VT Choices for Care & Brain Injury Program
804 Change Report Form Process

This document is intended to provide you with instructions for reporting changes in care settings/services for individuals who are **pending** Long Term Care (LTC) Medicaid eligibility or have LTC Medicaid in place. *The instructions will indicate **which** 804 form must be completed, **who** completes the form, **how** it must be completed and **where** it needs to be submitted*.

It is the responsibility of the admitting provider of service to submit the appropriate 804 form. The 804 forms are what notifies the Department of Disabilities, Aging and Independent Living (DAIL) and the Department of VT Health Access (DVHA) that the provider of services will start providing services, if there is a change in the service or a termination of services.

If the appropriate 804 form is not submitted to the correct agency promptly, this will affect the payment to the provider of services. See table below for information on how to find the forms, and where to submit each form.

Form#	DAIL	ADPC	Where can I find the form?
804	☑	☑	SAMS or: https://asd.vermont.gov/resources/forms
804A	☑	☑	SAMS or: https://asd.vermont.gov/resources/forms
804B		☑	http://www.vtmedicaid.com/#/forms
804C		☑	https://asd.vermont.gov/resources/forms
804D		☑	https://asd.vermont.gov/resources/forms

Send all completed forms when indicated:

DAIL (Disabilities, Aging and Independent Living) LTCCC Nurse:
To request a contact list, call DAIL-Adult Services Division (802) 241-0294
SAMS Users: Send SAMS Alert to LTCCC Nurse when form is completed

DVHA – Long Term Care Medicaid or
DCF – Economic Services Division by Mail or Fax to the following:
ADPC (Application and Document Processing Center):
280 State Drive Waterbury, VT 05671-1500
Fax (802) 241-0514

Admission to Services & Change Report Form

*Complete when **admitting** a CFC or Brain Injury program applicant pending Medicaid or an active program participant. Complete this form for an address change or change in Legal Guardian.*

Individual Name: _____ DOB: _____ SSN: _____

Address change: _____

Legal Guardian change: _____ Legal Guardian Phone Number: _____

A. Previous Setting

- ☐ Home-Based (CFC Traditional)
- ☐ Flexible Choices
- ☐ Adult Family Care
- ☐ Brain Injury Program Home Based
- ☐ Enhanced Residential Care
- ☐ Nursing Facility
- ☐ Hospital Swing Bed
- ☐ Brain Injury Program Shared Living

B. Admission *(Check the service option and write in the name of the service provider)*

Date: _____

- ☐ Home-Based (Traditional)
  - ☐ ARIS _____ Provider ID # _____
  - ☐ Home Health Agency: _____ Provider ID # _____
  - ☐ Brain Injury Program Agency: _____ Provider ID# _____
- ☐ Flexible Choices, Transition II
- ☐ Adult Family Care
  Authorized Agency: _____ Provider ID # _____
- ☐ Enhanced Residential Care: _____ Provider ID # _____
- ☐ Nursing Facility: _____ ProviderID# _____
  - ☐ Long Term Stay ☐ Short Term Stay
- ☐ Hospital Swing Bed: _____ Provider ID # _____

C. Case Management Agency *(For Home Based or Flexible Choices only)*

- ☐ Area Agency on Aging: _____
- ☐ Home Health Agency: _____
- ☐ Brain Injury Program Agency: _____

Completed by: _____ Date: _____

Phone: _____ Email: _____

Agency: _____ Provider ID#: _____

Send to: ADPC, 280 State Drive Waterbury, VT 05671-1500; Fax (802) 241-0514 **AND**
DAIL: Local Nurse (SAMS or Email/Fax) CALL 802-241-0294 For Contact List

804 FORM: (ADMISSION TO SERVICES & CHANGE REPORT FORM)

The 804 form is completed by the provider "admitting" a program participant to their service. The Long Panel for long term care will be changed in the ACCESS system to reflect the **admitting provider name**. *If your provider name <u>is not</u> in the system as the current provider of service, then* ***<u>you will not be paid when a</u> <u>claim is submitted</u>****.*
Please note: For *traditional home-based services* the Long Panel must reflect the name of the "Highest Paid Provider". This is usually the Home Health Agency, Adult Day Provider, ARIS Solutions or the Authorized Agency for Adult Family Care or Brain Injury Program provider.

