

Phone: _____ Email Address: _____

SS#_____ DOB_____ ICD-10 Code_____

Guardian/Surrogate Information ☐ Guardian ☐ Surrogate

Name: _____
Last *First* *MI*

Address: _____
Street/P.O. Box *City/Town* *State* *Zip*

Phone: _____ Email Address: _____

Allowance Calculation ☐ Initial Assessment ☐ Reassessment ☐ Change

Personal Care (per 2weeks) _____ X2.15 = Monthly Hours _____X $13.08 = Monthly Value $_____
(Round to nearest .25)

Adult Day (per 2weeks) _____X 2.15 = Monthly Hours _____ X 16.72 = Monthly Value $ _____
(Round to nearest .25)

Monthly Base Rate *$* 1,267.45

CALCULATION: Monthly Personal Care **Value** +
Monthly Adult Day **Value** +Monthly Base Rate = Monthly Allocation

***Total** (per month) $*_____

Spouse

Will the Spouse be a paid caregiver ☐YES ☐ NO
If "Yes", will the spouse be the sole Flexible Choices funded caregiver? ☐ YES ☐ NO

Signatures

Participant: _____ _____
Name – Print *Signature*

Consultant: _____ _____
Name – Print *Signature*

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

Allowance authorized effective Start Date: _____ through End Date: _____

_____ _____
DAIL Authorized Signature DATE

Instructions:

1. Consultant completes the identifying information for the participant and, if appropriate, their surrogate or guardian and notes whether this allowance request results from an initial assessment (all new participants in Flexible Choices are considered "initial"), a reassessment or a change.

2. Consultant completes the allowance calculation section using the following formulas:

    a. *Personal Care:* The number of hours per two weeks of personal care from the personal care worksheet built from the ILA assessment multiplied by the hourly wage rate (including employer taxes).
    b. *Adult Day:* The number of hours per two weeks of Adult Day services multiplied by the current Choices for Care Adult Day Medicaid rate. (Note: these dollars can only be spent on Adult Day services or for personal care hours when the participant was scheduled for Adult Day but was not able to attend.)
    c. *Base Rate:* This rate is set by DAIL and represents the value of all Choices for Care services other than Personal Care and Adult Day pro -rated to two week increments.
    d. *Totals:* The three areas are totaled for a two-week allowance figure. This will be the figure upon which budget planning will occur. This two-week figure is converted into a monthly figure by multiplying the two-week figure by 2.15. If approved by the LTCCC (see number 6), this monthly figure will be the participants "Approved Allowance."

3. The consultant and participant/surrogate sign the form showing their agreement with the total allowance figure.

4. The consultant forwards the completed form to the regional Long Term Care Clinical Coordinator along with a copy of the most recent ILA and Personal Care Worksheet.

5. Upon approving the allowance amount, the LTCCC:
    a. keeps the original for his/her files
    b. sends a copy to the consultant at: Transition II
       346 Shelburne Road
       Burlington, VT 05401
       Fax: (802) 846-7282
    c. sends a copy to the participant/surrogate.