VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING
DEVELOPMENTAL DISABILITIES SERVICES DIVISION
280 STATE DRIVE HC2 SOUTH
WATERBURY, VT 05671-2030
PHONE: 802-241-0304 FAX: 802-241-0410

CLIN – DD HCBS (211HCBS-ELIG)

DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY-BASED SERVICES

Eligibility Form

DA:
SSA:
Provider:

Name:
Address:

Date of Birth:

Legal Guardian or Other Representative (name and address):

1. Is the individual an eligible Medicaid recipient?

☐ NO. Individual is not eligible for home and community-based services.
GO TO NUMBER 8.

☐ YES. Fill in Medicaid number.

GO TO NUMBER 2.

2. Does the individual have a current diagnosis of an intellectual or developmental disability consistent with definition in Regulations?

☐ NO. Individual is not eligible for home and community-based services.
GO TO NUMBER 8.

☐ YES. Enter diagnosis and date.

Diagnosis **Month and Year** (e.g., Jan 18)

GO TO NUMBER 3.

Name:

3. Is the individual currently receiving the level of care provided in an ICF/DD which is reimbursable under the State Medicaid plan?

☐ NO. **GO TO NUMBER 4.**

☐ YES. Include a copy of the individual's most recent ISA. Describe briefly how the individual's needs can be met through providing home and community-based services.

GO TO NUMBER 5.

4. Would the individual be likely to receive the level of care provided in an ICF/DD which is reimbursable under the State Plan in the absence of home and community-based services?

☐ NO. Individual is not eligible for home and community-based services.
GO TO NUMBER 8.

☐ YES. What is the current information which indicates the individual's need for the level of care provided in an ICF/DD? List or attach results of formal assessments and describe current factors such as status of family, living situation, etc., that support the need for ICF/DD level of care. **NOTE: PSYCHOLOGICAL ASSESSMENT WITH ADAPTIVE BEHAVIOR VALUATION IS REQUIRED TO BE SUBMITTED WITH THIS FORM.**

5. Based on the State Funding Form document, the following allocation has been approved by DAIL:

$

Enter total funding approved, and date (to the right) **Month and Year**

Name: _____

6. Is the total cost of services less than or equal to the average annual cost of ICF/DD services that the individual would otherwise receive?

☐ NO. Individual may not be eligible for home and community-based services.

☐ YES. **GO TO NUMBER 7.**

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7 Individual has been found eligible for home and community-based services.

a. By what date will the individual and/or the individual's representative be notified of this eligibility?

_____

b. What is the anticipated start date of home and community-based services?

_____

NOTE: NOTIFY THE DEVELOPMENTAL DISABILITIES SERVICES DIVISION ASAP IF THE START DATE DIFFERS FROM THE DATE NOTED ABOVE, AND AMEND THE HCBS SPREADSHEET.

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8 Individual has been found to be ineligible for home and community-based services.

a. By what date will the individual and/or the individual's representative be notified of this determination and his/her right to appeal the determination? Attach copy of notification.

_____

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9 I have been informed of the alternatives available to me, and I choose (mark one):

☐ Feasible institutional services provided in an ICF/DD.

☐ Home and community-based services.

I understand that my signature below indicates that the above choices have been explained to me, and if I choose home and community-based services, I agree with the initial plan for services as presented here.

_____ _____

Date Signature of Individual (or parent/guardian if individual is a minor)

_____ _____

Date Signature of Guardian (if applicable)

Name: _____

10. Other Assessment Team Members:

Name and Title	Signature	Date
Name and Title	Signature	Date
Name and Title	Signature	Date

11. **The following information must be submitted with this original eligibility form:**

- ☐ Psychological evaluation with adaptive behavior assessment
- ☐ Individual Support Agreement
- ☐ Person's Story
- ☐ Signatures (pages 3 & 4)

QUESTIONS?
CALL THE DEVELOPMENTAL DISABILITIES SERVICES DIVISION AT (802) 241-0304

Name:	
Designated Agency (DA):	
Specialized Service Agency (SSA):	
Provider (if different from DA/SSA):	

For DDSD Use Only

This confirms the following individual's eligibility for home and community-based services:

Individual's Name:	
Effective Date:	
Approved Annual Budget:	
Procedure Code:	
Daily Rate:	
Annual Rate:	

For DA/SSA Follow-up ASAP:

The following information was not submitted with the Eligibility Form and is required in order to complete the eligibility package.

- ☐ Psychological evaluation with Adaptive Behavior Assessment
- ☐ Individual Support Agreement (ISA)
- ☐ Person's story
- ☐ Signatures (pages 3 & 4)

DDSD APPROVAL:

_____ _____
Signature Date

Distribution:

Person and/or Guardian (DA sends)
DS Director
DA/SSA Business Manager/HCBS Contact
DDSD QSR Contact Person
Other (list)