INSTRUCTIONS FOR COMPLETING THE VERMONT DAY HEALTH REHABILITATION SERVICES PRIOR AUTHORIZATION FORM

INTRODUCTION

Day Health Rehabilitation Services (DHRS) are provided to people with physical or cognitive impairments who are not residing in a nursing home, nor receiving enhanced residential care services or other similar services. DHRS are intended to maintain optimal functioning and prevent or delay the need for the level of services provided in a nursing facility. The services provided at a Day Health Rehabilitation Center are health assessment and screening, health monitoring and education, nursing, personal care, physical therapy, occupational therapy, speech therapy, social work, and nutrition counseling/services. The services provided to each participant must reflect his or her assessment and must be in accordance with the individual's assessment and plan of care. Services must be provided under the supervision of a registered nurse.

ELIGIBILITY CRITERIA

In order to be eligible for Medicaid reimbursement of DHR services, participants must require at least two of the following services: personal care, nursing services, special therapies, social work and nutrition counseling and services. They must receive both of the services at least weekly and must receive at least one of the services on any given day while attending the Day Health Rehabilitation Center. The maximum number of DHRS hours that any individual may receive is fifty (50) hours per week.

PROCEDURE FOR PRIOR AUTHORIZATION

The DHR Center must complete, or obtain from a qualified assessor, the Vermont Independent Living Assessment (ILA). The DHR Center must then complete a DHRS application based on the assessment data from the ILA and other information collected during the assessment process. In order to be eligible for Medicaid reimbursement of DHR services, beneficiaries must require services in at least two of the following service areas: personal care, nursing services, special therapies, social work and nutrition counseling and services. If the application documents that the applicant requires and shall be receiving services in at least two of the five broad service areas each week, with at least one on any given day at the DRH center, they shall be deemed to be pre-authorized by the Department of Disabilities, Aging and Independent Living. This application shall be kept in the participant's file.

INSTRUCTIONS FOR COMPLETING THE VT DHRS PRIOR AUTHORIZATION FORM

I. Participant Information

Participant Name: Enter the name of the person for which reimbursement is being sought (last, first, middle initial).

New / Renewal: Indicate if the authorization is for a new participant or a renewal for a current participant.

Date: Enter the date that the form was completed.

Mailing Address: Enter the beneficiary's full mailing address (street, apt. no., P.O. Box).

Telephone: Enter the beneficiary's residential telephone number.

DAIL Client Identification Number: Enter the DAIL client identification number, also referred to as the *unique client identification number*, as it appears on the ILA.

Date of ILA: Enter the date that the ILA was completed. ***ILA's that are outdated or over one year old may not be used for determination of eligibility for DHRS.***

Physician: Enter the name of the beneficiary's primary physician.

Name of Day Health Rehabilitation Center: Enter the name of the Day Health Rehabilitation Center.

Name of contact person: Enter the name of the person at the DHR Center who will be available to answer questions on the DHRS Eligibility Form.

Telephone: Enter the telephone number for the DHR Center.

VT State Resident: Indicate whether or not the applicant is a VT State Resident.

Medicaid Id. No.: Enter the ***participant's*** Medicaid Identification Number.

EDS Verified: Indicate DHRS center has confirmed through the EDS eligibility system that the participant is eligible for Medicaid.

No. Days/Wk: Enter the proposed days per week that the beneficiary will receive DHRS.

No. Hrs. / Wk: Enter the planned hours per week that the beneficiary will receive DHRS.

Proposed DHRS Start Date: Enter the date planned start date of DHRS. For a renewal, enter the day after the previous Notice of Decision expires.

Does the participant live in a residential care home? Indicate if the participant lives in a residential care home. If they do, enter the name of the home. Residents in residential care whose care if paid for through Medicaid may are not eligible for DHRS funding.

It is the responsibility of the DHR Center to verify that the applicant is not eligible for and/or participating in other public funding sources. A checkmark indicates that the DHR Center has verified that the funding source for the applicant has been checked and no duplication of funding was found. If you are unsure how to verify a funding source or are encountering difficulty in obtaining verification of a funding source, please call the Department of Disabilities, Aging and Independent Living.

II. Diagnoses/Active Problems:

Primary: Enter the beneficiary's primary diagnosis.

Secondary: Enter the beneficiary's secondary diagnosis, if any.

Other Problems: Enter any additional diagnoses/health related problems that the beneficiary has.

