

**FINAL – Revised 9/11/06 for Choices for Care  
Hospice/Choices for Care Services-Dual Participation  
Memorandum of Agreement-7/18/05**

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It is the goal of the Department of Disabilities, Aging and Independent Living (Department) and the VT Assembly of Home Health Agencies (VAHHA), to provide quality care to individuals in need of long-term care and hospice services. In order to facilitate improved access and continuity of care for individuals with a terminal diagnosis residing at home on the Choices for Care program, the Department and VAHHA have proposed the following.

Effective immediately, individuals currently participating on the Choices for Care program who become eligible for, and in need of Home Health Hospice services may do so without prior authorization from the Department. With this change, it is the understanding of both the Department and the Home Health hospice providers that dual participation will occur under the following conditions:

1. Hospice staff will inform the Choices for Care case manager immediately when a Choices for Care participant is admitted to hospice.
2. Individuals must continue to meet the criteria for both Choices for Care and hospice services.
3. When ever possible, hospice funded services must be maximized and utilized prior to Choices for Care services (e.g. LNA, Homemaker).
4. The cost of Choices for Care services will not increase after admission to hospice services.
5. When appropriate, the Choices for Care case manager will submit a plan of care change to reflect any reduction in waiver personal care time for activities that are being provided by hospice (e.g. bathing, grooming, homemaker).

It is the responsibility of the local home health agency to contact the Department no later than one week after a Choice for Care participant is admitted to hospice services. The Department will track the following information:

- Participant name,
- Agency name,
- Hospice diagnosis,
- Anticipated length of hospice service,
- Hospice admission date,
- Payment source,
- Hospice contact,
- Copy of Hospice plan.

This information must be mailed or faxed to the Department and Choices for Care case manager using the attached notice.

## **NOTICE**

### **Choices for Care Participant Admission to Hospice**

Date: \_\_\_\_\_

Individual Name: \_\_\_\_\_

Home Health Agency: \_\_\_\_\_

Hospice Diagnosis: \_\_\_\_\_ Admission Date: \_\_\_\_\_

Anticipated Length of Stay on Hospice: \_\_\_\_\_

Payment Source:  Medicare,  Medicaid,  Private Insurance,  Other: \_\_\_\_\_

Hospice Staff Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

*Use table below to indicate Hospice Plan or attach a copy:*

<b>Hospice Services</b> <i>(check all that apply)</i>	<b>Frequency of Hospice Services</b>
<input type="checkbox"/> Skilled RN:	
<input type="checkbox"/> LNA:	
<input type="checkbox"/> Homemaker:	
<input type="checkbox"/> MSW:	
<input type="checkbox"/> Volunteer:	
<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:	

*Comments:*

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**Mail or FAX to:** Choices for Care Case Manager

**Mail or FAX to:** Long-Term Care Clinical Coordinator

**Mail or FAX to:** Megan Tierney-Ward  
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