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

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