<u>When this form is used:</u>

- ❖ To report changes in care setting option for CFC applicants who are still pending LTC Medicaid or to report changes in care setting for active CFC Participants
- ❖ To report a change of address
- ❖ To report a change of Legal Guardian

<u>Who completes this form:</u>

- Choices for Care Case manager (AAA & HHA)
- Flexible Choices Advisor (Transition II)
- Authorized Agency (AA) for Adult Family Care
- Enhanced Residential Care (ERC) Provider
- Nursing Home
- Hospital Social Worker
- Brain Injury Program Case Manager/Provider Agency

<u>How to complete the 804 form:</u>

1. Complete the Individual's name, Address, SS# or MID, Date of Birth and Legal Guardian (if changing)
2. Previous setting: Check the box of the individual's previous setting (if there is a change in care setting option)
3. Admission
    a. Fill in the Admission Date
    b. Check the admission service options and
    c. Fill in the name of the provider of services and Provider ID #
4. Case Management Agency (for Home Based and Flexible Choices only)
    a. Check one of the Case Management boxes
    b. Fill in the Provider name
5. Fill in the name of the Person filling out the 804 form and contact information

<u>Where to submit the 804 form:</u>

DAIL (Disabilities, Aging and Independent Living) LTCCC Nurse:
To request a contact list, call DAIL-Adult Services Division (802) 241-0294
SAMS Users: Send SAMS Alert to LTCCC Nurse when form is completed

and

ADPC (Application and Document Processing Center):
Fax (802) 241-0514
280 State Drive Waterbury, VT 05671-1500

DAIL- Adult Services Division

Termination of Services Form (CFC 804A)

*Completed by provider reporting the **termination** of CFC or Brain Injury Program services.*

Individual Name: _____

Address *(only if changed)*: _____

DOB: _____ SSN: _____

Current Setting

- ☐ Home-Based (Traditional)
- ☐ Flexible Choices
- ☐ Nursing Home
- ☐ Brain Injury Program Home Based
- ☐ Enhanced Residential Care
- ☐ Adult Family Care
- ☐ Hospital Swing Bed
- ☐ Brain Injury Program Shared Living

Termination Date: _____

- ☐ Died
- ☐ Permanent move out of State
- ☐ Brain Injury Program -Graduation
- ☐ Other: _____
- ☐ Voluntary Withdrawal *(A notice with appeal rights will be provided if signature of Participant or Authorized representative is not included)*

I agree that I am voluntarily withdrawing from Choices for Care or the Brain Injury Program. I understand that I may reapply at any time.

_____ Date: _____

Signature of Participant or Authorized Representative

Completed by: _____ Date: _____

Email: _____ Phone: _____

Agency: _____ Provider ID#: _____

Send to:
- ☐ ADPC, 280 State Drive Waterbury, VT 05671-1500; Fax (802) 241-0514 **AND**
- ☐ DAIL: Local Nurse (SAMS or Email / Fax) CALL 802-241-0294 For Contact List **AND**
- ☐ ARIS: *Only For home based consumer/surrogate directed, or Flexible Choices*

804A FORM: TERMINATION OF SERVICES

This form is used to report **termination** of CFC or Brain Injury Program (BIP) services for active CFC or BIP participants receiving Home-Based, ERC, Adult Family Care, Brain Injury Program shared living, Flexible Choices, Hospital Swing Bed or Nursing Facility services. If an individual terminates services or voluntarily withdraws from CFC or BIP services, it is the responsibility of the current provider of services to notify the ADPC and the DAIL Nurse.

When this form is used:

- To report termination of CFC or BIP services for active CFC or BIP participants receiving Traditional Home- Based, ERC, Hospital Swing Bed, Nursing Facility Services, Adult Family Care, BIP Shared Living or Flexible Choices

Who completes this form:

- Choices for Care Case manager (AAA & HHA)
- Flexible Choices Advisor
- Authorized Agency (AA) for Adult Family Care
- Enhanced Residential Care (ERC) Provider
- Nursing Home
- Hospital Social Worker
- Brain Injury Program Case Manager/Provider Agency

How to complete the 804A form:

1. Complete the Individual's name, Address, SS# or MID, Date of Birth
2. Current Setting: Check the box of where the individual is currently receiving services
3. Termination:
    a. Fill in the effective Date of Termination of services
    b. Check the box for the reason for the termination of services
    c. Check the Voluntary Withdrawal box if the individual is withdrawing services by their choice
    d. The individual must sign the form if Voluntarily withdrawing
4. Fill in the name of the Person filling out the 804 A form and contact information

Where to submit the 804A form:

DAIL (Disabilities, Aging and Independent Living) LTCCC Nurse:
To request a contact list, call DAIL-Adult Services Division (802) 241-0294
SAMS Users: Send SAMS Alert to LTCCC Nurse when form is completed

and

ADPC (Application and Document Processing Center):
Fax (802) 241-0514
280 State Drive Waterbury, VT 05671-1500

CFC 804B

Choices for Care

Nursing Facility/Hospital Swing Bed

Acute Hospital Stay and Change of Payment Report Form

Complete all sections that apply for active and pending Choices for Care participants.

