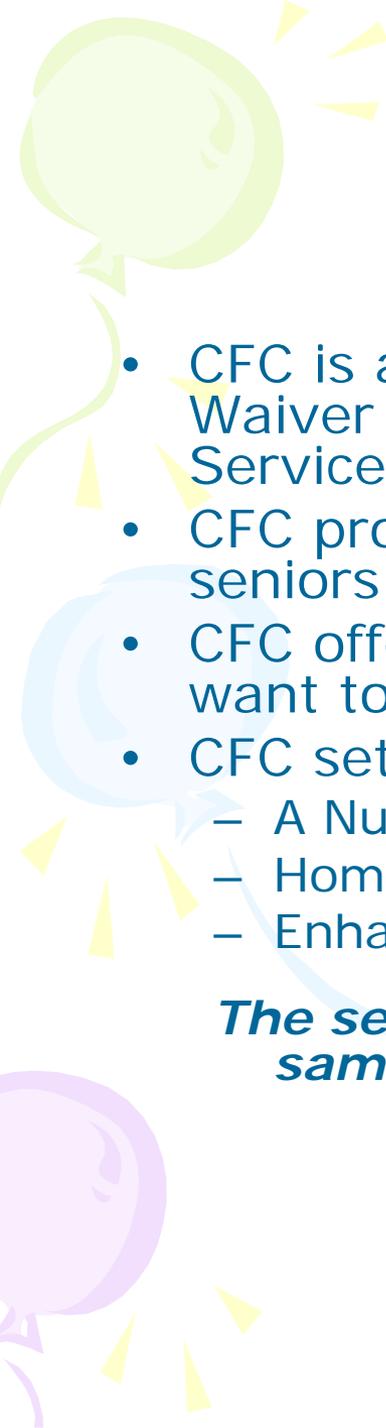




Choices for Care (CFC) Enhanced Residential Care (ERC)

**Medicaid in Level III Residential Care and
Assisted Living
Managers Certification Course
2014**

<http://www.dail.vermont.gov/>



What is CFC?

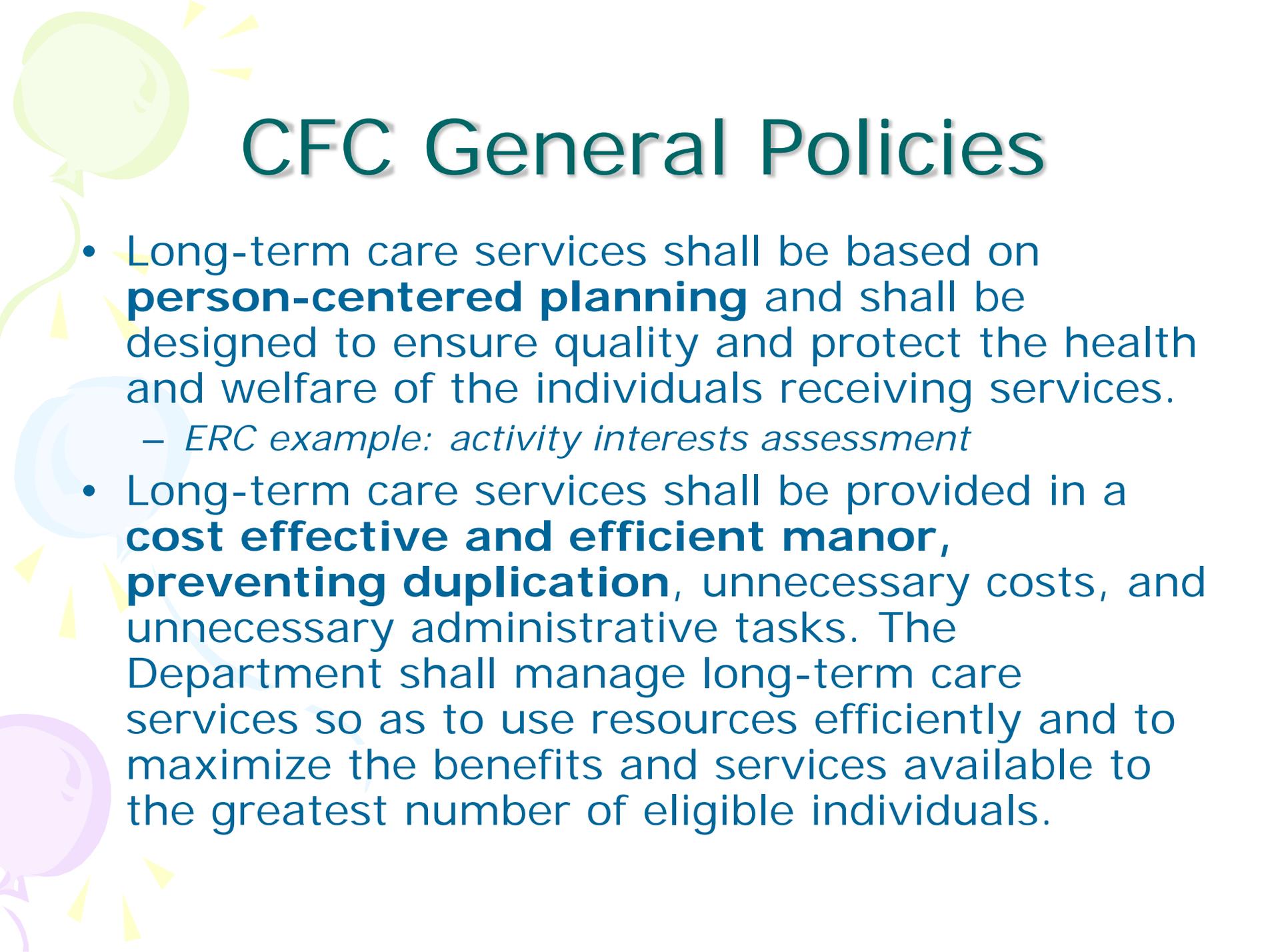
- CFC is an 1115 Research and Demonstration Medicaid Waiver approved by the Center for Medicare and Medicaid Services (CMS).
- CFC provides Long-Term Care Services to eligible VT seniors & adults with physical disabilities.
- CFC offers all eligible individuals a choice of where they want to receive their long-term care services.
- CFC settings:
 - A Nursing Facility (NF)
 - Home Setting (HB)
 - Enhanced Residential Care Setting (ERC)

The services offered in the different settings are not the same.



Choices for Care Goals

- Provide choice and equal access to long-term care
- Create a balanced long-term care system (facility & community services)
- Serve more people
- Manage the costs of long term care
- Improve the system
- Prevention (Moderate Needs)



CFC General Policies

- Long-term care services shall be based on **person-centered planning** and shall be designed to ensure quality and protect the health and welfare of the individuals receiving services.
 - *ERC example: activity interests assessment*
- Long-term care services shall be provided in a **cost effective and efficient manor, preventing duplication**, unnecessary costs, and unnecessary administrative tasks. The Department shall manage long-term care services so as to use resources efficiently and to maximize the benefits and services available to the greatest number of eligible individuals.



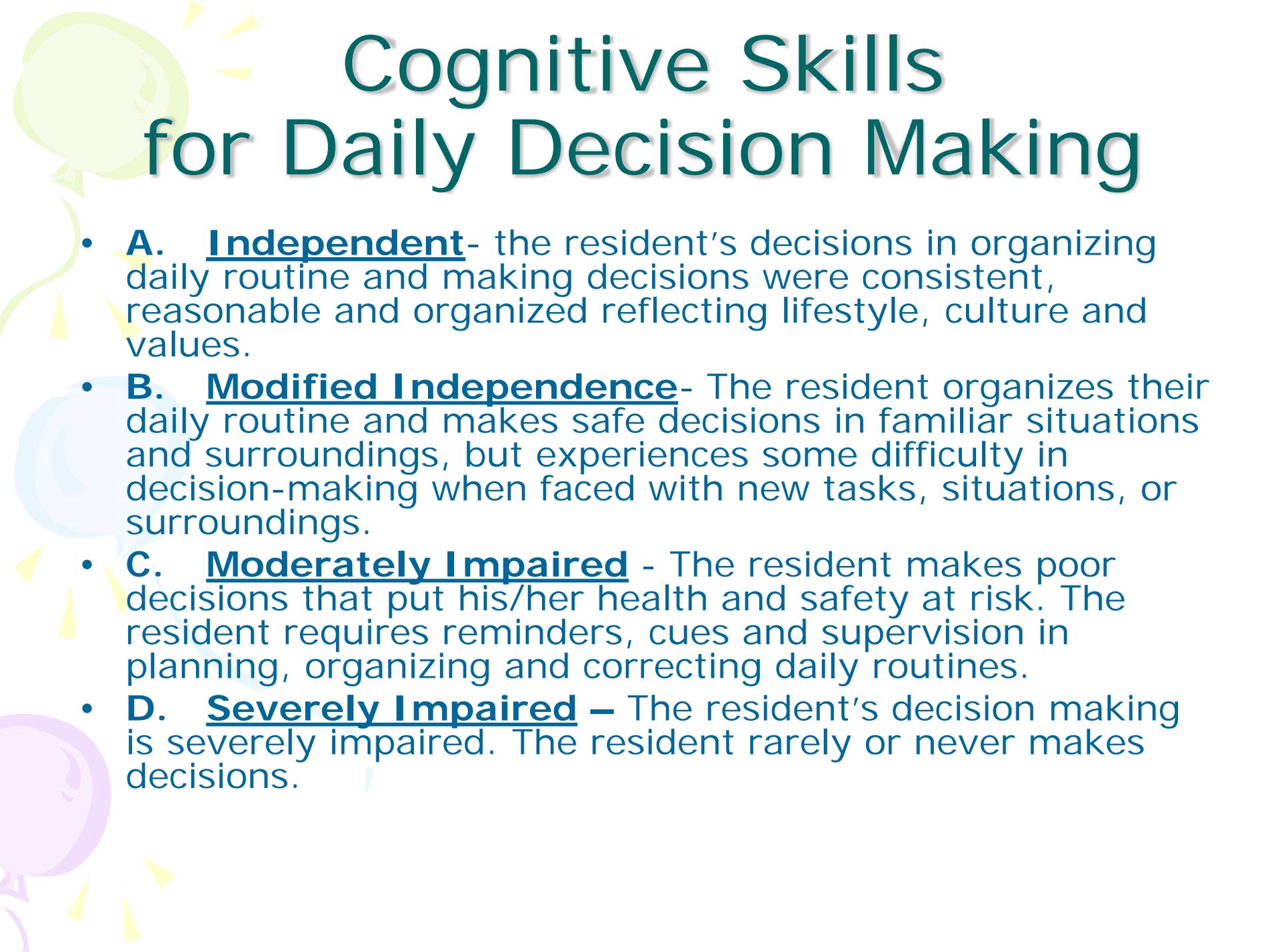
CFC Eligibility

To be eligible an individual must:

