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1000.1 Introduction- Eligibility for Institutionalized Persons

Before determining a person's financial eligibility for a long-term care coverage category, it must first be determined that the person is considered institutionalized and that all non-financial requirements under COMAR 10.09.24.05 have been met (see Section 500). Institutionalized persons must meet the same MA non-financial requirements under COMAR 10.09.24.05 as non-institutionalized persons.

Also, the application process specified under COMAR 10.09.24.04 must be followed by the CM and by the applicant or representative. The applicant is entitled to an eligibility determination within 30 days of the application date (or 60 days if a disability determination is required), unless the CM grants an extension of time limits (see Section 400).

There are specific provisions for evaluation of resources for institutionalized persons, especially married couples (including separated couples). The special treatment of resources for married couples is called the "Spousal Impoverishment" provision and is addressed in this chapter. The lien provision is also briefly addressed in this chapter; however, for a thorough explanation of this provision, the CM must refer to COMAR 10.09.24.15 (see Section 1500).

This chapter also deals with income eligibility for institutionalized persons, which is based on a comparison of a person's available income to the cost of the person's care in a Long-Term Care Facility. This comparison determines if the person is eligible for MA, as well as whether the Program will assist with payments towards the cost of care. If the Program assists with payments towards cost of care, the person is also required to contribute his available income towards this expense.

This section also addresses continuing eligibility for institutionalized persons.

(a) The Meaning of "Institutionalized"

Persons Aged 21 or Older

A person aged 21 or older is considered "institutionalized" when he/she:

- Resides in a licensed and certified Long-Term Care facility (LTCF);
- Has resided in an LTCF for a continuous period of 30 consecutive days or, if less than 30 consecutive days, is likely to remain there for 30 consecutive days; and
- Has a medical need for Long-Term Care (LTC) as certified by the Utilization Control Agent on the DHMH 257.

Note: If the CM does not receive the DHMH 257 from the LTCF by the due date for the MA-LTC eligibility determination, the application should be denied due to lack of this verification, in accordance with the provisions of COMAR 10.09.24.04J (3)—Information Required. However, before the application is denied, the applicant should be given timely notice of the need for receipt of the DHMH 257 and any other outstanding verifications, and be given a due date for return of the verifications.

A person who has been admitted to a LTCF and subsequently dies is considered institutionalized for eligibility purposes.

For a person who has resided in the LTCF less than 30 days, the CM must determine if the person is likely to remain for 30 consecutive days. This information may be obtained from the person's physician, a social worker who is familiar with the person's current medical condition and living arrangement, or the Utilization Control Agent. Documentation that has been collected to determine other eligibility factors may be used to determine if the person is expected to be in LTC for at least 30 consecutive days.

Examples:

Physician's Report (DHMH 4245)

LTC Patient Activity Report (DHMH 257)

Notice of Medical Review Decision (DHMH 4246 (LTC)). If these documents do not establish that the person is expected to remain at least 30 consecutive days, a written statement must be obtained from a knowledgeable source (physician, social worker, or the Utilization Control Agent. This statement must include the name of the person in LTC, date of admission, anticipated length of stay, and the name, title, and dated signature of the person making the statement. The statement must be based on recent medical and social data available to the writer.

A period of institutionalization is interrupted by absences from the LTCF of 30 consecutive days. When a person is discharged from the LTCF to an acute hospital, institutional status is not interrupted regardless of the length of hospital stay. Transfer from one LTCF to another does not interrupt institutional status. A person who was considered institutionalized based on the documentation described above, and who is subsequently discharged to the community before actually residing in the LTCF for 30 consecutive days, does not lose institutional status until the first full month after discharge. Any institutionalized person who is discharged to the community loses institutional status in the first full month after discharge unless readmitted within 30 days of the date of discharge.

Upon readmission to an LTCF after an absence of 30 days or more, a new period of institutionalization begins.

An unmarried person under 21 is considered institutionalized when he/she:

- Resides in a licensed and certified long term care facility (LTCF);
- Resided there on the first day of the month and throughout the entire month; and
- Has a medical need for Long Term Care (LTC).

Any person who does not meet all of the above criteria cannot be considered institutionalized and that person's eligibility must be determined under Section 900.

LTC is considered a medical need when a person requires an intermediate, skilled or chronic level of care. Residence in the LTCF and level of care are verified by the Utilization Control Agent (UCA), a private organization that is contracted by the Department to provide this information to the LDSS. Licensed and certified LTCFs are listed in Schedules MA-4 and MA-5.

A person's institutional status is not interrupted by:

- Medicare or other health insurance coverage;

- Transfer to an acute hospital;
- Expiration of bed reservation;
- Transfer from one LTCF to another; or
- Death.

(b) The Assistance Unit

The assistance unit consists of the institutionalized person only. A person discharged to the community remains a unit of one for the entire month of discharge. If a married couple is institutionalized, each spouse will be considered a separate unit and must file a separate application, even if the couple lives together in the facility.

A child (unmarried person under 21) is considered an assistance unit of one in the first full month of institutionalization and only the child's income and resources are considered. If a child is admitted to a LTCF on any day other than the first day of the month, he/she is considered a part of the family unit for that month and both the child's and parent's income and resources must be considered in determining eligibility in accordance with Sections 600 and 900.

(c) Non-Financial Eligibility Requirements

A person must meet all non-financial criteria and comply with all eligibility requirements. A person is ineligible in any month that non-financial criteria are not met or when the person fails to comply with any eligibility requirement.

The lien provision is specific to institutionalized persons. Refer to Section 1500 to determine applicability of the lien provision and procedures for implementation.

(d) Period Under Consideration

The period under consideration for institutionalized persons is that period for which income and resources are evaluated. The period under consideration may or may not correspond to the date of application or certification period.

- For persons who applied prior to being considered institutionalized and for whom the LDSS does not require a new application, the 6-month period under consideration begins with the first month of institutionalized status.
- For all other institutionalized persons, the 6-month period under consideration begins with the month of application.

Current eligibility for institutionalized persons is determined for the initial period under consideration as well as the succeeding 6-month period under consideration.

For retroactive eligibility, the period under consideration is the one, two, or three consecutive months for which coverage is requested within the three-month period prior to the month of application.

(e) Resources

Resources for institutionalized persons are evaluated in accordance with Section 800. For the purpose of assessing resources and determining resource eligibility, countable resources are those resources which are not subject to exclusion, e.g. bank accounts, non-home real property, cash, etc. Excludable resources are those resources which are not counted in determining resource eligibility. Such exclusions include the home, certain burial funds, personal effects, etc. Refer to COMAR 10.09.24.08 for countable and excludable resources.

For an institutionalized person who is not married, only the resources of the institutionalized person are considered.

If an institutionalized person is married and shares the same room with his/her spouse in the LTCF, their combined resources will be considered available to each other for the first six (6) months of institutionalization (beginning with the earliest month that either spouse is considered institutionalized) and the MA-2 standard for two persons will be applied. Beginning with the seventh (7th) month of institutionalization, if a husband and wife live together in the long term care facility, the resources of each will be considered separately even if they share the same room.

For a person who was institutionalized prior to 9/30/89 and has a spouse living in the community, only the resources of the institutionalized person will be considered.

For the persons listed above, countable resources of the institutionalized person are compared to Schedule MA-2. If countable resources are greater than the MA-2 standard, the person is not eligible. If resources are equal to or less than the standard, the person may be eligible and the person's income must be evaluated.

(f) Spousal Impoverishment

Financial eligibility for these institutionalized persons is determined according to regulations for preventing Spousal Impoverishment found in COMAR 10.09.24.10-1. Spousal impoverishment provisions apply when an applicant for MA-LTC is married to a person who is living in the community—that is, not in a medical institution or a nursing facility.

For an institutionalized person with a community spouse, there is a 3-step process for determining resource eligibility.

1. An assessment of the couple's countable resources as of the beginning of the first continuous period of institutionalization;
2. An eligibility determination based on attributing a specific portion of the resources to the institutionalized spouse and a specific portion to the community spouse; and
3. A post-eligibility period during which the resources attributed to the community spouse during the eligibility determination are actually placed in the name of that spouse.

A resource assessment is an evaluation of the couple's total combined resources as they existed at the beginning of the first continuous period of institutionalization. This assessment may be made prior to application for Medical Assistance at the request of either spouse or a representative. Upon admission, a nursing home is required to advise the client and family that a resource assessment is available upon request. The client and family should further be informed that the assessment is a necessary part of the Medical Assistance eligibility determination process. Should

the assessment be requested prior to application, it will be done by the Office of Eligibility Services (OES). A fee will be assessed for this service.

When a person applies for Medical Assistance, the CM must ask the applicant or representative if an assessment has been done. If it has, the LDSS must request a copy of the assessment from the OES by name and social security number of the applicant. Request a copy even if the A/R has a copy of his /her assessment notification. The assessment may be appealed at the time of the notification of the eligibility determination.

If an assessment was not made prior to application for Medical Assistance, the CM must make the assessment. There can be no charge for this, as it is part of the eligibility determination.

Resources must always be assessed as they existed at the beginning of the first continuous period of institutionalization, regardless of when the assessment is actually made or by whom.

To assess a couple's resources:

1. Determine when the first continuous period of institutionalization began. To decide this, the following questions will need to be answered:
 - When was the person first admitted to the LTCF?
 - Was the person admitted from the community or as a transfer from another LTCF? If a transfer, when was the admission to the first LTCF?
 - If the person was admitted from an acute care hospital, was he/she in LTC immediately preceding the hospitalization? If so, when was the person admitted to that facility?

