

**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:** \_\_\_\_\_

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**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.