- Be a Vermont resident, and
- Be 18 years of age or older, and
- Have a functional limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging, and
- Meet the clinical criteria for the program (**Highest or High**), and
- Meet all financial and non-financial criteria for VT Long-Term Care Medicaid, and
- Choose one of three settings in which to receive approved long-term care services:
 - Home-Based Setting
 - Enhanced Residential Care Setting
 - Nursing Facility Setting

ADL Key

- **KEY: Activities of Daily Living (ADL), Self-Performance**
- **0 = Independent** – No help or oversight **–OR–** help/oversight provided only 1 or 2 times during the last seven days.
- **1 = Supervision** – Oversight, encouragement or cueing provided 3 or more times **–OR–** Supervision (3 or more times) plus limited physical assistance provided only 1 or 2 times during the last seven days.
- **2 = Limited Assistance** – Individual highly involved in activity, received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times **–OR–** Limited assistance (3 or more times) plus extensive assistance provided only 1 or 2 times in the last 7 days.
- **3 = Extensive Assistance** – While individual performed part of activity, weight-bearing support or full caregiver performance 3 or more times over part (but not all) of the last seven days.
- **4 = Total Dependence** – Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would NOT be coded as a “4” Total Dependence.
- **BATHING Self-Performance Key**– Due to the nature and frequency of the bathing activity, the following self-performance scale is used.
- **0 = Independent** – No help or oversight provided.
- **1 = Supervision** – Oversight, encouragement or cueing only.
- **2 = Limited Assistance** – Individual highly involved in activity, received physical help to transfer only.
- **3 = Extensive Assistance** – While individual performed part of activity, physical help in part of the activity was provided.
- **4 = Total Dependence** – Full caregiver performance of the activity each time the activity occurred during the entire seven-day period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the caregiver performed an activity for the individual during the entire observation period, but the individual performed part of an activity him/herself, it would NOT be coded as a “4” Total Dependence.



Cognitive Skills for Daily Decision Making

- **A. Independent**- the resident's decisions in organizing daily routine and making decisions were consistent, reasonable and organized reflecting lifestyle, culture and values.
- **B. Modified Independence**- The resident organizes their daily routine and makes safe decisions in familiar situations and surroundings, but experiences some difficulty in decision-making when faced with new tasks, situations, or surroundings.
- **C. Moderately Impaired** - The resident makes poor decisions that put his/her health and safety at risk. The resident requires reminders, cues and supervision in planning, organizing and correcting daily routines.
- **D. Severely Impaired** – The resident's decision making is severely impaired. The resident rarely or never makes decisions.



CFC Clinical Eligibility Highest Need

HIGHEST NEED Clinical Criteria – an applicant must meet one of the following eligibility criteria to meet Highest Need.

(CFC Regulations)

1. Activities of Daily Living (ADLs)

- Individuals who require extensive or total assistance with at least one of the following Activities of Daily Living (ADLs): *toilet use; eating; bed mobility; or transfer*, and require *at least* limited assistance with any other ADL.

2. Cognition & Behavior

- Individuals who have a severe impairment with daily decision-making skills or a moderate impairment with decision-making skills and one of the following behavioral symptoms/conditions, which occurs frequently and is not easily altered: *Wandering, Resists Care, Behavioral Symptoms, Verbally Aggressive Behavior Physically Aggressive Behavior*.

Highest Need Continued...

HIGHEST NEED Clinical Criteria (cont.)

3. Conditions & Treatments

- Individuals who have at least one of the following conditions or treatments that require **skilled nursing** assessment, monitoring, and care on a **daily basis**: *Stage 3 or 4 Skin Ulcers, Ventilator/ Respirator, IV Medications, Naso-gastric Tube Feeding, End Stage Disease, Parenteral Feedings, Suctioning, 2nd or 3rd Degree Burns.*

4. Unstable Medical Conditions

- Individuals who have an **unstable medical** condition that requires **skilled nursing** assessment, monitoring and care on a **daily basis** related to, but not limited to, at least one of the following: *Dehydration, Aphasia, Vomiting, Internal Bleeding, Transfusions, Wound Care, Aspirations, Oxygen, Pneumonia, Dialysis, Multiple Sclerosis, Quadriplegia, Chemotherapy, Septicemia, Cerebral Palsy, Respiratory Therapy, Open Lesions, Radiation Therapy, Tracheotomy, Gastric Tube Feeding.*



High Needs Clinical Eligibility

HIGH NEEDS

1. Activities of Daily Living (ADLs)

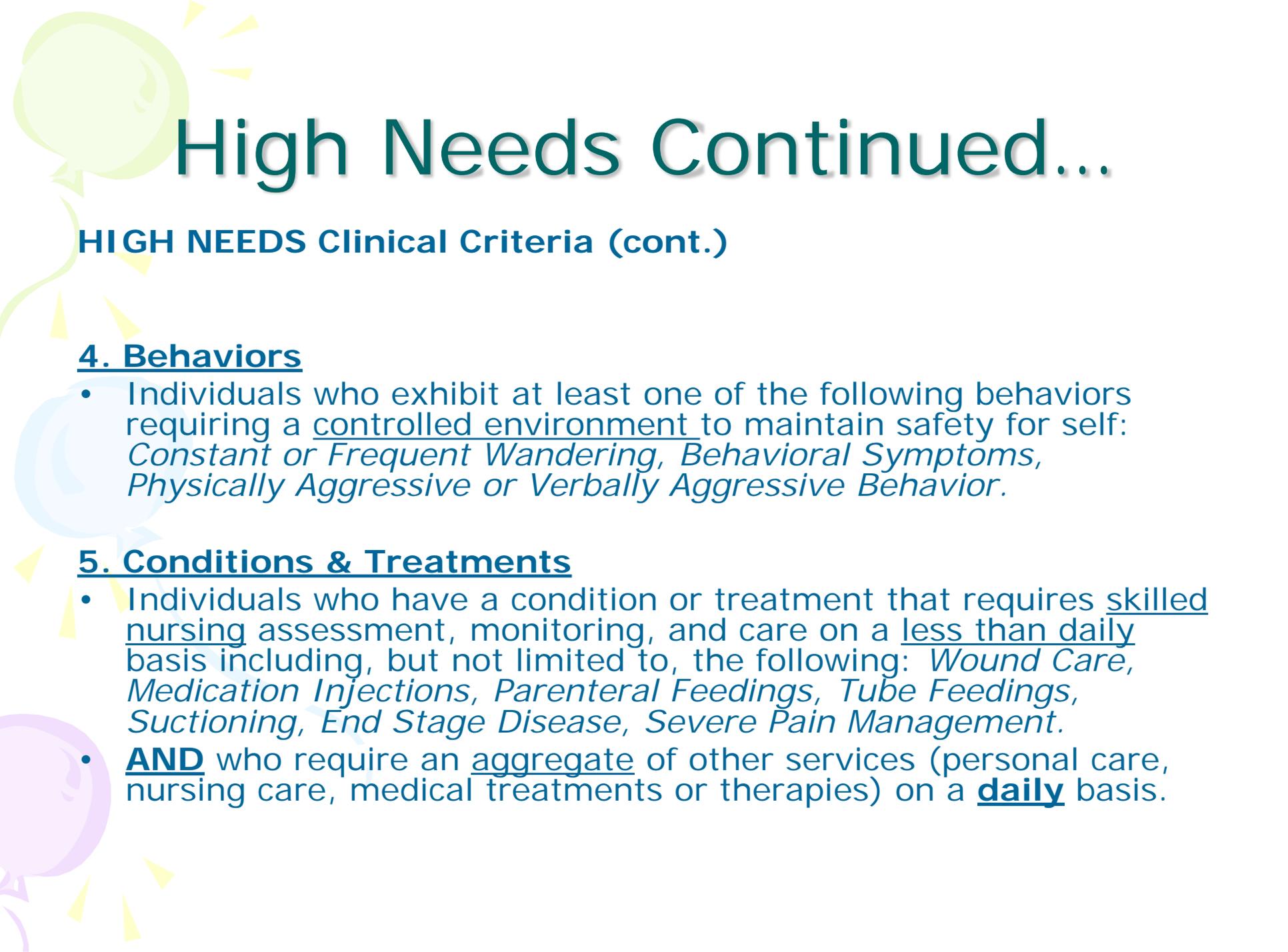
- Individuals who require extensive to total assistance on a **daily** basis with at least one of the following ADLs: *Bathing, Eating, Dressing, Toilet Use, Physical Assistance to Walk.*

2. Skilled Teaching - Daily

- Individuals who require skilled teaching on a **daily basis** to regain control of, or function with at least one of, the following: *Gait training, Range of Motion, Speech, Bowel or Bladder Training.*

3. Cognition

- Individuals who have impaired judgment or impaired decision-making skills that require **constant or frequent direction** to perform at least one of the following (ADL): *Bathing, Eating Transferring, Dressing, Toilet Use, Personal Hygiene.*
- 



High Needs Continued...

