

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: _____

Information may be gathered from current assessment (ILA) or directly from the individual, legal representative or provider(s).

Applicant Name: _____

SECTION 1 Pre-Eligibility Screening

- 1) Is the applicant a Vermont resident **and** age 18 or over? Yes No
IF NO ,STOP – Not Eligible
- 2) Can the needs of the individual be adequately met by services available through other sources (including but not limited to trusts, contracts for care, private insurance, Medicare, Community Medicaid, VA, VHAP, etc.)? Yes No
IF YES, STOP - Not Eligible

SECTION 2 Eligibility

- 1) Does the individual require supervision or any physical assistance three (3) or more times in seven (7) days with any single, or combination of, ADL's or IADL's?
Yes – Eligible No - Continue
- 2) Does the individual have impaired judgment or decision-making skills that require general supervision on a daily basis?
Yes – Eligible No - Continue
- 3) Does the individual require at least monthly monitoring for a chronic health condition?
Yes – Eligible No - Continue

Describe: _____

- 4) Will the individual's health condition worsen if services (adult day, homemaker) are not provided or if services are discontinued?

Yes – Eligible No – Not Eligible

Describe need: _____

Additional Comments: _____

Case Manager Signature: _____ Date: _____

Individual Name: _____ Date: _____

A. Monthly Gross Income

	Individual	Spouse
Social Security	\$	\$
SSI	\$	\$
Retirement/Pension	\$	\$
Interest	\$	\$
VA Benefits	\$	\$
Wages/Salaries/Earnings	\$	\$
Other (i.e. rental income)	\$	\$
Subtotal:	\$	\$
A. Total Monthly Gross Income:	\$	

B. *Asset Adjustment: (Include only "liquid" assets that are easily convertible into cash.)

	Individual	Spouse
Cash:	\$	\$
Savings:	\$	\$
Checking:	\$	\$
CD's:	\$	\$
Money Market:	\$	\$
Stocks/Bonds:	\$	\$
trusts:	\$	\$
Other:	\$	\$
Subtotal:	\$	\$
Total Combined Assets:	\$	
subtract \$10,000 asset disregard:	- 10,000	
divide by 12:	/12	
B. Asset Adjustment:	\$	

C. Monthly Medical Expenses (Divide one-time bills by 12.)

	Individual	Spouse
Prescriptions:	\$	\$
Over-the-counter medications:	\$	\$
Physician Bills:	\$	\$
Hospital Bills:	\$	\$
Health Ins Premiums (Medicare/BCBS, etc):	\$	\$
Therapy (OT/PT/ST):	\$	\$
Medical Equipment and Supplies:	\$	\$
Other (explain):	\$	\$
Subtotal:	\$	\$
C. Total Monthly Medical Expenses:	\$	

D. Adjusted Monthly Income

A. Total Monthly Gross Income (above): \$

plus (+)

B. Asset Adjustment (above): \$

minus (-)

C. Monthly Medical Expenses (above): \$

D.*Adjusted Monthly Income \$

***Financially eligible if "Adjusted Monthly Income" is at or below 300% SSI rate (2020).**

Individual = \$ 2,505.12 Couple = \$ 3,821.64

Name of person completing form: _____

Send with complete packet to: DAIL, Moderate Needs Program