VERMONT
DEPT. OF DISABILITIES, AGING & INDEPENDENT LIVING

Choices for Care – Moderate Needs Program

CFC/MOD 900
Application

The Moderate Need Program is for adult Vermonters who may not meet nursing home level of care but require some services to assist them to remain independent in their home, preventing a more intense level of service. Eligible applicants are Vermont residents, 18 years or older, and have a functional limitation related to a physical condition or associated with aging. **Completed applications can be faxed to Age Well at (802-865-0363) or mailed to: Age Well, 875 Roosevelt HWY, Suite 210, Colchester, VT. 05446.**

Information

Name: _____ ☐ Male ☐ Female
Last **First** **Middle Initial**

Mailing Address: _____ Phone: _____
Street/PO Box **City** **State** **Zip Code**

SSN#: _____ Date of Birth: _____ Medicaid: ☐ Yes ☐ No Medicaid#: _____

Moderate Needs Services (check all services being requested) **Moderate Needs services are limited to available funding.**

☐ Adult Day Services ☐ Home Maker ☐ Flexible funding for: _____

Agreement of Terms and Conditions

In this application form, the applicant/legal representative agrees to the following statements:

- I understand that I must meet all eligibility criteria to be eligible for Moderate Needs services.
- I understand that if funding or services are not available, I will be notified by the Case Management Agency and my name may be placed on a waiting list.
- I understand the amount of services authorized are based on my assessed needs, and a person-centered plan
- I understand that homemaker services are limited up to but no more than 6 hours/week.
- I understand that adult day services are limited up to but no more than 50 hours/week.
- I understand that flexible funding is limited to available funds.
- I agree to provide information to the people who will determine my eligibility and provide services.
- I give permission for the case management agency and the Department of Disabilities, Aging and Independent Living staff to contact my legal representative (if applicable), and providers I am currently involved with in order to determine eligibility and services
- I understand that if found ineligible for Moderate Needs services, I will be informed of my appeal rights.
- I understand if found eligible, I will contact my case manager to report changes in my contact information and all changes that may affect my eligibility for services.
- I understand that each provider of service has a complaint process. I may contact the case management agency or DAIL for assistance in resolving complaints.
- To the best of my knowledge, the information on this application is correct.

Applicant / Legal Representative Signature: _____ Date: _____

For more resources or contact information call 211 or the Help Line at (800) 642-5119