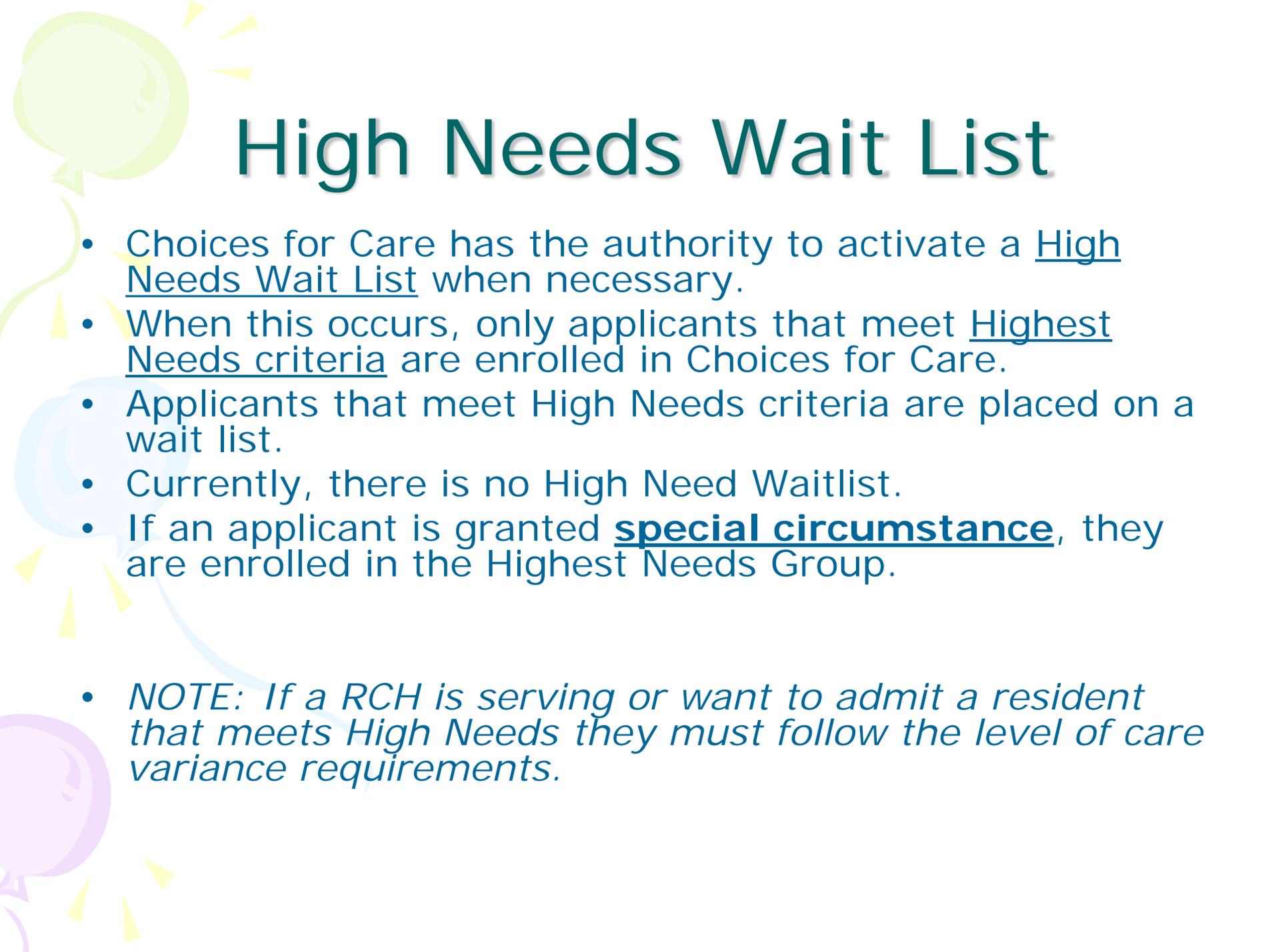
HIGH NEEDS Clinical Criteria (cont.)

4. Behaviors

- Individuals who exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self: *Constant or Frequent Wandering, Behavioral Symptoms, Physically Aggressive or Verbally Aggressive Behavior.*

5. Conditions & Treatments

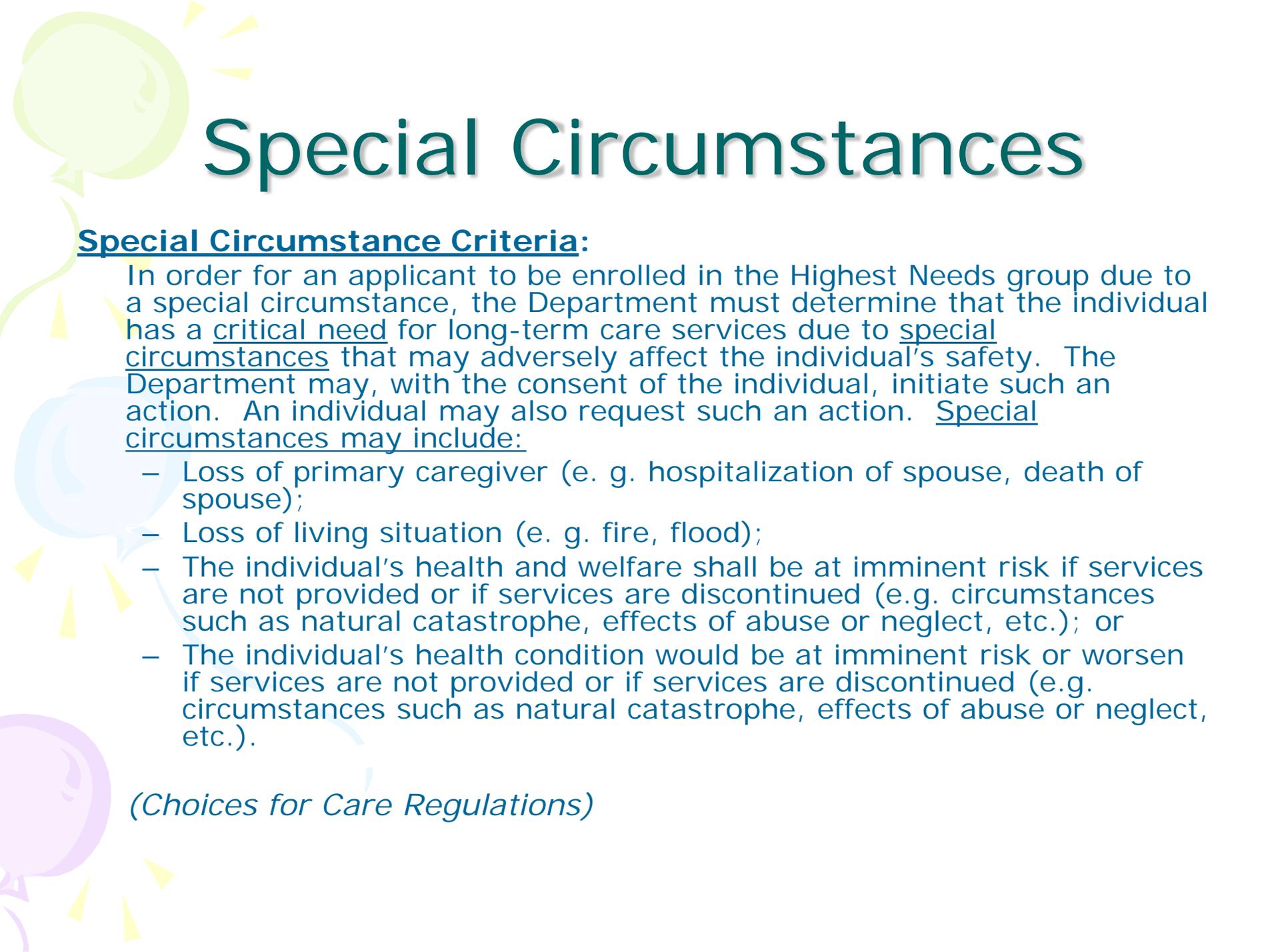
- Individuals who have a condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis including, but not limited to, the following: *Wound Care, Medication Injections, Parenteral Feedings, Tube Feedings, Suctioning, End Stage Disease, Severe Pain Management.*
- **AND** who require an aggregate of other services (personal care, nursing care, medical treatments or therapies) on a **daily** basis.



High Needs Wait List

- Choices for Care has the authority to activate a High Needs Wait List when necessary.
- When this occurs, only applicants that meet Highest Needs criteria are enrolled in Choices for Care.
- Applicants that meet High Needs criteria are placed on a wait list.
- Currently, there is no High Need Waitlist.
- If an applicant is granted special circumstance, they are enrolled in the Highest Needs Group.

