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| **APPLICATION FOR RATE ADJUSTMENT** | | | | | | | | | | | | | | | | | |
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| **Instructions**: | | | | | | | | Please complete this form in its entirety. This form should be accompanied by all documents and proofs necessary for the Division to make an informed decision pursuant to V.P.N.M.I.R. § 8. If sufficient information is not provided the Director may reject this application. V.P.N.M.I.R. § 8.2(b). | | | | | | | | | |
| **Provider’s name:** | | | | | |  | | | | | | | | | | | |
| **Describe the nature of this rate adjustment.** | | | | | | | | | | | | | | | | | |
| **What is the annual cost of this rate adjustment?** | | | | | | | | | | | | | | | | | |
| **Is the amount material pursuant to *PNMI P&P Issuance 14-2*?** **Yes**  **No .**  Attach work papers. | | | | | | | | | | | | | | | | | |
| **When was the increase in costs incurred?** | | | | | | | | | | | | | | | | | |
| **Will this cost increase be permanent? Yes**  **No .** | | | | | | | | | | | | | | | | | |
| **Explain why this rate adjustment is reasonable, necessary, and related to resident care?** | | | | | | | | | | | | | | | | | |
| **Is this rate adjustment the result of a:** | | | | | | | | | | | | | | | | | |
|  | | | | **Required program change,** | | | | | | | | | | | | | |
|  | | | | **True emergency, or** | | | | | | | | | | | | | |
|  | | | | **Circumstance that was not foreseeable at the time the current rate was set?** | | | | | | | | | | | | | |
| **Please explain.** | | | | | | | | | | | | | | | | | |
| **Are the spending increases due to changes in law or Vermont policies? Yes**  **No .**  If yes, attach a copy of the relevant statute, rule, regulation or order, and work papers that show the cost of compliance, the relevant base year costs (if any), and how the incremental costs have been calculated. | | | | | | | | | | | | | | | | | |
| **Does this request involve increases in staffing costs?**  **Yes**  **No .**  If yes, please provide staffing data comparing the staff full time equivalents and annual salaries by position type for the base year in effect and the current period. Please provide backup documentation, such as payroll register information. For additional staff, include hire dates. | | | | | | | | | | | | | | | | | |
| **Was there a change in the number of licensed beds? Yes**  **No .**  If yes, answer the following: | | | | | | | | | | | | | | | | | |
|  | **What was the change in licensed beds?** | | | | | | | | | | From |  | | to |  | |  |
|  | **When was this change effective?** | | | | | | | | |  | | | | |  | | |
|  | **Explain why this change would increase the average cost to care for the residents.** | | | | | | | | | | | | | | | | |
| **I am the representative of the above referenced provider for this matter pursuant to a Notice of Representation filed with the Division. I understand that all correspondence on this matter will be sent to me.** | | | | | | | | | | | | | | | | | |
| Signature | | | | |  | | | | | | | Date | |  | | | |
| Printed Name | | | | | |  | | | | | | | | | | | |
| Company Name | | | | | | |  | | | | | | | | | | |
| Address | | |  | | | | | | | | | | | | | | |
| City | |  | | | | | | | State | |  | | | Zip Code | |  | |
| Telephone | | | | |  | | | | | | Email | |  | | | | |
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| **For Division of Rate Setting’s Use Only.** | | | | | | | | | | | | | | | | | |
| **Request received:**  **(Date Stamp)** | | | | | | | | | | | **cc: Provider’s representative on:** | | | | | | |