DEPT. OF DISABILITIES, AGING & INDEPENDENT LIVING	- A second se			Service Request	
Participant Nam	าe:			Last 4 of SSN or DO	B:
Check One:	New Applica	int	Annual Review	Service Change	Reinstatement
Waitlist Applica	nt: 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 or Flex Funds (revenue code 071)		Up to \$ Transportation/week Up to \$ Flex Funds/year
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 terms of the plan.

Authorized MNG Case Manager (Print)

Agency

Date

Phone Number

Authorized MNG Case Manager Signature

## 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: \_\_\_\_\_



# **Choices for Care – Moderate Needs Program**

Individual Name:

<i>r</i> idual 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:	\$	

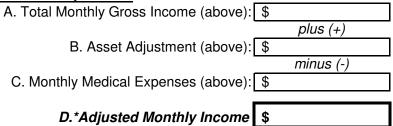
**<u>B.</u>** \*Asset Adjustment: (Include only "liquid" assets that are easily convertible into cash.)

	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



\*Financially eligible if "Adjusted Monthly Income" is at or below 300% SSI rate (2023). Individual = **\$ 2,898.12** Couple = \$4,409.64

Name of person completing form: \_\_\_\_\_

Send with complete packet to: DAIL, Moderate Needs Program