- *NOTE: If a RCH is serving or want to admit a resident that meets High Needs they must follow the level of care variance requirements.*



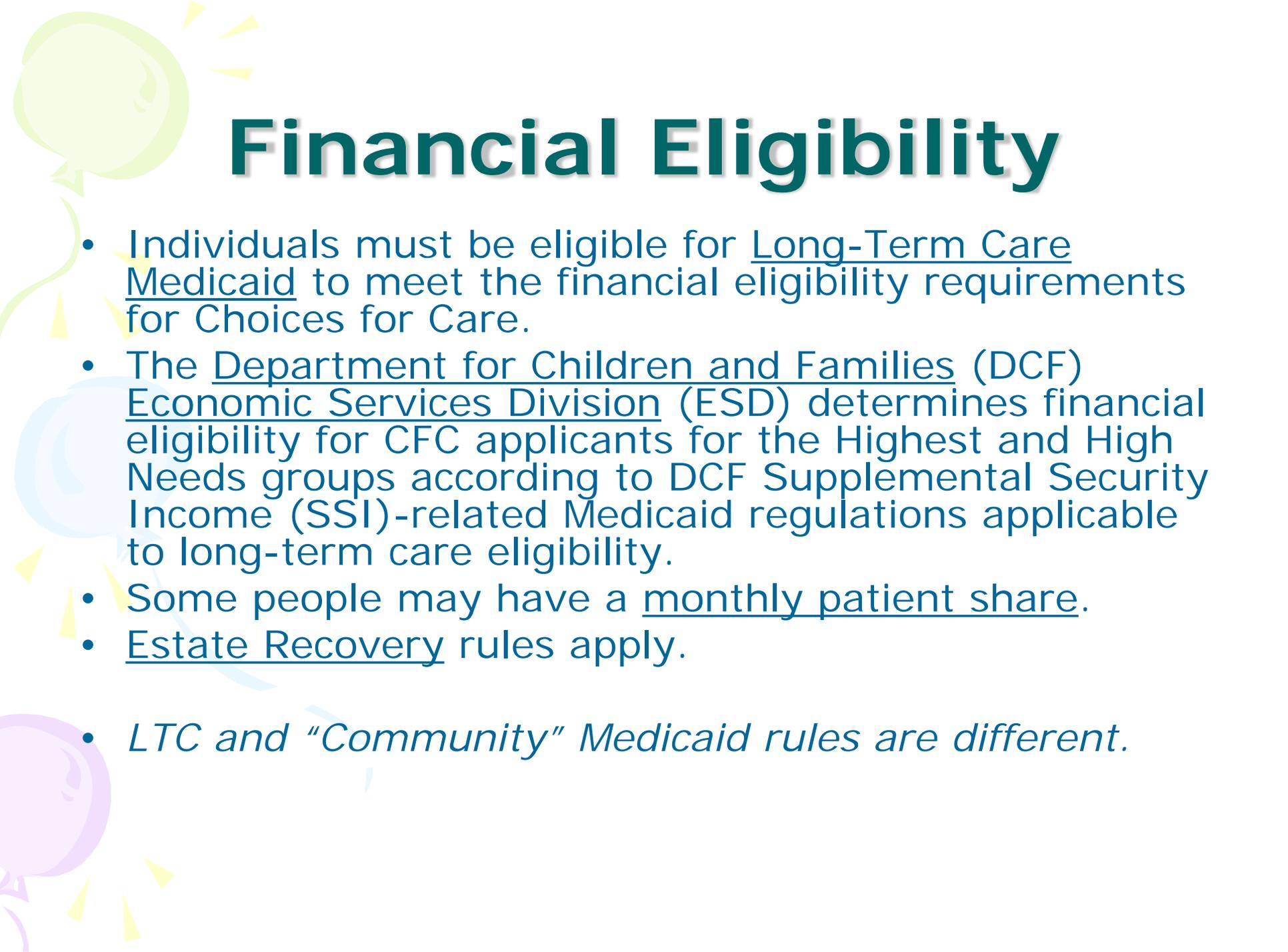
Special Circumstances

Special Circumstance Criteria:

In order for an applicant to be enrolled in the Highest Needs group due to a special circumstance, the Department must determine that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's safety. The Department may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:

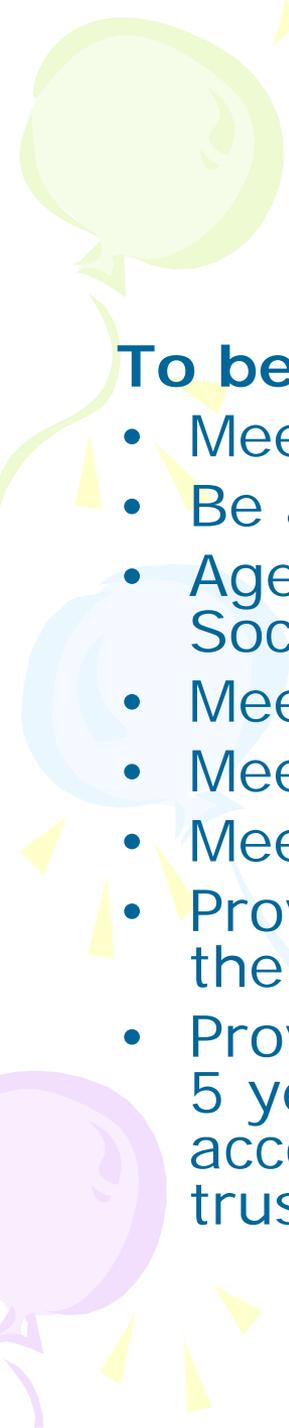
- Loss of primary caregiver (e. g. hospitalization of spouse, death of spouse);
- Loss of living situation (e. g. fire, flood);
- The individual's health and welfare shall be at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.); or
- The individual's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect, etc.).

(Choices for Care Regulations)

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Financial Eligibility

- Individuals must be eligible for Long-Term Care Medicaid to meet the financial eligibility requirements for Choices for Care.
- The Department for Children and Families (DCF) Economic Services Division (ESD) determines financial eligibility for CFC applicants for the Highest and High Needs groups according to DCF Supplemental Security Income (SSI)-related Medicaid regulations applicable to long-term care eligibility.
- Some people may have a monthly patient share.
- Estate Recovery rules apply.
- *LTC and "Community" Medicaid rules are different.*



Financial Eligibility Continued...

To be financially eligible:

- Meet CFC **Clinical** Criteria.
- Be a Vermont resident.
- Age 65 or older, or blind or disabled according to Social Security standards.
- Meet LTC institutional income standard.
- Meet LTC resource standards.
- Meet permissible transfer rules (Rules M440-M440.44)
- Provide proof of asset transfers in the 3 years prior to the date of application.*
- Provide proof of any irrevocable trusts created within 5 years of the date of application, including an accounting of all assets placed in or removed from the trust in the last 5 years.



Choices for Care ERC Eligibility

- In addition to the general, clinical and financial CFC eligibility requirements, ERC applicants must find an ERC Provider who is able to and agrees to serve them through CFC.
- The ERC Provider, RCH only, must be granted a level of care variance through DLP to admit or retain a resident unless the resident will be counted in their pre-approval variance allocation.



Level of Care (LOC) Variance

- Level III Residential Care Homes must be granted a variance to the Residential Care Home Regulation 5.1.a to retain or admit a resident whose needs exceed that for which the home is licensed to provide.
- RCH regulation 3.5 a-c, describes the requirement. There is a designated form to request this variance through DLP.
- Some homes have been allocated a number of pre-approved variances. For those homes, they must submit the variance as described above for any resident that exceeds their pre-approved assignment.
- *Note: The need for a LOC variance is based on level of care NOT FUNDING SOURCE.*

What Have You Learned so Far?

1. What is the name of the long-term care program in Vermont?
2. What is the minimum age to be eligible for the long-term care program?
3. What population does the VT long-term care program serve?
4. Where can eligible consumers receive their long-term care services?
5. Are applicants that meet Highest and/or High Needs clinically eligible?
6. What Department determines if an applicant is financially eligible for long-term care services?

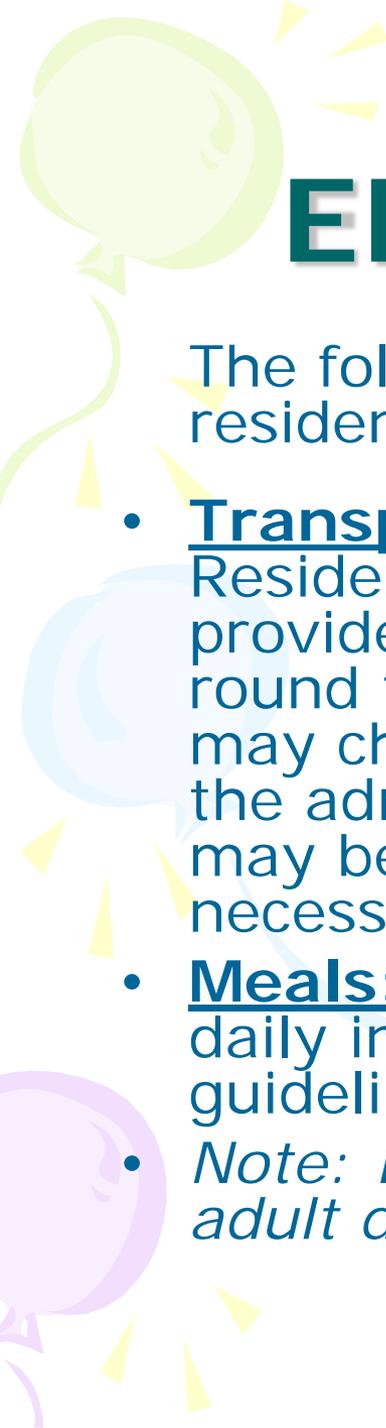
Enhanced Residential Care (ERC) Services

The following activities are included in the ERC services bundle:

- **Nursing Overview:** Assessment, health monitoring, and routine nursing care is provided or supervised through delegation by a Licensed Registered Nurse. The RN is on site at least one (1) hour per week per ERC resident. *The home must have sufficient RN services to meet the needs of all residents.*
- **Personal Care Service (ADL):** Assistance with eating, movement, bathing, dressing, transferring, personal hygiene, grooming and toileting for at least two (2) hours per day per ERC resident as needed.
- **Medication Management:** The process of assisting residents to self-administer their medications or administering medications, under the supervision and delegation by the RN.
- **Social & Recreation Activities:** Social or recreational activities, either in a group setting or individually, must be offered daily. Activities may be in the home or community. In house movies and TV are not considered activities.
- **24-Hour On-Site Supervision:** ERC staff must be on duty seven (7) days a week, twenty-four (24) hours a day.
- **Laundry Services:** Laundry services shall be provided as well as the opportunity to launder ones own clothing if desired.
- **Household Services:** Bed making and household cleaning.

