VERMONT
DEPT. OF DISABILITIES, AGING & INDEPENDENT LIVING

Choices for Care – Moderate Needs Program

CFC/MOD 903
Service Request

Participant Name: _____ Last 4 of SSN or DOB: _____

Check One: ☐ New Applicant ☐ Annual Review ☐ Service Change ☐ Reinstatement

Waitlist Applicant: ☐ Yes ☐ No ICD-10 Code: _____ Service Start Date: _____

Case Management Agency has confirmed funding with each Provider for the following services:

Service	Provider or Agency Name	Amount
☐ Case Management (revenue code 070)	_____	Up to 24 hours per calendar year
☐ Flexible Funding (revenue code 071)	Case Management Agency	Up to $ _____ per year
☐ Adult Day Services (revenue code 096)	_____	Up to _____ hours per week
☐ Adult Day Non-Medicaid Transportation (revenue code 071)	Adult Day Provider	Up to $ _____ per week
☐ Homemaker (revenue code 095)	_____	Up to _____ hours per week

Participants must contact their Case Manager regarding changes.

CONSENT TO PLAN OF CARE

☐ The Moderate Needs Case Manager certifies that the service plan was developed with the participant/applicant or their legal representative. All parties fully understand the terms of the proposed plan and consent to the terms of the plan.

_____ _____ _____
Authorized MNG Case Manger (Print) **Agency** **Phone #**

_____ _____
Authorized MNG Case Manager Signature **Date**

Case Manager must submit annual review 30 days prior to service end date.

For DAIL USE Only - DAIL Review and Authorization

Authorization Start Date: _____ to End Date: _____

DAIL Signature: _____ Date: _____