VERMONT
DEPT. OF DISABILITIES, AGING & INDEPENDENT LIVING

Choices for Care – Moderate Needs Program

(complete packet 1-1-2022)

CFC/MOD 903
Service Request

Participant Name: _____ Last 4 of SSN or DOB: _____

Check One: ☐ New Applicant ☐ Annual Review ☐ Service Change ☐ Reinstatement

Waitlist Applicant: ☐ Yes ☐ No ICD-10 Code: _____ Service Start Date: _____

Case Management Agency has confirmed funding with each Provider for the following services:

Service	Provider or Agency Name	Amount
☑ Case Management (revenue code 070)	_____	Up to 24 hours per calendar year
☐ Flexible Funding (revenue code 071)	Case Management Agency	Up to $ _____ per year
☐ Adult Day Services (revenue code 096)	_____	Up to _____ hours per week
☐ Adult Day Non-Medicaid Transportation or Flex Funds (revenue code 071)	_____	Up to $ _____ Transportation/week Up to $ _____ Flex Funds/year
☐ Homemaker (revenue code 095)	_____	Up to _____ hours per week

Participants must contact their Case Manager regarding changes.

CONSENT TO PLAN OF CARE

☐ The Moderate Needs Case Manager certifies that the service plan was developed with the participant/applicant or their legal representative. All parties fully understand the terms of the proposed plan and consent to terms of the plan.

_____ _____ _____
Authorized MNG Case Manager (Print) **Agency** **Phone Number**

_____ _____
Authorized MNG Case Manager Signature **Date**

Case Manager must submit annual review 30 days prior to service end date.

For DAIL USE Only - DAIL Review and Authorization

Authorization Start Date: _____ to End Date: _____

DAIL Signature: _____ Date: _____

Information may be gathered from current assessment (ILA) or directly from the individual, legal representative or provider(s).

Applicant Name: _____

SECTION 1 Pre-Eligibility Screening

1) Is the applicant a Vermont resident **and** age 18 or over? ☐ Yes ☐ No
   IF NO ,STOP – Not Eligible

2) Can the needs of the individual be adequately met by services available through other sources (including but not limited to trusts, contracts for care, private insurance, Medicare, Community Medicaid, VA, VHAP, etc.)?
   ☐ Yes ☐ No
   IF YES, STOP - Not Eligible

SECTION 2 Eligibility

1) Does the individual require supervision or any physical assistance three (3) or more times in seven (7) days with any single, or combination of, ADL's or IADL's?
   ☐ Yes – Eligible ☐ No - Continue

2) Does the individual have impaired judgment or decision-making skills that require general supervision on a daily basis?
   ☐ Yes – Eligible ☐ No - Continue

3) Does the individual require at least monthly monitoring for a chronic health condition?
   ☐ Yes – Eligible ☐ No - Continue

   Describe: _____

4) Will the individual's health condition worsen if services (adult day, homemaker) are not provided or if services are discontinued?
   ☐ Yes – Eligible ☐ No – Not Eligible

   Describe need: _____

Additional Comments: _____

_____

Case Manager Signature: _____ Date: _____

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CFC/MOD 902
Financial Worksheet

Individual Name: _____ Date: _____

A. Monthly Gross Income

	Individual	Spouse
Social Security	$	$
SSI	$	$
Retirement/Pension	$	$
Interest	$	$
VA Benefits	$	$
Wages/Salaries/Earnings	$	$
Other (i.e. rental income)	$	$
Subtotal:	$ 0.00	$ 0.00
A. Total Monthly Gross Income:	$ 0.00	

*B. *Asset Adjustment:* (Include only "liquid" assets that are easily convertible into cash.)

	Individual	Spouse
Cash:	$	$
Savings:	$	$
Checking:	$	$
CD's:	$	$
Money Market:	$	$
Stocks/Bonds:	$	$
trusts:	$	$
Other:	$	$
Subtotal:	$ 0.00	$ 0.00
Total Combined Assets:	$ 0.00	
subtract $10,000 asset disregard:	***- 10,000***	
divide by 12:	***/12***	
B. Asset Adjustment:	$ (833.33)	

C. Monthly Medical Expenses (Divide one-time bills by 12.)

	Individual	Spouse
Prescriptions:	$	$
Over-the-counter medications:	$	$
Physician Bills:	$	$
Hospital Bills:	$	$
Health Ins Premiums (Medicare/BCBS, etc):	$	$
Therapy (OT/PT/ST):	$	$
Medical Equipment and Supplies:	$	$
Other (explain):	$	$
Subtotal:	$ 0.00	$ 0.00
C. Total Monthly Medical Expenses:	$ 0	

D. Adjusted Monthly Income

A. Total Monthly Gross Income (above):	$ 0.00
plus (+)	
B. Asset Adjustment (above):	$ 0.00
minus (-)	
C. Monthly Medical Expenses (above):	$ 0.00
D.*Adjusted Monthly Income	$ 0.00

Clear Form

Financially eligible if "Adjusted Monthly Income" is at or below 300% SSI rate (2023).

Individual = **$ 2,898.12** Couple = **$ 4,409.64**

Name of person completing form: _____

Send with complete packet to: DAIL, Moderate Needs Program