Other:

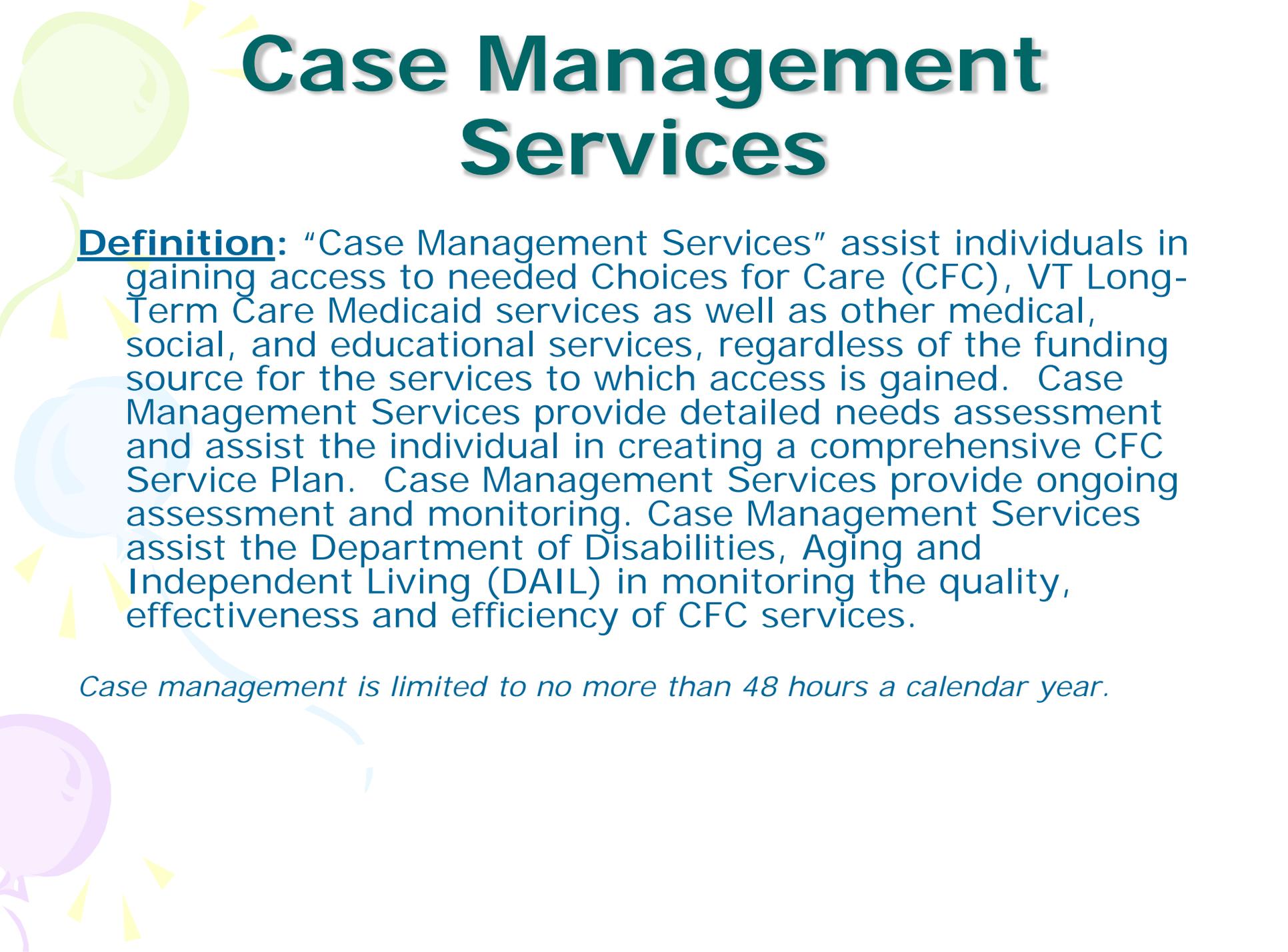
- **Case Management Services:** Maximum of 48 hours per calendar year is provided by Area Agency on Aging or Medicare Certified Home Health Agency.



ERC - Other Services

The following services are provided to all ERC residents but are not reimbursed for through CFC:

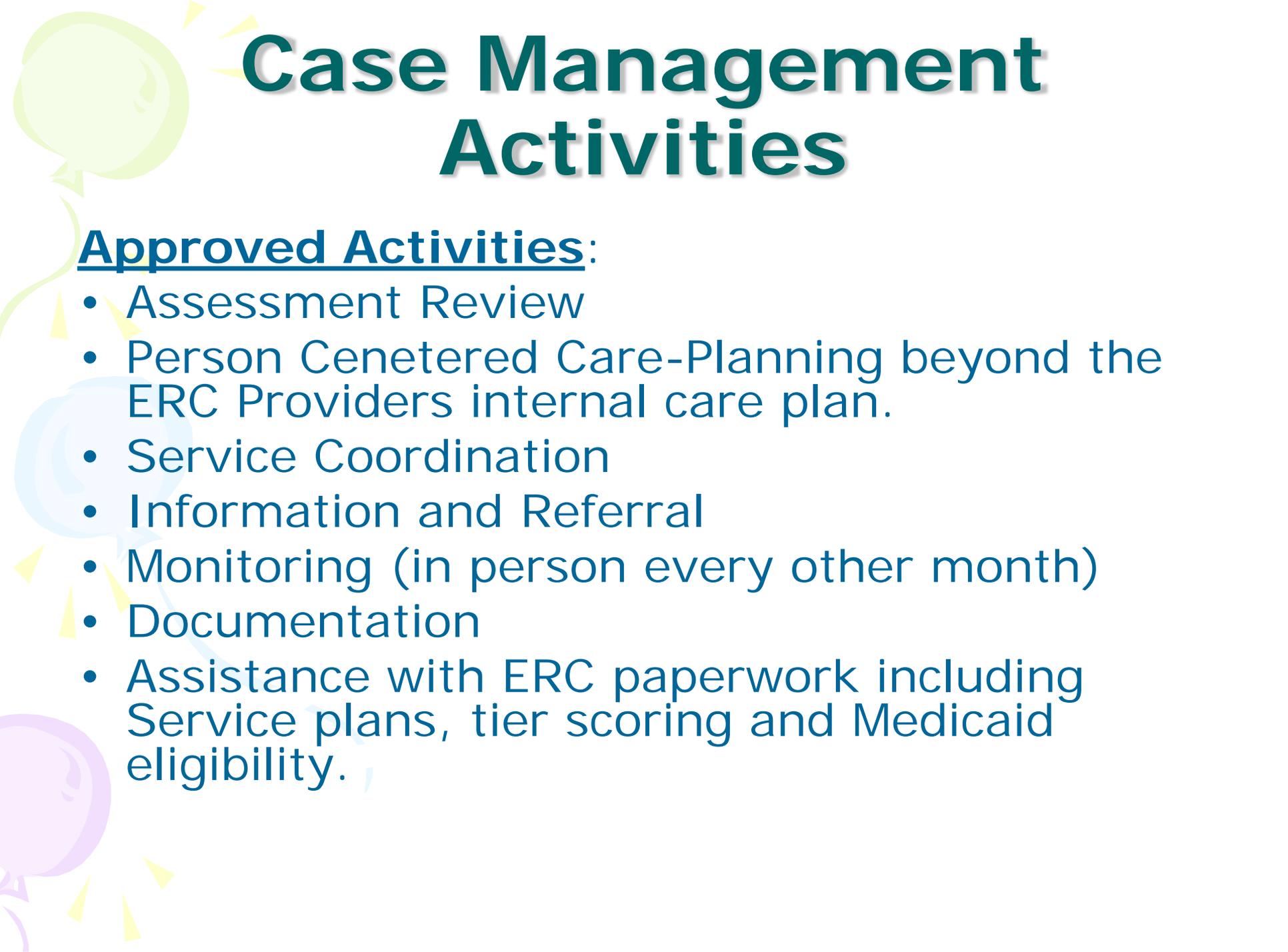
- **Transportation Services**: As outlined in the Residential Care Home regulations, the home shall provide, without charge, 4 trips per month, 20 miles round trip. After the 4 trips per month, the home may charge the resident the amount agreed upon in the admission agreement. Medicaid transportation may be utilized after the 4 trips if medically necessary.
- **Meals**: Three meals and snacks shall be provided daily in accordance with nutritional standards and guidelines.
- *Note: ERC residents may NOT have Medicaid pay for adult day attendance.*

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Case Management Services

Definition: “Case Management Services” assist individuals in gaining access to needed Choices for Care (CFC), VT Long-Term Care Medicaid services as well as other medical, social, and educational services, regardless of the funding source for the services to which access is gained. Case Management Services provide detailed needs assessment and assist the individual in creating a comprehensive CFC Service Plan. Case Management Services provide ongoing assessment and monitoring. Case Management Services assist the Department of Disabilities, Aging and Independent Living (DAIL) in monitoring the quality, effectiveness and efficiency of CFC services.

Case management is limited to no more than 48 hours a calendar year.



Case Management Activities

Approved Activities:

- Assessment Review
- Person Ceneentered Care-Planning beyond the ERC Providers internal care plan.
- Service Coordination
- Information and Referral
- Monitoring (in person every other month)
- Documentation
- Assistance with ERC paperwork including Service plans, tier scoring and Medicaid eligibility.



CFC Long Term Care Clinical Coordinators (LTCCC)

- DAIL staff
 - RNs
 - Regionally Located
 - Process CFC applications
 - Determine CFC Clinical Eligibility
 - Complete Utilization Review (tiers)
 - Facilitate local CFC Waiver teams
 - Technical assistance
 - Outreach
- 
- 



CFC ERC Application Process

Step I: Application

- An Application Form (ESD/ DCF 202LTC & other ESD forms) are completed and sent to the Application and Document Processing Center (ADPC). Applications may be obtained by calling 1-800-479-6151 or on the web: http://dcf.vermont.gov/esd/ltc_medicaid
- DCF forwards a copy of pages 1, 5 & 6 to the local Department of Disabilities Aging and Independent Living (DAIL) Long Term Care Clinical Coordinator (LTCCC) Nurse who arranges a face-to-face visit with the applicant.
- DAIL LTCCC completes a face-to-face clinical assessment and options education.