Diagnosis of Alzheimer's Disease or Related Dementia: Indicate if the participant has a physician's diagnosis of Alzheimer's Disease or Related Dementia.

III. Day Health Rehabilitation Services Needed:

A. Personal Care (Per Client Independent Living Assessment - ILA)

The ILA # refers to the question number for the corresponding Activity of Daily Living (ADL) on the ILA. In this section, put an "x" in any the box that coincides with the beneficiary's ILA score for each ADL. For people who ***do have*** a diagnosis of Alzheimer's Disease or Related Dementia, any score between 1 - 4 for the ADLs will meet the criteria for needing personal care at the DHR Center. For people who ***do not have*** a diagnosis of Alzheimer's Disease or Related Dementia, a score that falls within the ***unshaded portions*** of the form is required to meet the criteria for needing personal care at the DHR Center.

B. Nursing Services

Give a brief description of the nursing services to be provided. Indicate the frequency of the service (i.e. 2X/day, daily, weekly, monthly). Indicate the expected duration (i.e. 2 months, 4 months, ongoing) that the service(s) will be needed at the DHR Center. Please be as specific and accurate as possible. Documentation of the on-going nursing services that are provided must be maintained in the person's file at the DHR Center.

If a beneficiary requires any of the services listed, but they will not be needed or provided while at the DHR Center, this service, frequency and duration must be left blank and the eligibility criteria for DHRS will not be met.

C. Special Therapies

In order for the participant to qualify in the Special Therapies section, a licensed professional must complete an assessment and develop a treatment plan that will

be carried out by DHR Center staff. The licensed professional must monitor and update the treatment plan as necessary. The written plan and documentation of the on-going special therapy services provided must be maintained in the person's file at the DHR Center.

Indicate with an "x" any of the special therapies to be provided by the DHR Center.

Enter the name of the physical, occupational, or speech therapist that will develop and oversee the therapy plan.

Specify the type of specific services to be provided and give a brief description. Indicate the frequency of the service (i.e. 2X/day, daily, weekly, monthly). Indicate the expected duration (i.e. 2 months, 4 months, ongoing) that the service(s) will be needed at the DHR Center.

Again, this section must be left blank if the services will not be provided by the DHR Center, even if they are being received from another source.

D. Social Work

Participant/Family/Caregiver shows signs of: check any and all areas that apply in the following areas: stress/anxiety, situational depression, caregiver burnout, grief, isolation, abuse/neglect/exploitation. Indicate if there are other areas to be considered that may require social work services.
Enter the name and title of the individual who will provide Social Work Services.

Specify the type of social work services to be provided and give a brief description. Enter the frequency of the service as (i.e. 2X/day, daily, weekly, monthly). Enter the expected duration (i.e. 2 months, 4 months, ongoing) that the service(s) will be needed at the DHR Center. Documentation of the on-going social work services provided must be maintained in the person's file at the DHR Center.

E. Nutrition Counseling and Services

In order for the participant to qualify in the Nutrition Counseling and Services section, a Registered Dietician must complete an assessment and develop a nutrition plan that can be carried out by DHR Center staff. The Registered Dietician must monitor and update the nutrition plan as necessary. The written plan and documentation of the on-going nutrition services provided must be maintained in the person's file at the DHR Center.

Enter the name of the registered dietician that will develop and oversee the dietary plan.

Participant Indicators: Indicate with an "x" any and all conditions that currently apply to the beneficiary.

Services Required: Indicate with an "x" any nutrition services that the beneficiary needs and will be provided by the DHR Center. Give a brief description of the service to be provided. Indicate the frequency of the service (i.e. 2X/day, daily, weekly, monthly). Please be as specific and accurate as possible.

F. Additional Comments
Any additional information that would assist in clarifying the beneficiary's need for services should be included here.

IV. Eligibility Summary:

Indicate with an "x" any of the five categories of services where the beneficiary appears to have met the criteria for Day Health Rehabilitation Services.

The DHRS PA Form must be signed and dated by the Registered Nurse who will be supervising the care stated on the form. Supervision of care includes but is not limited to completing and reviewing the participant's Independent Living Assessments, plans of care, and progress notes, and overseeing the day to day care of the participant.

Please contact the Department of Disabilities, Aging and Independent Living if you need assistance with this form or have questions about the eligibility of a participant.

The completed and up-to-date form must be maintained with the Plan of Care in the participant's file at the DHR Center