VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES
ASSISTED LIVING/ADULT FOSTER CARE HOME FACILITY/SUPPORTIVE HOUSING

ELIGIBILITY COMMUNICATION DOCUMENT

To/From: Dept. of Social Services Eligibility Worker in _____
(City/County Responsible for Auxiliary Grant)

Address: _____

To/From: _____
(*Assessor/Case Manager)*

Address: _____

1. Assessor's provider #: _____ (**required**) for non-LDSS assessors

2. RESIDENT**:** _____ **3**. SSN**:** _____

4. ALF/AFCH/SH and Location**:** _____

5. Medicaid #: _____

PURPOSE OF COMMUNICATION (check 1, 2, or 3):

☐ **1.** ***ANNUAL REASSESSMENT COMPLETED;* Date of Reassessment**: __/__/____
- **a.** ☐ ***Resident Continues to Meet Criteria for ALF/AFCH/SH Placement at the following level of care:***
  ☐ Residential Living-11 ☐ Assisted Living-12
- **b.** ☐ ***Resident Does Not Meet Criteria for Residential or Assisted living***

☐ **2.** ***RESIDENT NO LONGER RESIDES IN ALF/AFCH/SH ON RECORD***. Resident has been discharged to:
- **a.** ☐ ***Another ALF/AFCH/SH.*** Last Date of Service in the ALF/AFCH/SH on Record: __/__/____
  Name of New ALF/AFCH/SH : _____
  Provider #: _____ Start of Care Date in New ALF/AFCH/SH: __/__/____
  Address of New ALF/AFCH/SH:_____
- **b.** ☐ ***Home.*** Last Date of Service in the ALF/AFCH/SH: __/__/____
  New Address: _____
- **c.** ☐ ***Other*** (please specify): _____
  Last Date of Service in the ALF/AFCH/SH: __/__/____
  New address: _____

☐ **3.** ***AUXILIARY GRANT ELIGIBILITY TERMINATED*** Effective Date: __/__/____
Reason: _____

(Name of Assessor/Case Manager Completing Form)		*(Name of Eligibility Worker Completing Form)*	
(Signature of Assessor/Case Manager Completing Form)		*(Signature of Eligibility Worker Completing Form)*	
(Date)	*(Telephone No.)*	*(Date)*	*(Telephone No.)*

ALF/AFCH/SH ELIGIBILITY COMMUNICATION DOCUMENT INSTRUCTIONS

WHEN TO USE THIS FORM

This form is a communication tool between the local departments of social services (LDSS) eligibility worker, the assessor/case manager responsible for the 12-month reassessment of the assisted living facility (ALF) resident, Adult Foster Care Home (AFCH), Supportive Housing (SH). This form is completed by:

1. The assessor to the eligibility worker at the time of a 12-month reassessment (a finding that the resident continues to meet either residential-11, assisted living-12 is required in order for the eligibility worker to re-determine eligibility for an Auxiliary Grant (AG) payment;
2. Either the assessor or eligibility worker to the other whenever either becomes aware of a change in address; and
3. The eligibility worker to the assessor whenever the AG is terminated.

TO/FROM SECTION

Both TO/FROM sections must be completed. Completely fill in the locality of the DSS eligibility worker with address and indicate whether document is to be sent to or from the eligibility worker by circling "TO" or "FROM." In the second TO/FROM section, completely fill in the assessor's name, address and provider number which is required for payment for non-LDSS assessors and indicate whether the document is to be sent to or from the assessor or case manager by circling "TO" or "FROM."

RESIDENT IDENTIFICATION SECTION

1. List the Assessors provider number if not from LDSS.
2. Legibly print name of ALF/AFCH/SH resident who is being assessed, who has moved, or whose AG has been terminated.
3. Write in the resident's social security number.
4. Legibly print the name of the ALF/AFCH/SH in which the resident resides.
   List the address in which the ALF/AFCH/SH is located.
5. Write in the resident's Medicaid number.

PURPOSE OF COMMUNICATION SECTION: Check 1, 2, or 3.

If 1 is checked: (Annual Reassessment Completed), fill in the date of the reassessment. Check either A. (Resident continues to meet criteria for ALF/AFCH/SH placement at the following level of care) or B. (Resident does not meet criteria for residential or assisted living. If A. is checked, indicate which level of care the individual meets. **When1. is checked**, the non-LDSS assessor sends a copy of the Uniform Assessment Instrument (UAI) and the ALF/AFCH Eligibility Communication Document (ECD) to Xerox. Complete the CMS-1500 on-line. In addition, all assessors sends a copy of the ECD to the LDSS eligibility worker; copies of the UAI and ECD to the ALF/AFCH/SH; and a decision letter to the individual being assessed. The assessor should keep a copy of each of these documents for a period of not less than six years from the date of the screening.

NOTE: If a reassessment indicates a change in level of care, treat the assessment as a change in level of care. That is, send a copy of the UAI and the DMAS-96 to DMAS. In addition, send the eligibility worker a copy of the DMAS-96; send to the ALF/AFCH/SH copies of the UAI, DMAS-96, and decision letter; and send a decision letter to the individual being assessed. The assessor should keep a copy of each for a period of not less than six years from the date of the screening.

If 2 is checked: (Resident no longer resides in ALF/AFCH/SH on record), indicate to where the resident moved (i.e., another ALF, another AFCH or SH). For each, indicate the last date of service in the ALF/AFCH/SH on record. Complete other information such as new address, etc., if known. When 2 is checked, the non-LDSS assessor/case manager or eligibility worker completing the ECD should send a copy to the other and keep a copy for him- or herself.

If 3 is checked: (Auxiliary Grant Eligibility Terminated), the eligibility worker indicates the effective date of termination and the reason. Then the eligibility worker sends a copy of the ECD to the assessor/case manager.

SIGNATURES SECTION

For each form completed, only one signature section will be completed. For example, if an assessor is completing the form for a reassessment, the left-hand side with assessor information will be completed. If the eligibility worker is completing the form for notification of AG eligibility termination, then the right-hand side is completed. Please completely fill in the applicable section with printed name of individual completing the form, signature, complete date with month/day/year, and telephone number with area code.

Please photocopy this form as needed; plain paper copies are acceptable.