Step II: Clinical Determination:

- DAIL LTCCC determines clinical eligibility and sends "Clinical Certification" form CFC 803 to DCF and the chosen case management agency. LTCCC sends the case management agency a copy of their clinical assessment and application if referral wasn't through case management agency and the agency doesn't use SAMS for Choices for Care.
- 

CFC Application Process Continued...

- The ERC provider completes a full assessment no later than 14 working days after receipt of Clinical Certification for current residents, OR 14 days after admission .
- The case manager obtains a copy of the ERC assessment, reviews with the applicant and ERC Provider and completes the Tier Score Sheet and Service Plan.
- ERC RCH providers must request and be granted a level of care variance for all ERC residents once they reach their pre-approved variance limit. Variances must be requested & granted prior to admission for new residents.
- The CFC case manager sends a copy of the assessment, Tier Score Sheet and Service Plan to the local DAIL LTCCC.
- After receipt, the LTCCC completes Utilization Review (UR). If paperwork is incomplete the LTCCC returns it to the case manager to be completed and resubmitted. If there are concerns or questions the LTCCC will contact the case manager and/or ERC provider. Through UR the tier will be assigned.
- *NOTE: All individuals must be assessed by the ERC Provider prior to admission to identify needs and ensure they can meet those needs. Providers should not assume that a resident in another setting on CFC will continue to be clinically eligible.*

CFC Application Process continued...

Step III: Financial Determination:

- After receipt of Clinical Certification (CFC 803), DCF completes the financial eligibility determination and patient share (if applicable).
- DCF sends Notice of Decision to applicant, legal representative, LTCCC and highest paid provider (ERC Provider).

Step IV: Final Authorization:

- After receipt of the DCF Notice of Decision, if financially eligible, the DAIL LTCCC authorizes the CFC Service Plan. A copy of the Service Plan is sent to the individual and applicable providers.

OTHER:

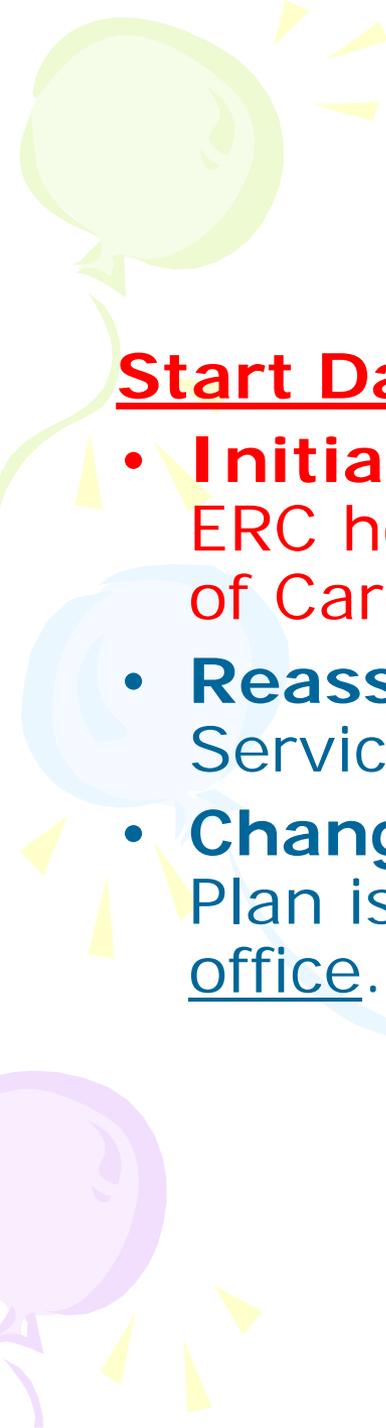
- When CFC program funds are not available to serve applicants meeting High Needs clinical criteria they will receive a written notice that they are being placed on a waiting list. They are not enrolled in Choices for Care.
- Individuals found clinically or financially ineligible will receive a written denial notice with appeal rights.



ERC Service Plans

The CFC ERC Service Plan is the CFC form “authorizing” a provider to submit ERC Medicaid claims. The service plan includes effective dates and the tier for reimbursement.

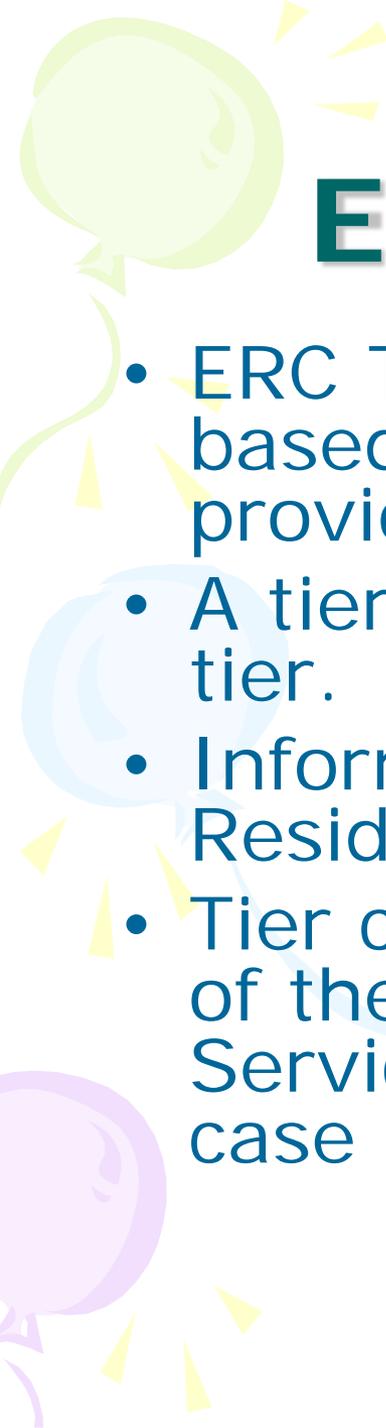
- Service Plan must be complete, including signatures.
 - ICD9 Codes - required for ALL Medicaid billing.
 - Providers may not bill ERC Medicaid until they have a DAIL authorized Service Plan.
 - Individual/guardian, ERC Provider and case manager must sign.
 - Service plans are generally approved for one year. A reassessment must be completed at least every year.
 - If a resident has a significant change during the year, the ERC Provider updates their assessment and care plan and informs the case manager. The case manager will review to determine if the resident will change tiers. If so, the case manager must submit the updated assessment, complete a tier score sheet and new service plan. All information is submitted to the LTCCC for review and authorization.
 - At annual reassessment the DAIL LTCCC review clinical eligibility and the tier.
- 



ERC Service Plan Start Dates

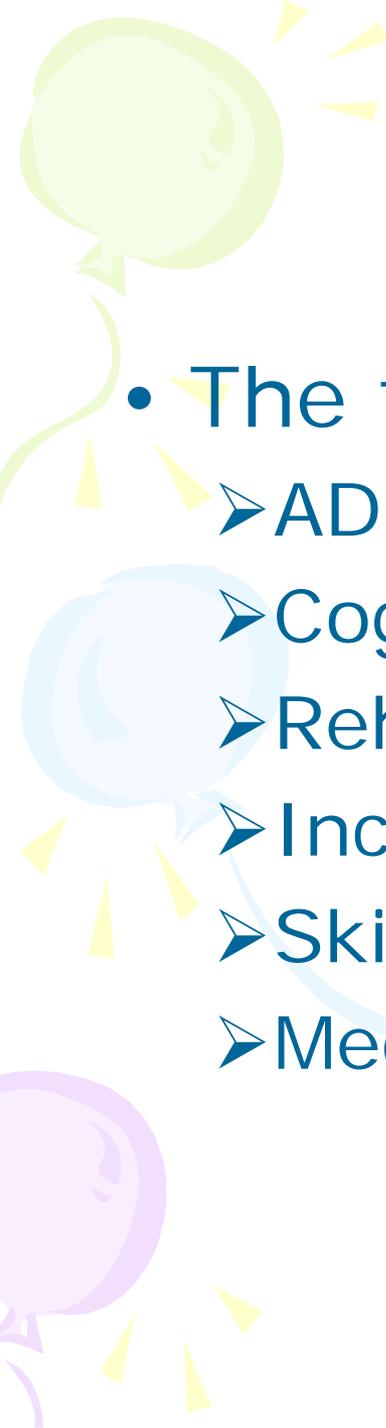
Start Dates:

- **Initial:** DAIL coordinates the start date with the ERC home and DLP according to when the Level of Care Variance was requested.
- **Reassessment:** The day after the previous Service Plan expired.
- **Changes:** No earlier than the date the Service Plan is received at the DAIL LTCCC regional office.

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ERC Tier Worksheet

- ERC Tiers for reimbursement rates are based on resident need and services provided.
- A tier worksheet is used to calculate the tier.
- Information for the tier comes from the Resident Assessment.
- Tier change request which include a copy of the assessment, tier score sheet and Service Plan are submitted through the case manager to LTCCC.



Tier Scoring

- The tier score sheet includes:
 - ADLs
 - Cognition & behaviors
 - Rehabilitation & Special Programs
 - Incontinence
 - Skin Treatments
 - Medication Administration

Terminations & Denials CFC

Voluntary Withdrawal: Individuals may voluntarily withdraw for any reason. They are asked to sign off on the 804, CFC Change Form.

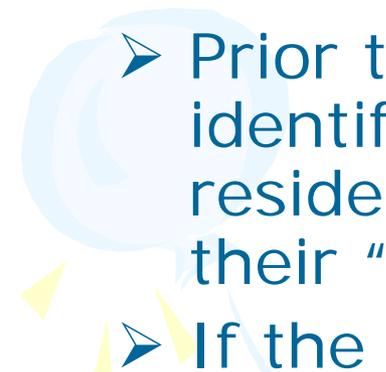
CFC applicants will be denied or participants terminated from CFC for the following reasons:

- Clinical ineligibility.
- Financial ineligibility.
- Death.
- Permanent move out of state.
- Temporary stay out of state exceeding 30 continuous days.
- The individual no longer requires Choices for Care services (condition has improved or other services meeting their needs).