For an applicant who has been recently institutionalized, this information should be readily available from the documents obtained during the eligibility determination process. For a person who has paid privately for some time, a more thorough inquiry must be made to accurately determine the month the first continuous period of institutionalization began.

2. Determine the couple's total combined countable resources as they existed in the month that the first continuous period of institutionalization began.

- The same rules used to determine resource eligibility are applicable in the assessment.
- All non-excludable resources owned by either or both spouses are included in the assessment.

3. Once the value of the couple's total combined countable resources has been determined, divide this figure by two. The result, one half of the total, is the Spousal Share. **This share remains unchanged throughout the continuous period of institutionalization, even though the amount of total resources may change.**

Once the spousal share has been established, either by the Office of Eligibility Services or the CM, the appropriate amount to attribute to each spouse must be decided upon. (At this point, the amount attributed to either spouse is unrelated to actual ownership of the resources. For example, jointly held resources may be entirely attributed to one spouse, or resources held in the husband's name only may be attributed to the wife.) The purpose of attributing resources is to

determine how much of the couple's resources are to be protected for use by the community spouse and how much is to be considered available to the institutionalized spouse in the eligibility determination. The amount to be protected for the community spouse is a spousal share of at least the minimum but not more than the maximum spousal share listed in Schedule MA-8. If the spousal share exceeds the maximum amount allowed, the excess will not be protected, but will be considered available to pay towards the cost of care for the institutionalized spouse. If the spousal share is less than the minimum amount allowed, more of the couple's resources will be attributed to the community spouse to allow that spouse to retain an amount as close to the minimum spousal share as possible. While these guidelines are established by federal law, a court-ordered support arrangement or the decision of an Administrative Law Judge would take precedence over these amounts.

The amounts to be attributed are determined at the time of application for Medical Assistance. To determine these amounts, the CM must:

1. Establish the couple's total combined countable resources as of the month of application;
2. Deduct from the above figure the greater of:
 - The spousal share (determined in the resource assessment) not to exceed the maximum (Schedule MA-8);
 - The community spouse minimum spousal share; or
 - The amount ordered by a court or a hearings officer.

The figure selected in this step is the amount to be protected for the community spouse.

3. The remainder is the amount to be attributed to the institutionalized spouse. Compare this to the Schedule MA-2 for one person. When the remaining resources are equal to or less than the amount in Schedule MA-2, the institutionalized spouse is resource eligible. If the remaining resources are above the standard, the institutionalized spouse is not eligible.

When the resources exceed Schedule MA-2, the institutionalized spouse is ineligible until the couple's total combined countable resources are reduced to the sum of:

- The amount to be protected for the community spouse (Step 2 above); plus
- The resource standard (Schedule MA-2) for the institutionalized person.

The excess resources must be used to pay for the cost of care or other documented medical or personal expenses.

Once an institutionalized spouse has been determined eligible, beginning with the second month of eligibility, only those resources held in the institutionalized spouse's name are used for future redeterminations, and resources owned by the community spouse are not considered available to the institutionalized spouse. Those resources owned by the institutionalized spouse will continue to be compared to the Schedule MA-2 standard for one person.

After the initial eligibility determination has been made, resources attributed to the community spouse must be legally transferred to that spouse when they are not already in his/her name.

The resources must actually be made available to the community spouse (i.e. must be

separated from the resources of the institutionalized spouse) if they have been attributed to him/her in determining eligibility for the institutionalized spouse.

Once eligibility has been determined, the institutionalized spouse must indicate to the LDSS his/her intent to transfer resources to the community spouse, the transfer must take place within the “protected period” of 90 days immediately following a determination of eligibility. If it has been determined, in a specific case, that a longer period is required to complete the transfer (e.g., when a court is involved in assigning a couple’s property through support actions, etc.), additional time may be granted based on the individual case situation. The case must be flagged to make sure the transfer takes place at the earliest possible time.

When an eligible institutionalized spouse has additional resources, the resources will not result in ineligibility when one or both of the following conditions exist:

- The new resources, combined with other resources the institutionalized spouse intends to retain, do not exceed the resource limit for one person; and/or
- The institutionalized spouse intends to transfer, within the protected period, new resources to a community spouse, if the community spouse’s resources:
 - Were below the minimum spousal share at the time of the determination of the spousal share; and
 - Would remain below the minimum spousal share if additional resources were transferred (Schedule MA-8).

If the new resources are promptly reported to the local department along with a statement of intent to transfer, a protected period of 90 days begins from the date of receipt of the resources. No protected period exists when, as of the date that the new resources are received, the community spouse already has in his/her name resources equal to or greater than the minimum spousal share.

Those resources owned by the institutionalized spouse and not transferred out of his/her name will be used to determine continuing eligibility, even if they had been attributed to the community spouse during the eligibility determination.

Resources held by an institutionalized spouse will not be counted in a redetermination if the resources are transferred to any party for which there is no penalty for failure to receive fair market value, or if the institutionalized spouse receives fair market value for the transferred resources within 30 days.

There are three instances in which the amount of resources to be protected for a community spouse may be increased. These are:

1. If it is determined by a hearings officer that the income generated from the spousal share is inadequate to meet the community spouse’s monthly maintenance needs;
2. If either member of the couple alleges that the initial determination was incorrect and the allegation is confirmed by a hearings officer; or
3. If it is determined by the LDSS that inaccurate information was provided when the spousal share was calculated.

(g) Income Evaluation

After an institutionalized spouse has been determined to be resource eligible, income must be evaluated and income eligibility determined. Income is evaluated in accordance with Section 700.

The institutionalized person is considered separated from the non-institutionalized spouse or family and only the income of the institutionalized person is considered. When a husband and wife share the same room in a LTCF, their income is not considered available to one another and the income of each will be considered separately.

The income evaluation must be made for all institutionalized persons, including SSI recipients. (Although the SSI benefit for an institutionalized person is reduced, it is still possible for the SSI recipient to have other income. Refer to the appropriate sections for treatment of an SSI recipient's income.)

Total monthly income, less the allowable deductions specified in this section, is the available income which is compared to the monthly cost of care (COC). If available income is less than the monthly COC, the person is eligible for MA and the Program will assist with payments towards COC. If available income is equal to COC, the person is eligible for MA, but the Program will not assist with COC. If available income is greater than monthly COC, the person may be eligible for MA under the spend-down provision, but the Program will not assist with COC.

(h) Determining Total Monthly Income

The income exclusions under COMAR 10.09.24.07(J) and (K) apply to the income of an institutionalized person.

For current eligibility, income is considered for the current 6-month period under consideration, beginning with the month of application or the first month, in which the person is considered institutionalized, whichever is later.

This is not true for an SSI recipient because an SSI recipient is categorically needy and, as such, does not contribute towards his/her COC, unless they have other income in addition to SSI. SSI offsets a recipient's monthly income to allow the person's income to meet the SSI standard. In the first month of institutionalization, the SSI recipient is given the Personal Needs Allowance and the Residential Maintenance Allowance. Since these two deductions are greater than the person's monthly income, there is no remaining income in the month of admission. Consequently, the SSI recipient with no monthly income other than SSI has no income to contribute towards his/her COC. Beginning the second month of institutionalization, the SSI benefits are reduced to the SSI standard of \$30, which is less than the MA Personal Needs Allowance. The person will continue to have nothing to contribute to his/her COC. Therefore, an SSI recipient in long-term care with no countable income is determined eligible in coverage group L01 with no contribution to COC.

If an SSI recipient receives countable monthly income in addition to SSI benefits, the person's other monthly income is considered in order to determine the recipient's contribution to cost of care. Eligibility is determined in coverage group L98. The LDSS must require an

application form to collect the information necessary to calculate the available income. (See Policy Alert 10-08 for redetermination procedures when SSI recipients enter LTC.)

Income that is received on a regular basis in a constant amount is considered based on documentation from the source of income. This includes benefits such as Social Security, pensions, V.A. benefits, etc. **The CM should set an alert to verify income that has an annual cost of living increase.**

Income that is variable in amount, or is received less frequently than once a month, is projected throughout the period under consideration based on the amounts received in the twelve months prior to the period under consideration, or on projections documented by the source of such income. This projection for the period under consideration is then converted to average monthly amounts. This type of income includes interest, dividends, one-time-only income, lump sum benefits, etc.

For current eligibility, the total monthly income equals the monthly amount of regular income plus the average monthly amount of variable income.

For a retroactive month, total monthly income is the amount actually received in the month.

(i) Determining Monthly Available Income

To determine monthly available income, begin with the total monthly income as determined above and deduct the following, in the following order (see Schedule MA-8 for the current amounts):

- A Personal Needs Allowance;
- A Residential Maintenance Allowance;
- A Spousal Allowance;
- Either a Family Allowance for minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse; or a Dependent Allowance, as appropriate;
- Incurred expenses for medical care or remedial services for the institutionalized spouse that are not subject to payment by a third party, including:
 - Medicare and other health insurance premiums, deductibles or co-insurance charges; and
 - Necessary medical care or remedial services recognized under State law but not covered under the Medical Assistance State Plan for the recipient.

The personal needs allowance is always deducted first, to ensure that the institutionalized person has this money available to him/her even if the remaining income is insufficient to cover the other deductions.

