VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES (DARS)
AUXILIARY GRANT PROGRAM

PROVIDER/DSS COMMUNICATION FORM

AG Case Number:_____ Provider Name:_____

Recipient Name:_____SSN:_____DOB:_____

Address:_____

Medicaid ID:_____

Section I - Provider Completes This Section

Individual Status (Complete Appropriate Blocks). Report any admission, discharge, incarcerations and/or change in resident's status.

Person admitted to assisted living facility(ALF)/adult foster care home (AFCH)/Supportive Housing(SH) on _____(date)

Level of care: □ Residential □ Assisted Living

Individual discharged or expired on _____(date)

Discharged to: □ SH □ Hospital □ ALF □ AFCH □ Nursing Home □ other _____
□ Expired

□ Case is in need of an assessment

□ Individual's income or deductions have changed

□ Other:
Explain_____
_____

Prepared by Name:_____

Title:_____

Telephone:_____ Date:_____

Section II - DSS Completes This Section

Eligibility Information:

□ Auxiliary Grant approved beginning _____(date)

□ Medicaid approved beginning _____(date)

□ Auxiliary Grant denied effective _____(date)

□ Ineligible for Auxiliary Grant

from_____to_____due to a resource transfer.

Approved AG Rate

NOTE: ALF/AFCH/SH providers cannot collect more than the AG rate from the individual. Any income received by the individual in excess of the AG rate is to be retained by the individual. The amount an individual will normally retain will exceed his/her personal needs allowance.

ALF/AFCH/SH Rate: _____ for month of _____ .

ALF/AFCH/SH Rate: _____ for month of _____ .

Worker Name:_____

Agency Name:_____

Agency Address:

_____

Telephone: _____ Date: _____

PROVIDER/DSS COMMUNICATION FORM
Instructions

PURPOSE OF FORM--To allow the local DSS and the assisted living facility, supportive housing or adult foster care home provider to exchange information regarding:

1. The AG and Medicaid eligibility status of an individual;
2. The amount of income an eligible individual must pay to the provider toward the cost of care;
3. Admission or discharge of a person to home, hospital, another ALF/AFCH/SH, jail or an institution, or to report the death of a patient;
4. Other information known to the provider that might cause a change in the eligibility status.

USE OF FORM--Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each applicant at the time initial eligibility is determined. A new form must be prepared by the local DSS whenever there is any change in the person's circumstances that results in the individual's ineligibility.

The provider must use the form to show admission date, to request an AG or Medicaid eligibility status, to request a Medicaid recipient I.D., to notify the local DSS of changes in the individual's circumstances, of discharge or death.

NUMBER OF COPIES--Original and one copy.

DISTRIBUTION OF COPIES--Send the original to the provider and file the copy in the eligibility case folder.

INSTRUCTIONS FOR PREPARATION OF THE FORM -- Complete the heading with the name of the AG Case Number, Provider Name, Recipient Name, Social Security Number, Date of Birth, the address, and Medicaid I.D. Number.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Section II - Eligibility Information:

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of the Auxiliary Grant.
2. Check the second block if the individual is eligible for Medicaid.
3. Check the third block if the Auxiliary Grant was denied.
4. Check the fourth block if ineligible for AG due to transfer of resources. Dates of disqualification must be listed on the form.

AG Rate:

Enter the amount of the ALF/AFCH/SH rate, and month and year in which the rate is effective.
Fill in Worker Name, Agency Name, Agency Address, Telephone Number and Date the form was completed.