When a resident is denied or terminated by DAIL they will receive a written notice that includes appeal rights.



ERC Discharge

- A discharge from an ERC Provider must follow the applicable RCH/ALR regulatory requirements.
 - Prior to admission, the Provider must assess and identify the resident's needs. By admitting the resident the home has committed to meeting their "enhanced" needs.
 - If the involuntary discharge is because the home can no longer meet the resident's needs, those needs must exceed what was identified through the assessment and variance process.
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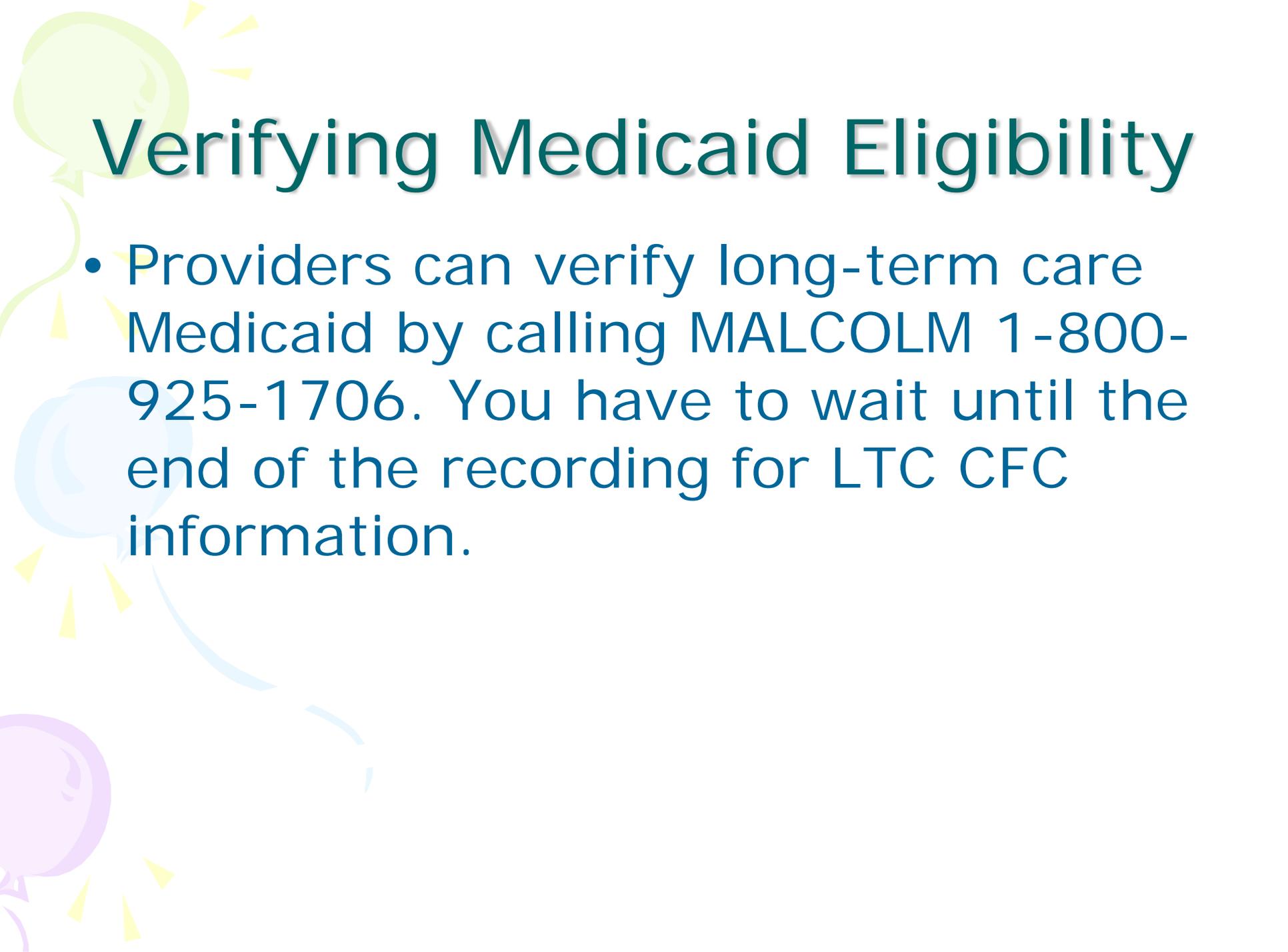
ERC Provider Responsibilities

- Assess potential residents prior to admission.
- Enter into an admission agreement with the resident which reflects ERC services and payments.
- Assess residents for the activity interests.
- Provide ERC services.
- Communicate with and update the ERC case manager.
- Adhere to the DAIL room and board policy.
- Submit Medicaid claims for eligible residents using your ERC Medicaid provider number through HP. **Claims may not be submitted until you have a authorized CFC Service Plan.**
- Accept Medicaid reimbursement as the full and final reimbursement for covered services.
- Bill residents for patient share when applicable.

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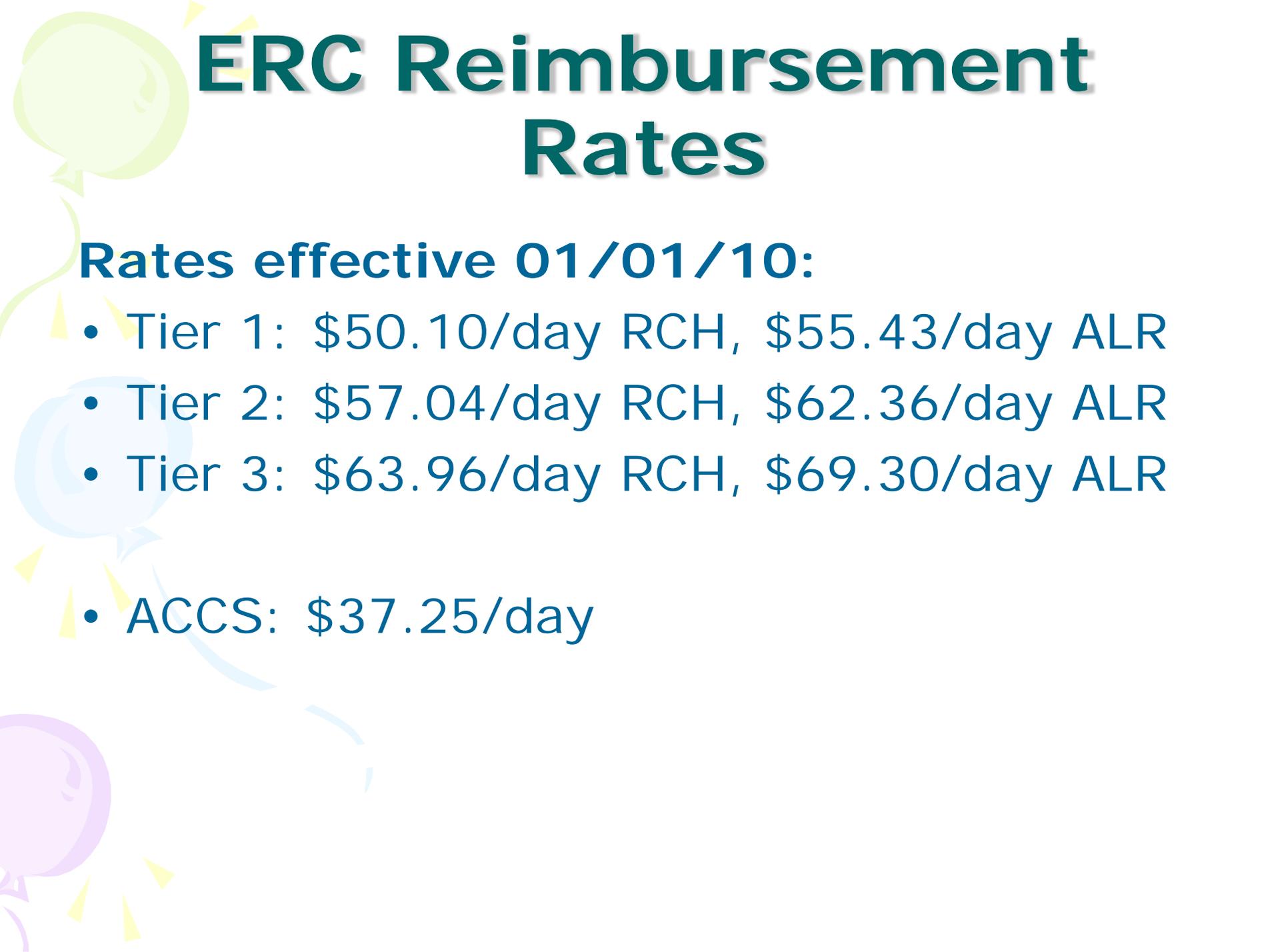
CFC ERC Admission Agreement Language

- Must reflect the homes policy to admit residents that exceed level III needs (RCH only).
- Must reflect the homes policy to accept Medicaid reimbursement for ERC.
- Must include the ERC bundled services.
- Must indicate the expectation that if applicable the resident will pay the patient share to the provider monthly. Must include the rate for room & board.
- Indicate that Room & Board plus the Medicaid (ACCS & ERC) reimbursement are the sole reimbursements for covered services.
- *DAIL has sample admission agreement language providers may use.*



Verifying Medicaid Eligibility

- Providers can verify long-term care Medicaid by calling MALCOLM 1-800-925-1706. You have to wait until the end of the recording for LTC CFC information.



ERC Reimbursement Rates

Rates effective 01/01/10:

- Tier 1: \$50.10/day RCH, \$55.43/day ALR
- Tier 2: \$57.04/day RCH, \$62.36/day ALR
- Tier 3: \$63.96/day RCH, \$69.30/day ALR
- ACCS: \$37.25/day



Total Reimbursement

- ERC Providers are reimbursement by the following:
 - From the Resident
 - Room & Board (in accordance with DAIL policy)
 - Patient Share if applicable
 - From Medicaid
 - ERC Tier as approved on CFC ERC Service Plan
 - ACCS daily rate

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Room & Board

- The resident pays the home directly for their room & board. They pay from their social security, pensions or other income.