To determine which deductions are applicable and the appropriate amount of each deduction, use the following guidelines:

1. Personal Needs Allowance

This is an allowance to enable the person to meet daily living expenses in the long- term care facility that is not covered by the Program.

For a person who resides in intermediate care facility for the mentally disabled or mental institution and receives pay for therapeutic work activities, the personal needs allowance is \$100.00. If documented work expenses exceed this amount, additional allowance may be made for these up to the medically needy income limit (MNIL).

2. Residential Maintenance Allowance

This is a deduction to enable a lone person to maintain a community residence. A lone person is one who does not have a spouse or dependent children at home. This allowance is given if the person must pay expenses such as rent, mortgage, taxes or utilities in order to maintain his community residence.

The residential maintenance allowance is applicable in three circumstances:

- When a person's intent to return home within 6 months is supported by
- medical documentation;
- In the month of admission; and
- In the month of discharge to the community.

The allowance may be given up to the amount of the MNIL for one person, based on the documented household expenses. If the expenses are less than the MNIL, only the actual monthly amount of expenses is allowed.

Application of the Residential Maintenance Allowance:

When a Person Intends to Return Home Within Six Months

This deduction applies to a person who:

- Has resided in a LTCF less than six full months;
- Intends to return to his/her community residence within six months of the current admission to the LTCF and his/her ability to do so has been verified by a written physician's statement. DHMH Form 4245 (LTC) Revised 11/03, Physician Report, is used for this purpose. If the report indicates the person's anticipated length of stay is six months or less, the Residential Maintenance Allowance is given. A medical review by the Utilization Control Agent is not required for this allowance.

If the person has been institutionalized for more than six consecutive months as either private pay and/or MA, the Residential Maintenance Allowance may not be given. The person's institutional status is not interrupted by transfer from one LTCF to another or by admission to an acute hospital. This allowance is given for a maximum of six months and possibly less, based on the date of institutionalization, and may not be extended regardless of the person's condition and intent.

NOTE: DHMH Form 4245 (LTC) Revised 11/03, Physician Report, is a two purpose form. It is also used in implementing the Medical Review process for LTC home

property owners under lien procedures. When the lien process is applicable to the LTC person, refer to Section 15 for specific procedures concerning the use of this form for the Medical Review process.

Month of Admission

For a lone person over 21 who is admitted to an LTCF on any day other than the first day of the month, the residential maintenance allowance is given to enable the person to meet financial obligations associated with living in the community, such as rent and utilities.

Month of Discharge

For a lone person over 21 who is discharged from an LTCF to the community, the Residential Maintenance Allowance is given to enable the person to meet expenses related to resuming community residence, such as rent and utilities.

While the allowance in the months of admission and discharge is unrelated to the first circumstance described above, there is still a regulatory limit of 6 months for the residential maintenance allowance. Therefore, when a person receives this allowance in the month of admission, then presents medical documentation to support the intent to return home within 6 months, this allowance can be given for 5 additional months, for a total of 6 months. If the person receives this allowance for the maximum of 6 months, and does not return at the end of that time, the allowance cannot be given again in the month of discharge.

3. Spousal Allowance

This is a deduction from the income of the institutionalized person to enable the spouse to be maintained in the community. This applies only to a legal spouse, including a spouse from whom the institutionalized person was separated prior to institutionalization.

Under the Spousal Impoverishment provision, the Spousal Allowance is based on an amount related to the Federal Poverty Level for two persons. This amount is intended to meet the basic maintenance and shelter needs of the community spouse, enabling the person to maintain the living arrangement the couple had prior to the institutionalization of one spouse. If a person's shelter costs exceed 30% of that amount, the community spouse may qualify for an excess shelter allowance in addition to the basic maintenance and shelter. The sum of the basic maintenance and shelter and the amount for "excess shelter" may not exceed the amount in Schedule MA-8. There is no limit to the amount of resources a community spouse can retain and still be eligible for this allowance.

The following standards, found in Schedule MA-8, are to be used in calculating the community spousal income.

1. Basic Maintenance and Shelter (BMS);
2. Excess Shelter Standards (ESS);
3. Maximum Allowable Maintenance and Shelter Costs (MAMSC); and
4. Utility Standards (US).

Using the appropriate figures, take the following steps to determine the community spousal income allowance:

1. Determine the amount of income the community spouse needs to meet his or her monthly maintenance and shelter needs. This is equal to the sum of:
 - A BMS Need; plus
 - An amount for excess shelter, if the spouse qualifies for one.
2. To determine if the spouse qualifies for excess shelter and, if so, the amount:
 - Calculate the community spouse's total expenses for shelter. Expenses for shelter include rent or mortgage payment, property taxes and homeowner's insurance for the spouse's principal place of residence plus a Utility Standard as appropriate; and
 - Compare to the ESS.

If the sum of the community spouse's shelter expenses exceeds the ESS, allow the spouse an amount for excess shelter equal to the amount by which the shelter expenses exceed the ESS, up to the MAMSC. If the spouse's total expenses for shelter do not exceed the ESS, do not give an excess shelter allowance.

3. From the total maintenance and shelter costs (the sum of the BMS plus the excess shelter as determined in Steps 1 and 2), subtract the amount of other income the spouse has available to him/her. In determining the amount of income that would be available to the community spouse, do not count any income that is excludable under COMAR 10.09.24.07J or K. Use gross income figures and do not apply any income disregards. The total maintenance and shelter less the income available to the community spouse is the Spousal Allowance. Deduct it from the institutionalized spouse's monthly income.

NOTE: To qualify as a deduction, the spousal allowance must actually be made available to the community spouse. If it is not made available to the community spouse on a regular basis, do not allow it as a deduction.

4. **Family/ Dependent Allowance**

A. Family Allowance

The family allowance may be deducted for each of the following family members of the institutionalized spouse or the community spouse who are living with the community spouse:

- Minor or dependent children; and
- Dependent parents; and
- Dependent siblings.

For the purpose of the Family Allowance, "dependent" means that the child, parent or sibling is claimed as a dependent by either member of the couple for tax purposes with the

Internal Revenue Service. A minor child (under 21) living with the community spouse is automatically considered a dependent.

To determine if the family member is entitled to the Family Allowance:

1. Calculate the family member's gross monthly income. Do not count any income excludable under COMAR 10.09.24.07J or K. Do not apply any income disregards.
2. Compare the figure to the BMS amount.
 - If the family member's gross monthly income exceeds the BMS, the family allowance is not applicable.
 - If the income is less than the BMS, divide the difference by 3. The result is the amount of the Family Allowance for that family member.

Deduct the Family Allowance from the institutionalized spouse's monthly income.

If a court or a hearings officer has ordered support payments greater than the amount **determined by this method, allow the larger amount.**

B. Dependent Allowance

This is a deduction from the income of an institutionalized person who does not have a spouse living in the community to enable that person's dependents to be maintained at the MNIL appropriate to the family size. This applies only to unmarried children under 21 years from whom the institutionalized person is separated solely due to institutionalization.

- The resources of the dependents are evaluated under Section 800. To allow this deduction, countable resources must be within the appropriate MA-2 standard.
- The income of the dependents includes earned and unearned income as specified in COMAR 10.09.24.07H and I.
- To calculate the income of the dependents, apply the income exclusions specified in COMAR 10.09.24.07 J and K with the following exceptions:
 - Money received from performing volunteer work;
 - Educational expenses;
 - Earned income of a blind or disabled child;
 - Infrequent or irregular earned income;
 - Infrequent or irregular unearned income;
 - Work study; and
 - Earnings of a person younger than 21.

Income from these sources is not excluded in determining family income. No income disregards are allowed when determining family income. The appropriate MNIL, based on family size, less total countable (non-excluded) family income, equals the dependant allowance.

5. Medicare and Other Health Insurance Premiums

Medicare premiums are deducted in the first two months of MA eligibility. Beginning with the third consecutive month of MA eligibility, State Buy-In becomes effective. This means that the State will pay the Medicare premium for the eligible person beginning the third month of MA eligibility; therefore, the Medicare premium may no longer be allowed as a deduction from the person's income. Buy-In continues as long as the person remains eligible for MA and is only terminated or cancelled on-line via the Certification/Turnaround Document (C-TAD).

When Buy-In is interrupted by a period of ineligibility it will be two months before recertification resumes. The delay is caused by the processing time between the Department of Health and Mental Hygiene and the Centers for Medicare and Medicaid Services. Premiums withheld due to the processing delay will be refunded to the recipient by the Centers for Medicare and Medicaid Services.

Health insurance premiums are an allowable deduction only if paid from the income of the institutionalized person for coverage of the institutionalized person. The amount of the deduction is based on the most recent bill. If the bill is paid monthly, the amount of the bill is deducted each month. If the premium is paid quarterly, semi-annually, or annually, the premium is prorated to arrive at a monthly cost. This cost is deducted each month. Semi-annual and annual premiums may be deducted on a one-time-only basis if proration of the premium and accumulation of the funds may result in excess resources.

6. Medical Care or Remedial Service

This is an allowance for those medical or remedial items or services that are recognized under State law but not covered by the State Plan. These are expenses such as dentures, hearing aids and prosthetic devices. Refer to Appendix II in Section 900 for a more complete list of items and services not covered by the Medicaid State Plan. These expenses are usually documented by a bill or a paid receipt.

