VERMONT CHOICES FOR CARE MEDICAID PROGRAM
ENHANCED RESIDENTIAL CARE (ERC)
Provider Enrollment Application

All Enhanced Residential Care (ERC) providers must receive prior approval from the Department of Disabilities, Aging and Independent Living (DAIL) **before** enrollment as a Vermont Medicaid provider. Carefully review the instructions and referenced materials, then complete this application and mail, fax or email to:

DAIL - Adult Services Division
Attention: New ERC Provider Enrollment
280 State Drive, HC2 South
Waterbury, VT 05671-2070
FAX: (802) 241-0385 or Email: AHS.DAILASDProviderEnrollment@vermont.gov

Facility Name:_____ Phone: _____

Mailing Address: _____

Street Address if different: _____

Owner:_____ Manager:_____

Administrator:_____ RN:_____

FAX:_____ Email:_____

Directions to the Facility: _____

_____

Check one:

☐ This is an application for a new Level III Residential Care Home (RCH) or Assisted Living Residence (ALR) with no previous ownership or operatorship.
☐ This is an application for a change in licensure from previous owner or operatorship.

- Has the facility changed its name? ☐ Yes or ☐ No
- If yes, provide previous name: _____

If your facility has been assigned a pre-approved level of care variance number by the Division of Licensing and Protection indicate it here._____

How many residents do you expect to serve through Choices for Care ERC? _____

Section A FACILITY DESCRIPTION

1. Is the facility currently licensed as or applying to become (Check all that apply)?:

   ☐ Vermont Level III Residential Care Home (RCH)
   ☐ Vermont Assisted Living Residence (ALR)
   ☐ Medicaid Assistive Community Care Services (ACCS) provider

2. Total number of licensed beds? _____

3. Is the facility sprinklered? ☐Yes ☐ No
4. Number of rooms that are private?_____Semi-private? _____

5. ERC residents will be offered which type(s) of room? ☐ private ☐ semi-private

6. Current resident census? _____

7. Identify common areas (for socialization/meals and/or other spaces)

_____

_____

8. Check each accessibility feature the facility includes:

☐ wheelchair ramps ☐ electronic door opened ☐ wandering alert system
☐ stair lift ☐ elevator ☐ call button system
☐ roll-in showers ☐ lift chairs in common rooms ☐ hallway rails/grab bars
☐ recreational gardening outdoor space
☐ other (describe)_____

Section B. ADMISSION & DISCHARGE & CENSUS

1. Please describe at what point an ERC resident's functional status will result in discharge (i.e., two-person assist, wandering). _____

_____

_____

2. In the last year, how many persons served had a diagnosis of Alzheimer's Disease or a related dementia? _____

3. Is the facility able to retain residents that wander? ☐ Yes ☐ No

4. How many residents is the facility willing to serve at the Medicaid Assistive Community Care Services (ACCS) rate? (Non-ERC): _____

5. How many residents were discharged to a nursing facility or hospital in the last year? _____
Describe specific reason(s) why: _____

_____

_____

Section C. RN STAFFING & PERSONAL CARE SERVICES

1. How many hours a week is the RN scheduled in the facility? _____

2. What amount of personal care time per day is available to each ERC resident? _____

Section D. ACTIVITY INFORMATION

The ERC activity requirement is daily social and recreational offerings either "in house" or in the community. How will you meet that need? Who will organize and conduct the activities?

_____

_____

_____

Section E. FINANCIAL INFORMATION

1. Who will be responsible for ERC Medicaid billing? _____

2. Is the facility considering selling: ☐ Yes ☐ No

SECTION F. ATTACHMENTS

Attach all the following sections with this application packet.

- ☒ **Attachment A**: Admission policy that reflects ERC residents (nursing home level of care).
- ☒ **Attachment B:** Discharge policy.
- ☒ **Attachment C:** Revised resident admission agreement *(ERC providers must include the ERC/ACCS addendum as prescribed by the Department.)*
- ☒ **Attachment D:** Uniform Disclosure with the admission agreement*. (ALR only)*
- ☒ **Attachment E:** Most recent Dept. of Public Safety, Division of Fire Safety inspection report.
- ☒ **Attachment F:** Weekly or monthly staff schedule to include all staff positions.
- ☒ **Attachment G:** Weekly or monthly activity schedule.
- ☒ **Attachment H:** Certificate of insurance.
- ☒ **Attachment I:** Two letters of reference from consumers that currently use or will use your services and two letters of reference from Vermont stakeholders that currently use or will use your services if approved.

SECTION G. STATEMENT OF UNDERSTANDING & SIGNATURE

By signing this application, you certify that you have read, understand and will comply with:

1. The Residential Care Home Licensing Regulations and, if applicable, the Assisted Living Residence Licensing Regulations online: http://dlp.vermont.gov/survey-cert/facility-regs
2. The DAIL Room & Board Standards, updated annually online: http://asd.vermont.gov/resources/guidance-memos.
3. The Universal Provider Standards found in the Choices for Care High/Highest Program Manual online: http://asd.vermont.gov/resources/program-manuals
4. The Enhanced Residential Care service section of the Choices for Care High/Highest Program Manual. (link above)
5. The Enhanced Residential Care Medicaid rates for revenue codes and rates found in the rate table online. http://asd.vermont.gov/resources/rates
6. The Medicaid provider enrollment instructions found on the Vermont Medicaid Provider Portal. http://www.vtmedicaid.com/#/provEnrollInstructions
7. The Medicaid general provider agreement found on the VT Medicaid Provider Portal. http://www.vtmedicaid.com/#/provEnrollDataMaint
8. The Vermont Department of Vermont Health Access Program Integrity information regarding Medicaid fraud, waste and abuse. http://dvha.vermont.gov/for-providers/program-integrity
9. The Vermont Adult Protective Services mandated reporting laws. http://dlp.vermont.gov/aps/mandatory-reporting

By signing, you also understand that submission of this application does not guarantee approved enrollment as a Vermont Medicaid provider and that you will be notified in writing of the decision within 30 days of receipt of this complete application.

If approved, you will be instructed to submit a Vermont Medicaid Provider Enrollment application to DXC with a copy of the DAIL approval notification. Call (802) 241-0294 with questions about this application. Call (802) 879-4450 with questions about the Medicaid Provider Enrollment process.

Completed by:_____ Title: _____

Signature:_____ Date: _____