Room & Board Factors

- The following factors effect what a Provider may charge for room & board for resident's whose care is paid for though Medicaid:
 - Shared or Private room/unit
 - The resident's income
 - The Medicaid program the resident is enrolled in
- The next few slides will explain the policy for resident's who are enrolled in Choices for Care ERC. For other programs such as the Development Services waiver or TBI program please refer to those programs.



Shared Occupancy

- Residents who reside in a shared room or unit may be charged up to the federal portion of the SSI rate in Living Arrangement C, as long as the resident retains at least \$65/month for personal spending.
- The current room & board rate for shared occupancy is a maximum of \$704.38 per month. If necessary, for the resident to retain \$65/month the home must accept less.



Private Occupancy

- Resident rooms and units are considered **private** when they are occupied by a household of one or a household of two comprised of a couple (spouses, civil union partners or relatives).
 - In a private room/unit, the resident's income effects what the Provider may charge for room & board.
- 
- 

Private Occupancy

Continued...

- For residents whose income is greater than SSI (\$769.38) and less than \$828.68 per month the home may charge up to \$704.38 per month.
- When a resident's income is greater than \$828.68/month and they are in a private room/unit the provider may chose to charge the resident 85% of their income after Medicaid. The resident's income will NEVER exceed the PIL (protected income level).



Determining Income

- The provider must know what the residents' income is.
 - Providers must gather income information from the resident or their legal representative.
 - Refer to the DCF Medicaid Notice of Decision to learn if the resident has a Patient Share.
 - Work with the CFC Case Manager.

Room & Board Calculations

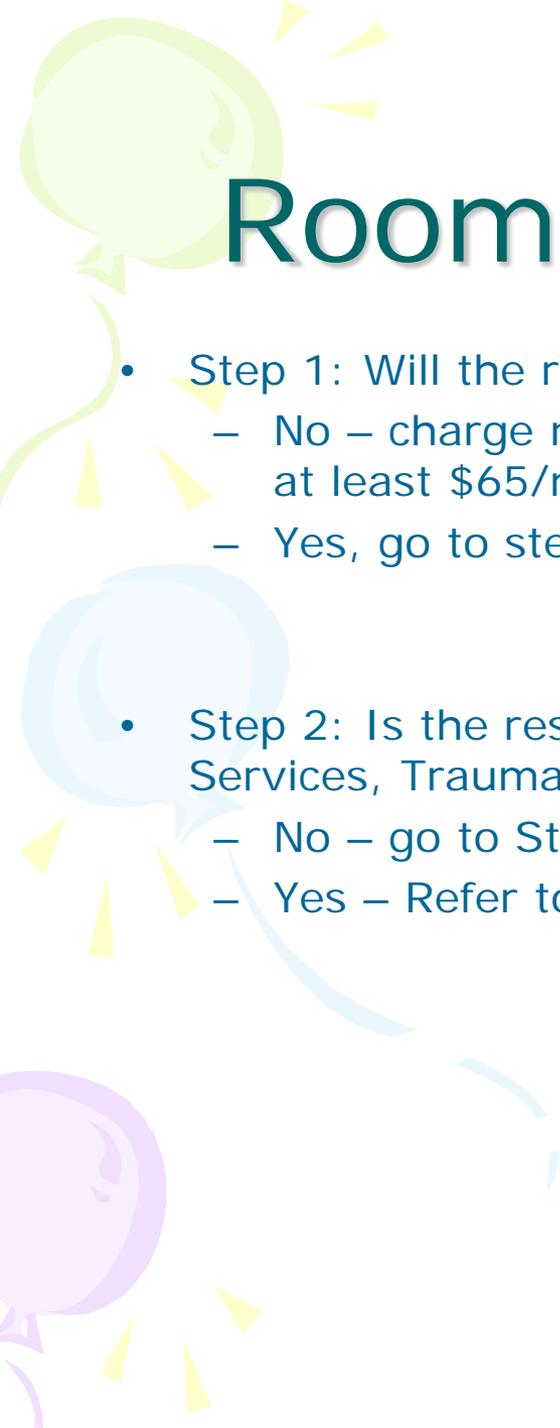
- While the terms are not equal between financial eligibility and room & board, if DCF has determined that an ERC resident has a patient share you can charge them 85% of the PIL inside Chittenden.

$$(\text{PIL for ERC}) \$1066 \times .85 = \$906.10$$

- **ERC residents in some cases may also allocate income to a spouse. If technical assistance is needed you can contact the ERC case manager.**

What a Provider must do before changing a Room & Board rate

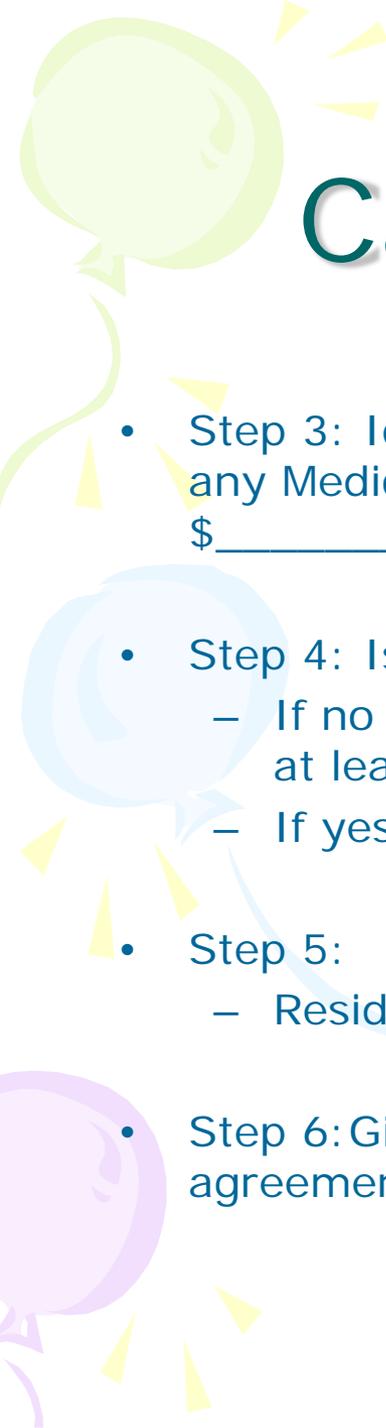
- Before changing a resident's room & board rate, the provider must give the resident a written notice of rate change.
 - Residential Care Homes – 30 days
 - Assisted Living Residences – 90 days
- Keep a copy of the rate change notice in the resident's file.



Room & Board Calculator

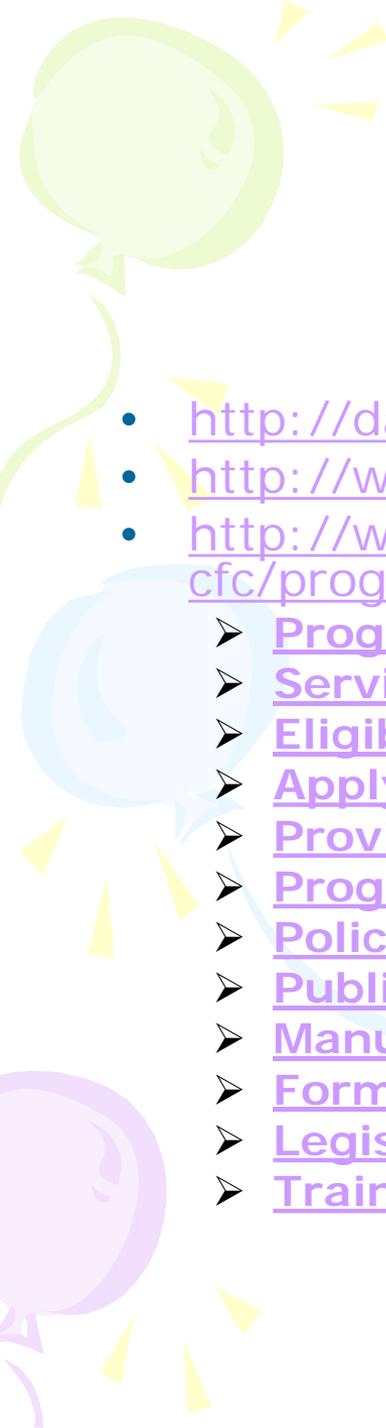
- Step 1: Will the resident occupy a private room?
 - No – charge no more than \$704.38/month. The resident must retain at least \$65/month spending money.
 - Yes, go to step 2.

- Step 2: Is the residents' care paid for through the Developmental Services, Traumatic Brain Injury or Mental Health (CRT) waiver?
 - No – go to Step 3.
 - Yes – Refer to that programs requirements.



Room & Board Calculator Continued...

- Step 3: Identify the residents' available monthly protected income (after any Medicaid patient share or allocation to a community spouse for ERC)?
\$_____ per month.
- Step 4: Is the resident's income greater than \$828.68 per month?
 - If no – charge no more than \$704.38/month. The resident must retain at least \$65/month spending money.
 - If yes – go to Step 5.
- Step 5:
 - Residents monthly income _____ multiplied by .85 = _____.
- Step 6: Give the affected resident a written notice and amend admission agreement.



CFC Resources

- <http://dail.vermont.gov/> (DAIL)
- <http://www.dail.state.vt.us/lp/> (DLP)
- <http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page> (CFC)
 - [Programs](#)
 - [Services](#)
 - [Eligibility](#)
 - [Applying for Services](#)
 - [Providers of Services](#)
 - [Program Contacts](#)
 - [Policies and Guidelines](#)
 - [Publications](#)
 - [Manuals](#)
 - [Forms](#)
 - [Legislation, Statutes and Regulations](#)
 - [Training, Conferences and Events Calendar](#)



Who Can I Call for More information?

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