A person may be in need of an item such as dentures or eyeglasses, but unable to obtain it without a guarantee of payment to the provider. A written and signed contract with the provider that obligates the person to pay in a lump-sum or installments is acceptable documentation to allow the deduction from the recipient's available income.

For a Medicaid application, a deduction from available income for cost of care may also be made for medical or remedial services covered by Medicaid (e.g., nursing facility) but not covered for the **recipient because the recipient was not Medicaid eligible as of the service date**. The recipient's incurred expenses may only be deducted if the services were received during any months in the three-month period prior to the month of the **current** Medicaid application, in which the recipient was determined not Medicaid eligible. **Incurred expenses may also be deducted for any months that the recipient was ineligible between the month of application and the effective date of Medicaid eligibility.** The bill must still be unpaid and remain the recipient's obligation to pay, as verified by a current detailed bill from the provider. Unpaid bills for medical or remedial services received before the three-month period may **not be deducted** from the recipient's available income for the cost of care.

There is no deduction for non-covered services received during a penalty period; therefore, the amount deducted is \$0.

For services received during ineligible months, the provider's charge is deducted. For non-covered services received **when the recipient is MA eligible, the lesser** of the provider's charge or the Medicaid fee is deducted. If a Medicaid fee is not established, the provider's charge is deducted. Requests for pre-eligibility medical expenses (PEME) submitted at the time of the MA-LTC application will be deducted beginning in the first month of eligibility. Requests for non-covered services submitted during periods of eligibility will be deducted beginning in the month the request and required documentation was submitted, as this is an interim change. The deduction, when added to all other deductions, may not exceed the recipient's total countable income for the month.

To determine the allowable deduction, the CM sends a **completed** OES 001, a self-addressed envelope, a copy of the CARES STAT Screen for all denied months, and a copy of the detailed itemized current bill, receipt, or contract to:

DHMH
201 West Preston Street, Room SS-10
Baltimore, MD 21201
Attn: Non-Covered Services

The bill, receipt, or contract **must** contain all of the following:

1. The providers name, address and telephone number;
2. The A/R's name that received the service (s);
3. A service date;
4. The amount(s) charged:
 - Per service; and
 - Per date;
5. Detailed description of the item or service:
6. Applicable service code(s) for each of the following services:
 - Dental services;
 - Podiatry services;
 - Audiology services;
 - Vision services; and
7. All payments received by the provider for the charges billed.

For services already furnished and billed to an A/R, the CM must request documentation of any payments applied to the charges billed.

If an A/R is a Medicare recipient or has another insurer, the bill will not be considered until it is verified what portion is paid or denied by Medicare or other insurance.

The CM should only forward to DHMH a Request for Non-Covered Services that is supported by bills, receipts, or contracts that contain the required information listed above. The CM should return unacceptable bills, receipts, or contracts to the A/R and request the specific documentation required.

DHMH will review the request and send the CM a memo with the allowable amount noted along with the A/R's Non-Covered Service Report.

Please note the following:

- These deductible expenses cannot be covered by Medicaid, Medicare, any other health insurance, or 3rd party payment (e.g., long-term care insurance, disability insurance).
- This allowance may not be given to reimburse a relative or someone else who has already paid the bill.
- A deduction is not made for medical or remedial services received before the 3-month period prior to current application.
- Since the deduction is only made for medical or remedial services, any extraneous charges such as for the barber/beauty parlor, TV rental, or personal items are not allowed.
- The deduction may not include services covered by Medicaid that were received when the recipient was Medicaid-eligible, but for which the Program denied payment because the services were not medically necessary, were not authorized, were not provided by an enrolled and qualified provider, or were billed after the 12-month billing limitation.
- If there is a contract for regular payments for an item or service, the monthly obligation may be allowed for the period specified in the contract.
- If the amount of the medical expense in addition to other allowable deductions exceeds the recipient's total countable income for the month, the excess portion of the deduction for the medical expenses may be carried forward to the ongoing month or months and, if necessary, may be carried forward into a subsequent 6-month period under consideration.
- The CM should set a "745" alert in CARES to recalculate the recipient's available income as of the month that the deduction is scheduled to end.

There are no deductions from total income except those listed above. If total deductions for a month are greater than or equal to the recipient's total countable monthly income, the person's available income is \$0. With the exception of medical care or remedial services, as specified above, deductions in excess of total countable income are not carried forward to subsequent months. If total deductions are less than the total income for the month, the amount remaining after these deductions is the available income.

1000.2 Cost of Care

For current eligibility, determine average monthly cost of care by multiplying the private per diem rate by 30.3.

For retroactive eligibility, determine monthly cost of care by multiplying the actual number of days in each month that are not subject to third party payment or reimbursement by the private per diem rate.

1000.3 Eligibility Determination and Certification

To determine current eligibility, compare the monthly available income to the average monthly cost of care.

To determine retroactive eligibility, compare the actual monthly available income for each month to the actual cost of care for each retroactive month. If eligible, certification is under Section 1200.

1000.4 Available Income Less than Cost of Care

If the available income is less than the average monthly cost of care, the person is eligible for MA and the Program will assist with payments towards cost of care.

Certification begins on the first day of the period under consideration. If the institutionalized person is not in need of MA in the month of application, certification may begin in the following month. Certify for a twelve month period.

For a person for whom the Program will assist with payments towards cost of care, all available income for the month is to be contributed to the cost of care for that month. Notify the person, their representative, and the LTCF of eligibility and of the amount of available income that must be paid towards the cost of care.

Any income not applied to cost of care due to hospitalization or insurance coverage becomes a countable resource if maintained into a subsequent period under consideration.

1000.5 Available Income Equal to Cost of Care

If the available income is equal to the average monthly cost of care, the person is eligible for Medical Assistance, but is not eligible for Program payments towards cost of care.

Certification begins on the first day of the period under consideration. Certify for a twelve month period. Notify the person, their representative, and the LTCF of eligibility.

1000.6 Available Income Greater than Cost of Care

If the monthly available income is greater than the average monthly cost of care, the Program will not assist with payments towards the cost of care, but the person may be eligible for MA under spend-down. To determine whether the person is eligible, compare the excess available income for the entire period under consideration to the incurred medical expenses for the period. If the incurred expenses equal or exceed the excess available income, the person is eligible for MA and certification begins on the day spend-down is met.

1000.7 Determine Excess Available Income

1. Calculate the total income for the entire period under consideration. For current eligibility, total income for the period will be the total monthly income as determined above multiplied by six.

For the retroactive eligibility, any consecutive months are one period under consideration and the income considered will be that actually received during the retroactive period.

2. Determine the total amount of allowances for the period under consideration. These are limited to Personal Needs Allowance, and Spousal/Family or Dependent Allowance, and Residential Maintenance Allowance.

Subtract the total allowance from the total income (as determined in Step 1). The result is the available income for the period under consideration.

3. Determine projected cost of care by multiplying the number of days in the period under consideration by the private per diem rate. Subtract the projected cost of care from the available income (as determined in Step 2). The result is the excess available income. This is the amount that the person must spend-down in order to become eligible for MA.

1000.8 Determine Spend-Down Eligibility

Deduct the following from the excess available income;

1. Medical expenses incurred before the month of application which:
 - Were not used in establishing eligibility for any prior certification;
 - Are not subject to the third party payment or reimbursement (this may not include medical expenses from a period when the person was determined eligible for MA that were not submitted for coverage.);
 - Do not represent the patient contribution to cost of care for any prior period; and
 - Remain the person's obligation.

These may include medical expenses from a period for which the person has previously applied for Medical Assistance but was found ineligible, and may include expenses for a period prior to application for MA.

For retroactive spend-down, these may include expenses incurred during the retroactive period, but not prior to that period.

2. Medicare premiums;
3. Other health insurance premiums as paid or incurred;
4. Deductibles and co-insurance charges;
5. Expenses incurred for necessary medical care or remedial services that are recognized under State law but not covered under the State Plan;
6. Expenses incurred for necessary medical care or remedial services that are covered under the State Plan.

These expenses may not be considered if they are subject to third party payment or are forgiven by the provider. The date of service, type of item or service and cost must be verified by a bill or statement from the provider.

Eligibility begins on the day on which incurred medical expenses equal or exceed excess available income. Certify for Medical Assistance for the remainder of the 6-month period under consideration on a one-time-only basis. (Do not redetermine eligibility. To be considered for a subsequent period, the person must reapply.) The Program will not assist with payments towards the cost of care. The cost of care paid or incurred during this period under consideration may not be used in any subsequent determination of eligibility or available income.

If spend-down eligibility is not established during the application process, place the case in preserved status for the 6-month period under consideration. If spend-down eligibility is not established during the preserved period, the person must reapply to be considered for a future period. If a person becomes non-institutionalized while the institutionalized application is preserved, shorten the period under consideration and recalculate income. Consider the actual cost of care during this period. If still in need of MA, the person must file a new application as non-institutionalized and a new period under consideration must be established.

1000.9 Continuing Eligibility

Eligibility is determined for the first six month period under consideration and, based on this determination, the LDSS may anticipate the person's continued eligibility throughout the next 6-month period under consideration, unless the person has been certified under spend-down, or a change can be reasonably anticipated, or circumstances require an interim change or unscheduled redetermination.

1000.10 Scheduled Redetermination

The LDSS must make a scheduled redetermination twelve months from the first month of LTC eligibility and every 12 months thereafter. All non-financial and financial factors of eligibility are reevaluated at redetermination.