Individual Name:_____ Date of Birth: _____

SSN:_____

Facility Name/Provider #:_____ Phone: _____

A. Acute Hospital Admission/Discharges

☐ Admission to Hospital date:_____ Hospital:_____
☐ Re-admission from Hospital date: _____
Total # of days in hospital: _____ ***With*** BED HOLD ☐ YES ☐ NO

Payment source upon re-admission to facility:
☐ Medicare, ☐ VT Medicaid, ☐ Private Insurance:_____, ☐ Other: _____

B. Change in Payment Source

☐ Change from VT Medicaid coverage to the following payment source:
- ☐ MEDICARE effective date _____
- ☐ Other insurance effective date_____/ Insurance:_____
- ☐ Private pay effective date _____

☐ Return to VT Medicaid coverage (Choices for Care or Brain Injury Program) date: _____ Total # of days at previous payment source _____

☐ MEDICARE Co-insurance start date:_____ through end date: _____

C. Hospice

Hospice Start Date: _____
Home Health Hospice Provider: _____
LTC Patient Share Responsible Party Billing Contact: _____
Responsible Party Address and Phone #: _____

Comments (if needed):

Person Completing Form (print): _____

Signature:_____ Date: _____

Send a Copy to:

- DVHA – Long Term Care Medicaid or
  DCF – Economic Services Division by Mail or
  Fax to the following:
  ADPC (Application and Document Processing Center):
  280 State Drive Waterbury, VT 05671-1500
  Fax (802) 241-0514

804B FORM: HOSPITAL & NURSING FACILITY ADMISSIONS/DISCHARGES

This form is used by Hospitals and Nursing Facilities to report *Acute hospital* admissions and discharges. This form is also used to *report a change in payment source* and *Hospice admission.*

When this form is used:

- To report Acute Hospital admissions and discharges
- To report a change in payment source
- To report Hospice admissions

Where form is found:
http://vtmedicaid.com/#/forms

Who completes this form:

- Nursing Home
- Hospital Social Worker

How to complete the 804B form:

1. Complete the Individual's name, SS# or MID, Date of Birth, Facility Name and Phone
2. Acute Hospital Admissions/Discharge
    a. Check the appropriate box for
        i. Admission to Hospital, Hospital Name
        ii. Bed Hold – if appropriate
        iii. Facility Admission to Nursing Home from the hospital
        iv. Fill in admission/re-admission date
        v. Payment Source upon re-admission to the facility
3. Change in Payment Source
    a. Check the appropriate box for:
        i. Medicare Co-insurance Start Date and End Date
        ii. Return to VT Medicaid Coverage (Choices for Care) with the start date and indicate total # of days covered by previous payor
        iii. Change from VT Medicaid to a different payment source - indicate new payment source with the effective date and name if commercial insurance carrier
4. Hospice – complete all fields
5. Fill in the name of the Person completing this form with signature and date

Where to submit the 804B form:

ADPC (Application and Document Processing Center):
Fax (802) 241-0514
280 State Drive Waterbury, VT 05671-1500

Short-Term *Medicaid Only* Rehab Form

*Complete this form if the individual is **active** Vermont Medicaid and is **not** covered by other insurance and is not active in Choices for Care*

Individual Name: _____

DOB: _____ SSN: _____

Facility: _____ Provider ID#: _____

Phone: _____

A. **Vermont *Medicaid Only* Rehab** (*If stay is covered all or in part by Medicare, use form **804D**)*

- ☐ Follows the Department of Vermont Health Access (DVHA) Operating Procedures, *Medicaid Nursing Facility Short Stays*.
- ☐ Benefit covers nursing facility and hospital swing bed stay of no more than 30 days per episode (maximum of 60 days per calendar year).

B. **Admission** *(Submit completed form within **10 days** from the release date)*

Admission date to nursing facility or hospital swing bed: _____

Requested Medicaid start date: _____

Admitted from:

- ☐ Hospital
- ☐ Home
- ☐ Other: _____

Last date Medicaid coverage needed: _____

Reason for Medicaid end:

- ☐ Discharged
- ☐ Deceased
- ☐ No longer meets coverage criteria
- ☐ Benefit maxed-out

C. **Long-Term Care** *(Coverage for stay of 31 days or more)*

- ☐ Must apply for Choices for Care Long-Term Care Medicaid
  http://www.greenmountaincare.org/long-term-care-medicaid
- ☐ Must meet clinical and financial eligibility criteria.

