

Vermont Department of Disabilities, Aging and Independent Living
Choices for Care - Enhanced Residential Care Service Plan

Participant Name: _____ SS# (last 4 digits): _____
(Please Print)

Address: _____ Initial Assessment Reassessment Change
(Street)

(Town) (Zip Code)

Phone Number: _____

Start Date: _____

Diagnosis: _____

ICD-10 CODE: _____

DAIL UR _____

Service	Provider (Write in provider name)	Hours of Service	Rates (check one)	Cost per Month
<input checked="" type="checkbox"/> Enhanced Residential Care	ERC Provider Name:	24 hrs./day 7 days/wk.	TIER 1 <input type="checkbox"/> \$63.51/day RCH \$1924.35/RCH <input type="checkbox"/> \$70.26/day ALR \$2128.88/ALR	
		24 hrs./day 7 days/wk.	TIER 2 <input type="checkbox"/> \$72.29/day RCH \$2190.39/RCH <input type="checkbox"/> \$79.03/day ALR \$2394.61/ALR	
		24 hrs./day 7 days/wk.	TIER 3 <input type="checkbox"/> \$81.07/day RCH \$2456.42/RCH <input type="checkbox"/> \$87.84/day ALR \$2661.55/ALR	

Services not funded by Choices for Care – Formal Services (indicate funding source)

Services	Service Provider	Funding Source	Frequency	Cost per Month
<input checked="" type="checkbox"/> ACCS	\$84.66/day	MEDICAID	DAILY	\$2565.20
<input checked="" type="checkbox"/> Room & Board		SELF	MONTHLY	
<input type="checkbox"/> Hospice				
<input type="checkbox"/> Skilled Services				

Department of Disabilities, Aging and Independent Living Authorization/Official Use Only

Services are authorized effective: Start Date: _____ through End Date: _____
 (A full reassessment must be completed prior to the end date in order for ERC services to continue)

 DAIL Authorized Signature

 Date

CONSENT TO PLAN OF CARE

The ERC Provider certifies that the service plan was developed with the participant /applicant or their legal representative and all parties fully understand the terms of the proposed plan and consent to the terms of the plan. The participant /applicant or their legal representative accept it as an alternative to the Home-Based or Nursing Home setting

Yes



ERC Provider Signature _____

Date: _____

Service Plan Changes: Complete a new Service Plan and briefly describe the reason for change. (Attach supporting information.)

Important Information

Appeal Rights: See attached letter if services were reduced or denied by DAIL.

Changes: The individual or legal representative must report all changes in status to the ERC provider.

Patient Share: Refer to the Department of Vermont Health Access (DVHA) Notice of Decision for patient share amount (if any) and for the provider that the patient share is to be paid each month.

Provider Billing: Providers must retain a copy of the current approved Service Plan as authorization to bill for services. Providers may only bill for services provided within the limits indicated on the Service Plan.

Reassessments: Annual reassessments will start on the date after the previous Service Plan ends.

Service Plan Changes: Approved Service Plan changes will start no earlier than the date the Service Plan is received at the DAIL regional office.

*****Level of Care Variances for ERC:** A request for a variance from section 5.1.a of the VT RCH Licensing Regulations to retain or admit a resident whose needs exceed that for which the home is licensed to provide must be made to the VT Division of Licensing and Protection (DLP). This must be done for all residents being admitted or retained who meet nursing home level of care to receive ERC services. See page 7 section III. Variances in the VT RCH Licensing Regulations for details of how to make the request. <http://www.dlp.vermont.gov/> **For new CFC/ERC participants, the start date for ERC services will be the date the Level of Care Variance is approved.**