Any irregular or variable income that has been projected inaccurately is adjusted at the scheduled redetermination by a one-time-only adjustment to available income. The recipient and representative must be notified of the adjustment prior to the effective date. This method applies only to irregular income that has been reported and projected. This method cannot be used to adjust income that has not been reported in a timely manner or that has been reported but not acted upon in a timely manner by the LDSS.

If a one-time-only adjustment to available income results in available income that exceeds cost of care, the person is responsible for the full cost of care in the month of adjustment, but MA eligibility is continued uninterrupted. For the following month, recalculate available income and resume Program payments towards COC.

1000.11 Interim Changes

The LDSS may need to make interim changes (changes that occur between scheduled redeterminations). A change in income, resources, deductions, cost of care, or institutionalized status may affect available income and eligibility.

A. Timely Reporting, Local Department of Social Services (LDSS) and Notification

- A person must report any change in resources, income, deductions, or institutionalized status within 10 working days of the change.
- The LDSS must act on any change no later than 30 days from the date the change is reported.
- The LDSS must provide written notification to the recipient, representative, and LTCF regarding any change in available income or eligibility.

Notification of a change in available income must be sent before or at the same time the LDSS notifies the LTCF of the change. If a change results in ineligibility for MA, timely notice must be given before MA is cancelled.

B. Changes Not Reported in a Timely Manner

If a change is not reported to the LDSS in a timely manner and results in increased available income or ineligibility for Medical Assistance, the LDSS must act upon the change within 30 days of the date the change became known.

1. Adjust available income or cancel payment to the facility effective the month the change became known to the LDSS.
2. Make a referral for investigation and recovery using DHMH 4243 form. The Recoveries unit will determine the appropriate action to recover funds improperly paid by the Program.
3. If a change results in ineligibility, close the case with a 10-day timely notice period.
4. If the change results in decreased available income but the person failed to report it in a timely manner, make the change effective the month in which the change was reported, but not retroactively to the month of change.

C. Changes Not Acted Upon in a Timely Manner

Under certain circumstances the LDSS may find it administratively impossible to act on a change in a timely manner. The LDSS is in error if, for any reason, it fails to act on a change within 30 days of learning of the change.

When a change results in ineligibility or increased available income, the agency may not affect the change retroactively to the month it occurred nor to the month it was reported. Increased available income may be effective no earlier than the month in which the agency takes action. If the change results in ineligibility for MA, timely notice must be given before MA may be cancelled. This delayed action results in improper payments by the Program; therefore, this must be reported for recovery using the DHMH 1169 form.

When a change reported in a timely manner results in decreased available income, the LDSS must adjust the available income retroactively to the month it becomes effective. If the change was not

reported in a timely manner, the LDSS must adjust available income retroactively to the month the change was reported.

D. Change in Resources

A decrease in resources does not affect eligibility and requires no action by the LDSS other than recording it in the case record.

An increase in resources affects eligibility if it results in resources that exceed the MA-2 standard. When resources exceed the MA-2 standard, close the case, cancel MA with timely notice, and cancel payment to the LTCF effective the same day the MA cancellation is effective.

If an increase in resources which results in ineligibility is not reported in a timely manner, make a referral for investigation and recovery using DHMH 4243 form, even if resources are subsequently reduced and eligibility is continued. This includes a situation where excess resources existed in a prior month or months of eligibility and were not reported until the resource had already been reduced to the MA-2 standard. A DHMH 4243 is also required if excess resources still exist and the case is closed.

E. Proper Reduction of Excess Resources

If an increase in resources which results in ineligibility is reported in a timely manner and resources are properly reduced within 30 days of the notice of ineligibility, eligibility may be continued without interruption. A disposal of resources for less than fair market value must be evaluated according to the procedures in Section 800.

Resources that are spent on usual living or medical expenses are considered properly disposed.

Resources that are used to reimburse the State for money paid out on behalf of the recipient are also considered properly disposed. Voluntary reimbursement procedures are applicable if all of the following conditions are met:

- The excess resources were reported in a timely manner;
- The program has paid, on the recipient's behalf, medical expenses at least equal to the amount of the excess resources; and
- The excess resources, in addition to two months of available income, are equal to or less than twice the average monthly cost of care.

If all of the above conditions exist, take steps to close the case with timely notice. In addition to the DHMH 4235, complete the DES 100 and the DHMH 4342, Excess Resources Reimbursement Form. All three documents must be distributed to the recipient, representative, long term care facility, and case record.

If the receipt portion of the DHMH 4342 is received indicating that the excess resources were paid to the Division of Recoveries within 30 days of the date that the DHMH 4235, DES 100, and DHMH 4342 were mailed, reopen the case effective the month of cancellation. If this condition is met, the recipient loses no program coverage.

If the recipient indicates that payment was made after the 30-day period, evaluate the circumstances regarding the delay. If extenuating circumstances existed that may reasonably have inhibited the ability to make the payment within the 30 days, eligibility may be continued without a loss of benefits.

If the receipt is not received, no further action is required on the closed case. Upon reapplication, apply standard procedures and policies for determining current eligibility.

F. Change in Income

A change in a recipient's income affects the recipient's available income for the cost of care, and may affect the recipient's eligibility. The revised income is presumed to continue until the local department is notified otherwise.

A decrease in income will not affect a recipient's MA long-term care eligibility, but will affect the amount of available income to be paid towards the cost of care. The CM must recalculate the recipient's available income and effect the change according to the requirements for timely notice to the recipient, any representative, and the long-term care provider.

When an increase in the recipient's income is reported or discovered, the CM should initiate an unscheduled redetermination. Eligibility may not be redetermined for the current month or a prior month, but may only be redetermined prospectively beginning in an ongoing month for a new 6-month current period under consideration. Likewise, a recipient's contribution towards the cost of care may not be increased retrospectively, just prospectively after timely and adequate notice of this adverse action. The notice must be mailed to the recipient, any representative, and the long-term care provider at least 10 days before the effective date of the action.

- An increase in regular income is presumed to continue at the new rate until the local department is notified otherwise.
- Lump sum income is prorated through the 6-month period under consideration that is established for the eligibility determination or redetermination. See Section 700 of this Manual for the policies and procedures for consideration of lump sum income.

An increase in total income will result in an increase in available income. The CM must recalculate the recipient's available income and compare it to the recipient's cost of care in the long-term care facility. If the new available income is less than the cost of care, the recipient remains eligible, but must pay more towards the cost of care.

The recipient, representative, and LTCF must be sent a notice to inform them of the increased amount that the recipient is to pay towards the cost of care.

If the recipient's available income is now greater than the cost of care, the recipient is no longer eligible, and the CM must give timely notice of adverse action. The MA-LTC assistance unit will trickle to spend-down (L99) due to excess income. If the individual has incurred medical expenses (not including bills for the non-covered long-term care services), the individual may qualify under spend-down for MA to cover State Plan services other than long-term care, once a spend-down of the excess income is met (coverage group L99). Effective the first day of the

month after ineligibility due to “spend-down”, the individual is responsible for the full cost of care in the LTCF.

If an individual reapplies after the “spend-down” period expires, a new period under consideration is established. Any income that has been retained from the prior period under consideration is considered as a resource in the new period under consideration.

G. Change in Deductions

When the CM is informed of a change in a recipient’s deductions, this affects the recipient’s available income for the cost of care. A change is presumed to continue until the local department is otherwise notified. The CM recalculates the available income. A notice about the change in the recipient’s contribution towards the cost of care must be mailed to the recipient, any representative, and the LTCF at least 10 days before the effective date of the action.

- A decrease in the recipient’s contribution towards the cost of care may take effect retroactively, in order to benefit the recipient.
- An increase in the recipient’s contribution towards the cost of care may not take effect retroactively, only prospectively after timely and adequate notice of this adverse action.

H. Change in Level of Care

An increase in level of care will not affect MA eligibility or available income.

If a person’s level of care is reduced to less than intermediate, the person no longer has a medical need for LTC. The LDSS may not cancel payment to the facility based solely on the reduced level of care until the facility notifies the LDSS that the patient has been discharged, or the LDSS determines that the patient is otherwise ineligible. Medicaid will continue to make payments to the LTCF at the facility’s lowest rate as long as the facility documents, to the satisfaction of the UCA, that it is looking for suitable placement for the patient. Eligibility may be continued as long as this condition is met.

I. Medicare Coverage

A person receiving Medicare may be eligible to have Medicare pay all or part of the LTC expenses. Medicare will only pay LTC expenses for a person who requires skilled or chronic care and only for a limited period of time. Medicare will pay a portion of the daily rate, and the remainder is the “co-pay” rate (the amount to be paid by the person, the Program or other insurance).

There is no action required by the LDSS when a LTC MA recipient begins or ends Medicare coverage. However, if an applicant is determined eligible for MA long-term care and needs coverage of Medicare co-pays or the cost of the Medicare deductible, the LTCF must send a 257 to the LDSS. The 257 does not require UCA approval since Medicare’s UCA has already determined the person’s level of care as either skilled or chronic. Upon receipt of the 257 request to begin Medicare co-payment, the CM must enter the following onto the “INST” screen:

- Enter “NH” under the “INST Type” field.
- Enter the date of entry under the “Entry Date” field.
- Enter “S” under the “Level” field.
- Enter the requested begin payment date under the “LTC Payment Auth Date” field.
- Enter “A” under the “Medicare Cert” field.