Completed by: _____ Date: _____

Email: _____ Agency: _____

Phone: _____

Send to: ☐ ADPC, 280 State Drive Waterbury, VT 05671-1500 Fax (802) 241-0514

804C FORM: SHORT TERM VT *MEDICAID ONLY* REHAB STAYS

This form is used by Skilled Nursing Facilities and Hospitals that have Swing Bed status. This form is used to report Short Term *Medicaid Only* Rehabilitation Stays. Please use this form if the beneficiary currently has active Medicaid. The VT Medicaid Rehab benefit covers stays less than 30 days per episode/60 days per calendar year following the Department of VT Health Access (DVHA) Operating Procedures, *Medicaid Nursing Facility Short Stays*. **If Medicare is covering part of the stay, use form 804D.**

When this form is used:

- Short Term Medicaid Only Rehabilitation Stays

Who completes this form:

1. Nursing Home
2. Hospital Social Worker

How to complete the 804C form:

1. Complete the Individual's name, Address, SS# or MID, Date of Birth
2. Admission**:**
    a. Complete this form within 10 days after the coverage was needed
    b. Fill in the Admission Date
    c. Fill in Requested Start Date of Medicaid Coverage
    d. Check the box to indicate where the beneficiary was admitted from
    e. Fill in the last date that Medicaid coverage was needed
    f. Check the reason for no longer needing Medicaid coverage
3. Provide the Name of the Nursing Facility/Hospital and Person Completing the form

Where to submit the 804C form:

ADPC (Application and Document Processing Center):
Fax (802) 241-0514
280 State Drive Waterbury, VT 05671-1500

Dual Medicare / Vermont Medicaid Short-Term Rehab Form

*Complete this form if the individual is **active** Medicare **and** Vermont Medicaid. Do not complete if individual is active on Choices for Care*

Individual Name: _____

DOB: _____ SSN: _____

Facility: _____ Provider ID#: _____

Phone: _____

A. Dual Medicare / Vermont Medicaid Rehab *(If stay is **not** covered by Medicare, use form **804 or 804C**)*

- ☐ Follows Medicare standards, including 3-day qualifying hospital stay. Medicare standards found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf
- ☐ Vermont Medicaid co-pay covers days 21 – 100 of the Medicare stay.
- ☐ Medicare is ***always*** the primary payor for individuals with both Medicare and Medicaid.
- ☐ Private long-term care insurance must be billed prior to Vermont Medicaid.

B. Long-Term Care *(Coverage for stay exceeding Medicare co-insurance – 100 days)*

- ☐ Must apply for Choices for Care Long-Term Care Medicaid http://www.greenmountaincare.org/long-term-care-medicaid
- ☐ Must meet clinical and financial eligibility criteria.

C. Admission *(Submit completed form within **10 days** of Medicare/Medicaid end date)*

Admission date to nursing facility or hospital swing bed: _____

Requested Medicaid co-pay start date: _____

Estimated length of stay, _____ days.

Date discharged or last date Medicaid coverage needed: _____

Reason for end of Medicaid coverage:

- ☐ Discharged
- ☐ No longer meets coverage criteria
- ☐ Deceased
- ☐ Other: _____

Completed by: _____ Date: _____

Email: _____ Agency: _____

Phone: _____

Send to: ☐ ADPC, 280 State Drive Waterbury, VT 05671-1500; Fax (802) 241-0514

804D FORM: VT *MEDICAID/MEDICARE* STAYS

This form is used by Skilled Nursing Facilities and Hospitals that have Swing Bed status. This form is used to report dual Medicare/Medicaid Rehabilitation Stays. Please use this form if the beneficiary currently has an active Medicare/Medicaid eligibility and is in need of short-term coverage. Medicare is always the primary payor for individuals with both Medicare and Medicaid. VT Medicaid co-insurance coverage is day 21 to day 100 of the Medicare stay, following all Medicare standards, including a qualifying 3 – day hospital stay. Other private insurance must be billed prior to VT Medicaid. **If the beneficiary does not have Medicare, use form 804C.**

When this form is used:

- To report dual Medicaid/Medicare Rehabilitation Stays
- Beneficiary has Active Medicare/Medicaid eligibility and needs short term coverage

Who completes this form:

1. Nursing Home
2. Hospital Social Worker

How to complete the 804D form:

1. Complete the Individual's name, Address, SS# or MID, Date of Birth
2. Provide the Name of the Nursing Facility/Hospital and Person Completing the form
3. Complete Section C of this form within 10 days of the need for Medicaid to pay the Medicare co-payment and within 10 days after the end of coverage for both Medicare/Medicaid.
    a. Fill in the Admission Date,
    b. Requested Start Date of Medicaid co-insurance
    c. Check the box where the beneficiary was admitted from
    d. Fill in the last date that Medicaid coverage was needed
    e. Check the reason for no longer needing Medicaid coverage

Where to submit the 804D form:

ADPC (Application and Document Processing Center):
Fax (802) 241-0514
280 State Drive Waterbury, VT 05671-1500