On the “DEM1” screen, under “Living Arrgmt,” enter “SN” for skilled or “CC” for chronic care. When the Medicare co-payment period has ended, no action is required by the LDSS.

J. Transfer From One LTCF to Another

An institutionalized person may transfer from one LTCF to another. The former LTCF should notify the LDSS by a 257 that the person has been discharged to another facility. The new LTCF must notify the LDSS of the admission date by a 257. The LDSS must enter the appropriate discharge date from the former facility to the new facility on the “INST” screen.

If the discharging facility fails to issue a 257 prior to receipt of the 257 from the new facility, do not delay entry of the admission date if a valid 257 confirming the admission is received from the new facility. In the absence of the discharging 257, use the date of admission to the new facility as the date of discharge. **Please Note: the process of transferring from one facility to another will take 2 days to complete.** First, the CM must enter the date of discharge from the previous facility onto the “INST” screen. Secondly, the CM must send an Alert (745) for the next day to go back onto the “INST” screen and enter the new facility’s information on the line below the previous facility’s information. The second action must take place after over-night batch has run so that the leave date from the previous facility can be committed to CARES before the new information is received.

The full available income, less the cost of care from the discharging facility, is the available income to be reported on the 206C to begin pay to the new facility. The 206C to begin pay must also change the income back to the full available income for the next month.

K. Discharge to the Community

When an institutionalized individual is discharged to the community, the month of discharge is an institutional month. The CM should initiate an unscheduled redetermination of eligibility. The portion of available income to be paid to the LTCF for the month of discharge needs to be recalculated. The individual’s Medical Assistance eligibility should then be evaluated using community MA rules (see the MA Manual Section 900) for the consideration period following the month of discharge.

- If the individual is returning to a home with spouse or family, the individual is considered institutionalized for the entire month of discharge and remains an assistance unit of one.
- When a child is discharged from the facility, the income and resources of the parent(s) are not counted until the first full month after institutionalization, provided an application is filed for continued MA. MA eligibility is extended for at least 90 days for a child discharged from an IMD, a RICA, or a RTC to allow time for a child’s redetermination of

eligibility in community MA (see the MA Manual Policy Alert 10-09 and Policy Alert 10-09 Supplement).

- If an unmarried adult, living alone, is discharged to the community, recalculate the available income allowing the residential maintenance allowance in the month of discharge, providing the individual has not yet received this allowance for the maximum of 6 months.

L. Closing Due to Death

When an institutionalized individual dies, the timely notice requirement does not apply; however, written notice of the case closing must be sent to the representative and the LTCF. Cancel payment to the LTCF as of the date of death. If payment to the LTCF has been cancelled for another reason prior to the date of death, no further action via the 206C is required.

When a benefit check of a deceased individual is available or can be made available by reissuance to a family member, guardian, or representative, the benefit must be considered available for payment towards cost-of-care in the month of death. The LDSS will need to inform the family member, guardian, or representative of the need to request reissuance of the check and of his/her responsibility to pay the nursing home.

If there is no one to request reissuance of the check, the payor will reissue the check to the estate of the deceased. In this instance, do not include the amount of the benefit check on the 206C (if there is no other income available, report "0" on the 206C) and promptly send to the Division of Recoveries on DHMH 1169 form showing, in addition to all excluded and non-excluded resources, the amount of the benefit check for possible recovery from the estate of the deceased.

M. Other Closings

A case may be closed without adverse action notice if the recipient or representative makes a written request to the LDSS to close the case. Cancel the payment to the LTCF effective the first of the month for which the written request is made. Cancel the MA card the first of the following month. Send written notice of the case closing stating the reason for ineligibility.

A recipient or representative may report a change that results in ineligibility and request the case to be closed. A person is not required to verify information that clearly results in ineligibility, but the information must be recorded on the case summary. Close the case with timely and adequate notice which specifies the reason for ineligibility. If the person reapplies, the information that resulted in ineligibility must be verified.

When an institutionalized person is discharged to the community or dies, the LDSS should be notified via a 257. However, if the CM learns of these occurrences from other sources, it is necessary to document the occurrence and annotate the case record with these facts and the source. If the 257 is not received within 10 days of the occurrence, take appropriate action on the case regardless of the non-receipt of the 257.

1000.12 Long- Term Care (LTC) and Forms and Notices

Once a form has been revised, older version are obsolete. Please verify you are using the correct form.

1. **DES 501-** Less Than 30 Day Stay Form

This form is used when the DHMH 257 is received by the LDSS showing a LTC stay less than 30 days. The form is sent to the Division of Recipient Eligibility Programs (DREP). A completed DHMH 257 must accompany the DES 501. If the recipient is enrolled in an MCO on the date of admission, the form cannot be processed because the MCO is responsible for the first 30 days of admission.

2. **DES 601 A (LTC)-** Spousal and Family Allowance Worksheet

This worksheet is used in determining the monthly maintenance allowance for a spouse or the monthly maintenance allowance for a family (see Section 1000).

3. **DES 601 B (LTC)-** Dependent Allowance Worksheet

This worksheet is used in determining the monthly maintenance allowance for a dependent child, when the institutionalized individual does not have a spouse living in the community (see Section 1000).

4. **DES 602 (LTC)-** Notice- Consideration of Resources in Continuing Eligibility

Notice indicating a couple's total combined resources and the amounts attributed to the institutionalized individual and to the community spouse. It also advises the community spouse of the 90-day time frame to transfer certain resources of the institutionalized spouse into the community spouse's name.

5. **DES/LTC 811 -**Transfer/Disposal of Assets Worksheet

This worksheet is used to determine when a penalty applies for disposal or transfer of assets. It is also used to calculate the amount of the penalty and the penalty period. If the client has an active penalty period, the CM must complete and fax the DES/LTC 813 to the Division of Recipient Eligibility Programs (DREP).

6. **DES/LTC 812-** Home Equity Value Worksheet

This worksheet is to be completed to evaluate the equity value of the home property. When the equity value exceeds the current home equity limit in Schedule MA-10, by any amount, the caseworker must complete and fax the DES/LTC 813 to the Division of Recipient Eligibility Program (DREP).

7. **DES/LTC 813 -**Manual MMIS Instructions for Screen 4/Sscreen 8

This form is sent to the Division of Recipient Eligibility Programs (DREP) when a penalty exists or the home equity value exceeds the current home equity limit. DREP

voids MMIS screen 4 (LTC) or screen 8 (waivers) to prevent payment to the LTCF, or for waiver services. The individual remains eligible for Medicaid services as indicated on MMIS screen 1.

8. **DES/LTC 814-** Trust/Document Review Request

This form is used to request a review of a trust or other document from the Division of Eligibility Services.

9. **DES 1000** -Certification of Institutionalization & HealthChoice Disenrollment or Notification of Discharge from Long-Term Care (SAMPLE)

This form is used to disenroll a recipient from HealthChoice when they are in a long-term care facility (LTCF) for more than 30 days. The form is completed by the LTCF and the Administrative Services Organization. The original is sent to the Medical Assistance CM at the LDSS.

10. **DES 2000 (LTC)-** Physician's Statement of Incapacitation

The CM uses this form when it is necessary for customer's physician to verify that an applicant/recipient is not capable of participating in the application process. When this occurs a representative is needed to complete and sign the application and otherwise act in the customer's behalf in the application process.

11. **DES 2001 (LTC)-** Request for Life Insurance Information

This form is used to obtain information from a specific life insurance company. The CM completes part one of the form. The second section is completed and signed by the representative, when the applicant/recipient is unable to sign the form, agreeing to provide information to the LDSS.

12. **DES 2002 (LTC) -**Consent to Release Information to LDSS

Form signed by the applicant/recipient/representative authorizing release of information to the LDSS.

13. **DES 2003 (LTC) -**Income and Shelter Expense Reporting Form for Community Spouse

This form is used by the community spouse stating the amount of income he/she receives and the amount of his/her shelter expenses, for use in determining the spousal allowance.

14. **DES 2004 (LTC) -**Representative's Statement

Form with two optional sections:

- In the first section the applicant/recipient indicates who is to act as the representative. It is signed, by both the applicant/recipient and the representative, agreeing to provide information to the LDSS.
- The second section is completed and signed by the representative, when the applicant/recipient is unable to sign the form, agreeing to provide information to the LDSS.

15. **DES 2005 (LTC)**- Consent for Release of Information (LTCF)

This form is signed by the applicant/recipient to authorize the LDSS to release information to the LTCF.

16. **DHMH 257**- Long-Term Care Patient Activity Report (SAMPLE)

The form is used to notify the LDSS of any action that is required regarding a Medical Assistance payment to the LTCF. The DHMH 257 is initiated by the LTCF and is approved by the UCA. The DHMH 257 form and the DHMH 3871B form to the UCA. The DHMH 257 and the DHMH 3871B forms are returned to the LTCF and the UCA sends the original DHMH 257 to the LDSS.

17. **DHMH 259**- Medical Care Transaction Form (SAMPLE)

This form is used to change the level of care between nursing facility services and chronic services. A change from one level of care to another is treated as a discharge from one level and admission to another. The DHMH 259 discharging a person from one level of care does not require UCA approval; however, the DHMH 259 to begin pay for the admission to another level of care does. Therefore, a change in the level of care to or from chronic care requires two DHMH 259 forms.

18. **DHMH 3871B** - Medical Eligibility Review Form (SAMPLE)

This form has multiple sections for completion. Part A of the form is completed by the representative or the long-term care facility (LTCF) and it is submitted to the attending physician. The physician completes Parts B-E and returns the 3871B to the LTCF. The LTCF completes the top half of DHMH 257 and sends both the DHMH 257 and the DHMH 3871B to the Utilization Control agent (UCA) for completion. The UCA completes part F of the DHMH 3871B. The UCA sends a copy of the DHMH 257 and the DHMH 3871B to the LTCF and sends the original DHMH 257 to the LDSS.

19. **DHMH 1159D (LTC)** -Worksheet for Institutionalized Persons- Cost of Care/Available Income

This worksheet is used by the CM to calculate the cost of care, monthly income, deductions, and available income. This worksheet is used for difficult calculations that might not be calculated correctly by CARES, such as deductions for non-covered services over multiple months. The CM then enters the correct information on the appropriate CARES screens.

20. **DHMH 4210 (LTC)**- Notice of Ineligibility for Non-Financial Reasons

This notice is used when the applicant/recipient is not eligible for MA due to non-financial reasons. It advises the applicant/recipient of the documents still outstanding and of the reactivation date. When needed, it may indicate that the applicant/recipient is within the income and resource limits but a DHMH 257 with the level of care certification has not been received by the LDSS.

21. **DHMH 4233 (LTC)**- Notice of Eligibility

Use this manual eligibility approval notice and suppress the CARES notice when it is difficult to get CARES to put the correct information on the system-generated notice.

22. **DHMH 4235 (LTC)**-Notice of Ineligibility Due to Excess Resources

This manual notice is used to advise the applicant/recipient (A/R), representative, and LTCF of the A/R's ineligibility for MA because the A/R's resources exceed the allowable resource standard. The CM enters the amount of excess resources, checks off whether the individual is denied eligibility or terminated and, if terminated, enters the effective date of termination. The DHMH 4235 notice informs the A/R and the representative of their appeal rights and the process to request a hearing. This notice is to be used until the appropriate LTC notice is available through CARES. If terminated, the DHMH 4235, DES 100, and DHMH 4342 must be issued together.

23. **DES 100 (LTC) Attachment to DHMH 4235**- Explanation of Ineligibility Due to Excess Resources

This is an attachment to the DHMH 4235 notice. It indicates that the A/R is ineligible for MA due to excess resources, gives the amount of over scale resources, and advises that benefits may be restored for a recipient if the excess amount of the resources is used to reimburse the Medicaid program for its payments.

24. **DHMH 4235A (LTC)**- Notice of Non-Coverage of Nursing Facility Services Due to Disposal of Assets for Less Than Fair Market Value

This manual notice is used to advise the A/R, representative, and nursing facility of a penalty period for non-coverage of nursing facility services because the applicant/recipient/spouse transferred or otherwise disposed of assets for less than fair market value. The notice also informed the A/R and representative of their appeal rights and the process to request a hearing. This notice is to be used until the appropriate LTC notice is available through CARES.

25. **DHMH 4235B (LTC)**- Notice of Non-Coverage of Nursing Facility Services Due to Substantial Home Equity

This manual notice is used to advise the A/R, representative, and nursing facility of a penalty period for non-coverage of nursing facility services because the applicant/recipient owns equity interest in home property (after deducting any encumbrances) that exceeds the current home equity limit. The notice also informs the A/R and representative of their appeal rights and the process to request a hearing. This notice is to be used until the appropriate LTC notice is available through CARES.

26. **DHMH 4235C (LTC)**- Notice of Non-Coverage of Nursing Facility Services Due to Annuity

This manual notice is used to advise the A/R, representative, and nursing facility of a penalty period of non-coverage of nursing facility services because certain specified requirements related to an annuity owned by the A/R or spouse were not met. The notice informs the A/R and representative of their right to contact the case worker and request an "Undue Hardship Waiver". The notice and attachment also inform the A/R and representative of their appeal rights and the process to request a hearing. This notice is to be used until the appropriate LTC notice is available through CARES.

27. **DHMH 4236 (LTC)**- Notice of Ineligibility Due to Excess Income

This manual notice is used to advise the applicant/recipient of his/her ineligibility for Medical Assistance due to excess income. It also advises them that they may submit non covered medical expenses to meet spend down. The CM must also include the form, DHMH 4200 (Record of Medical Expenses), for the individual to track his/her medical expenses.

28. **DHMH 4239 (LTC)**- Discharge From Long Term Care

This manual notice is used when the recipient is discharged from a long-term care facility. The notice is sent to the recipient/representative and the LTCF to show the income calculation for the portion of available income to be paid to the LTCF for the month of discharge. It also advises the recipient/representative if Medical Assistance will continue or be terminated due a redetermination of eligibility based on the changes in the living arrangements. This notice is to be used until the appropriate LTC notice is available through CARES.

29. **DHMH 4240 (LTC)** - Notice of Change in Available Income

This manual notice is used to inform the recipient and the LTCF of a change in the recipient's available income for the cost of care. The CARES notice is suppressed if CARES is unable to put the correct information on the system generated notice.

30. **DHMH 4241**- Notice to Review Medical Assistance Eligibility for SSI-LTC

This manual notice is sent to SSI recipients to advise the recipient that their Medical Assistance eligibility under SSI needs to be reviewed and that they have 10 business days to report any changes in their circumstances.

31. **DHMH 4245**- Physician Report

This form is completed by the applicant/recipient's physician to indicate how long the physician anticipates the individual will remain in the LTCF.

32. **DHMH 4246 (LTC)** -Notice of Medical Review Decision-Home Property

This form is completed by the Utilization Control Agent (UCA). The UCA determines if an individual is able to resume living in his/her home property in order to determine if the home property is an excludable resource.

33. **DHMH 4255 (LTC)**- Exclusion- Statement of Intent

This form is completed whenever a person has home property, to indicate the institutionalized person's intent to return to the home property (see MA Manual Section 800). It is used to evaluate the consideration of home property and the residential maintenance allowance.

34. **DHMH 4342**- Excess Resources Reimbursement Form

This manual notice is used to advise the A/R of the exact amount of excess resources. This form is completed by the A/R when they opt to pay the excess amount to the Division of Recoveries.

35. **DHMH 4343-** Declaration of Joint Bank Account Ownership Interest

This form is completed and signed by the recipient A/R and any co-owners who have a bank account(s) or other liquid assets in common. The owners must also indicate their ownership interest in each account (see MA Manual Section 800).

36. **DHMH 4354** - Resource Evaluation for Married Applicants Institutionalized

The worksheet is used to assess the resources of a married applicant and the spouse for: the month of institutionalization, the month of application and the post-eligibility transfer period.

37. **DHR/FIA 1052-LTC-** Long Term Care Request for Information to Verify Eligibility

This form is used by the Medical Assistance LTC CM to request information necessary to determine Medical Assistance eligibility for the applicant or recipient.

38. **206-C** -Interface Correction Report

This form is sent to the Division of Recipient Eligibility Program (DREP) to correct changes on MMIS that were unable to be transmitted from CARES:

- for multiple transactions;
- for changes to income or resources;
- to report a death;
- when an individual is discharged from a LTCF or is transferred from one facility to another;
- to report provider changes; and
- to document multiple spans for MMIS screen 4 (Long-Term Care Spans), etc.

39. **C-TAD-** Certification/Turnabout Document

This form is sent to the Division of Recipient Eligibility Program (DREP) to establish MA eligibility on MMIS screen 1 or to change the eligibility data on screen 1.

40. **OES 001 (Revised 05/12)** - Request for Non-Covered Services Pre/Post-Eligibility Deductions

This form is completed by the CM and sent to the Office of Eligibility Services to request a pre/post-eligibility deduction and/or a non-covered service deduction.

41. **OES 011 (LTC)** -Notice of Eligibility for the Post-Eligibility Medical Expense Deduction

This manual notice is used to advise the recipient, representative, and nursing facility of the amounts that have been approved and disapproved. The CM will receive a printout with the decision from the Office of Eligibility Services stating each medical service, the amount approved, and the amount disapproved (if any). This printout needs to be attached to this letter and sent to the recipient, representative, and nursing facility. In addition, this letter also informs the recipients, representative, and nursing facility how long the deduction will continue to be subtracted from the cost of care.

To: Division of Recipient Eligibility Programs
201 West Preston Street
Room SS-7C
Baltimore, Maryland 21201

From: _____ Department of Social Services
Local Department

Name of Recipient _____
First M.I. Last

M.A. I.D. _____

Name of Facility _____

MMIS Provider I.D. _____

Requested Begin Pay Date _____

Date of Discharge _____

Recipient Certified under Spend-down

Excess income remaining on first day of eligibility: \$ _____

Worker Signature: _____ Date _____

Telephone No. _____

DES 501 (Revised 12/08)
White-DREP Yellow- Long Term Care Facility Pink- Case Record

SPOUSAL AND FAMILY ALLOWANCE WORKSHEET

Date: _____

C.I.D.# _____

Name: _____

I. Spousal Allowance

Monthly Shelter Expenses:

Rent/Mortgage \$ _____
 Property Taxes _____
 Homeowner's Insurance _____
 Utility Standard _____
 Other _____

a. Total Shelter Costs \$ _____
 b. Excess Shelter Standard - _____
 c. Excess Shelter Allowance = _____
 d. Basic Maintenance & Shelter _____
 e. Total of lines c. & d. _____
 f. Maximum Maintenance & Shelter _____

Lesser of lines e. or f. \$ _____

Monthly Income:

Social Security _____
 V.A. Benefit _____
 Pension _____
 Earned Income _____
 Other _____

Total Monthly Income - _____

Spousal Allowance = _____

II. Family Allowance for _____

Basic Maintenance and Shelter \$ _____

Monthly Income:

Social Security _____
 V.A. Benefit _____
 Pension _____
 Earned Income _____
 Other _____

Total Monthly Income - _____

Difference _____

Family Allowance = Difference = _____ = _____

3 3

DES 601A (LTC) 11/03

DEPENDENT ALLOWANCE WORKSHEET

C.I.D. # _____
Name _____
Date: _____

III. Dependent Allowance for _____

Medically Needy Income Level \$ _____

Monthly Income:

Social Security _____

V.A. Benefits _____

Earned Income _____

Other _____

Total Monthly Income - _____

Dependent Allowance \$ _____

HOW TO REQUEST A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- Call the telephone number on the other side of this notice to ask for a conference.
- Request a hearing by:
- Calling 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- Visiting your local department office and requesting a hearing; or
- Mailing or giving a request for a hearing in writing to your local department office, or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- If you don't want to fill out the form to request the hearing:
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than 90 days after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than 10 days after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision that you are appealing, at least 6 days before your hearing.

**Maryland Medical Assistance Program
TRANSFER/DISPOSAL OF ASSETS WORKSHEET**

(Complete a worksheet for each transfer)

Client's Name: _____ Client ID: _____

Local Department of Social Services/DEWS: _____

Application Date: _____ Date of Transfer: _____

Date of Eligibility: _____

Check all that apply:

1. Was the Resource transferred to, or for the sole benefit, of any of the individuals identified below?

____ Spouse,

____ Blind or Disabled Son or Daughter,

____ Unmarried Child under 21 Years of Age

2. Was a Trust Fund established for the Sole Benefit of a Disabled Person Under 65 Years of Age ? _____

3. Was Home Property Transferred to the Person's:

____ Spouse,

____ Sibling with an equity interest, currently residing in the home, and resided at least 1 year prior to institutionalization;

____ Unmarried Child under 21 Years of Age;

____ Blind or Disabled Son or Daughter; or

____ Son or Daughter currently residing in the home, resided at least 2 years prior to institutionalization and verified parental care was provided to enable the institutionalized parent to reside at home rather than in an institution?

**If the transfer was made to any of the above identified individuals, STOP HERE!
If not, proceed to the next section.**

Fair Market Value (FMV) at Time of Transfer: _____

Encumbrances at Time of Transfer: _____

Equity Value at Time of Transfer: _____

Compensation Received: _____

Uncompensated Value: _____

Uncompensated Value ÷ _____ (MA-6 Monthly Average Cost of Care) =

Length of Computed Penalty - Month(s): _____

Partial Month Uncompensated Value ÷ _____ (MA-6 Daily Average Cost of Care) =

Length of Partial Month Penalty – Day(s): _____

Penalty Begin Date: _____

Penalty End Date: _____

Case Manager: _____

If the client has an active penalty period, complete the DES/LTC 813 and fax to the Division of Recipient Eligibility Programs (DREP) at (410) 333-5087 on the same day that the case is finalized on CARES to void the individual's span on MMIS recipient screen 4 for coverage of nursing facility services or on MMIS recipient screen 8 for HCB Waiver services.

The individual's Medicaid eligibility (MMIS screen 1) is not affected.

Maryland Medical Assistance Program
HOME EQUITY VALUE WORKSHEET

Client's Name: _____ Client ID: _____

Local Department of Social Services/DEWS: _____
Application/Redetermination Date: _____
Date of Evaluation: _____

Owner(s): _____

Fair Market Value: _____

Encumbrances: _____

Total Encumbrances: _____

Equity Value: _____
(=FMV minus Encumbrances)

When the equity value exceeds the current home equity limit in Schedule MA-10 by any amount, complete and fax the DES/LTC 813 to the Division of Recipient Eligibility Programs (DREP) at (410) 333-5087 on the same day that the case is finalized on CARES to void the individual's span on MMIS recipient screen 4 for coverage of nursing facility services or on MMIS screen 8 for HCB Waiver services.

The individual's Medicaid eligibility (MMIS screen 1) is not affected.

Maryland Medical Assistance Program

MANUAL MMIS INSTRUCTIONS FOR SCREEN 4/ SCREEN 8

When a penalty has been calculated using the DES/LTC 811, please complete this document and fax a copy to the Division of Recipient Eligibility Programs (DREP) at (410) 333-5087.

Timely submission of this form will ensure that MMIS recipient screen 4 (LTC) or MMIS recipient screen 8 (Waiver) is closed during the client's penalty period.

Client's Name _____ Client ID _____ AU ID: _____

Social Security Number _____ Date of Birth _____

Penalty Begin Date _____ Penalty End Date _____

[FOR MMIS USE ONLY] Closing/Termination Code: **I**

MANUAL HOME EQUITY INSTRUCTIONS FOR SCREEN 4/SCREEN 8

When the total equity value exceeds the current home equity limit in Schedule MA-10 by any amount, after completing the DES/LTC 812, fax this form to DREP at (410) 333-5087 to void Screen 4/Screen 8.

Client's Name: _____ Client ID: _____ AU ID: _____

Social Security Number: _____ Date of Birth: _____ Date of

Ineligibility: _____

[FOR MMIS USE ONLY] Closing/Termination Code: **I**

Case Manager _____ District Office _____ Telephone Number _____

YOU MUST RETAIN A COPY OF THIS FORM IN THE CLIENT'S CASE RECORD

TRUST/DOCUMENT REVIEW REQUEST

To: Office of Eligibility Services
Department of Health and Mental Hygiene
201 W. Preston Street, Room SS-10
Baltimore, Maryland 21201

Date _____

From: Local DSS: _____

Case Manager Name: _____

Address: _____

Telephone: _____

RE: Trust Documents

Other: _____

Case Name: _____ Case Number: _____ Date of Application: _____

Please review the attached documents and respond below:

Does the document represent a countable resource to this A/R?

Does the document represent a disposal of resources for less than fair market value?

Other information requested:

_____.

Date Response Needed: _____

[To Be Completed By Reviewer]

Initial OES Reviewer Name: _____ Telephone: _____

Initial Reviewer Response:

Additional Information Requested by Reviewer: Yes No Date Returned: _____

Date Additional Information Requested: _____

DES/LTC 814 Revised 10/13

PLEASE CHECK REQUESTED ACTION:

CERTIFICATION OF INSTITUTIONALIZATION & HEALTHCHOICE DISENROLLMENT

NOTIFICATION OF DISCHARGE FROM LONG-TERM CARE

TO: DHR/LDSS CM
District Office: _____
Address: _____

TO: **DHMH HealthChoice
Enrollment Section, Room L-9
201 W. Preston Street
Baltimore, Maryland 21201**

Part I. Recipient Identification

Last Name _____	First _____	M.I. ____	D.O.B. _____
M.A. Number _____	Social Security Number _____ - _____ - _____		
Date of Admission to the Facility _____			

Part II. Facility Identification

Name _____	CARES Vendor ID Number _____
Address _____	MMIS Provider ID Number _____
_____	Facility Phone Number _____
_____	Facility Contact Person _____

Part III. Recipient Under 21 Years Old

To be completed after <i>one full calendar month</i> in the facility. This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on _____ / <u>1</u> / _____ .
--

Part IV. Recipient Aged 21 Through 64

To be completed after <i>the 30th consecutive day</i> in the institution or after the <i>60th cumulative day during a calendar year</i> in an institution. This certifies that this individual has been institutionalized in the above facility <input type="checkbox"/> For 30 consecutive days, effective _____ <input type="checkbox"/> For 60 days during the calendar year, effective _____
--

Part V. Recipient 65 Years Old or Older

To be completed after the <i>30th consecutive day</i> in the facility. This certifies that this individual was admitted to the above facility on _____ and is considered institutionalized on that date.
--

Part VI. Discharge Information For Recipients Under 21 & Over 65 Years of Age

To be completed <i>upon discharge from the facility</i> . This certifies that this individual was <i>discharged from the above facility</i> on _____ to <input type="checkbox"/> Home _____ <input type="checkbox"/> LTCF _____ <input type="checkbox"/> Other _____
--

Facility Certification:

Signature _____ Date _____ Phone _____

Administrative Services Organization Authorization:

Signature _____ Date _____ Phone _____

DES 1000 Revised 01/09 White – LDSS/DEWS Yellow- DHMH Pink- IMD Blue- ASO

INSTRUCTIONS

Facility:

1. Complete Part I and II for all Medical Assistance recipients admitted to your facility.
2. Follow the instructions in section III, IV and V to determine *when* to complete and submit this form for each recipient.
3. The facility's authorized representative ***must*** sign and date the form.
4. Submit the entire, completed, signed form to the Administrative Services Organization (ASO) for their signature.
5. When the ASO returns the signed form to you:
 - a. Send original to the Medical Assistance Case Manager
 - b. Send the second copy to the DHMH HealthChoice Enrollment Section
 - c. Retain the last copy for your files.

Administrative Services Organization:

1. Review form to determine that the period from the date of admission through the effective dates specified in the certification (Part III, IV, or V) is an authorized inpatient stay at this facility.
2. If the period is fully authorized, sign the form, retain the last copy for your files, and return the original and all other copies to the facility.
3. If any portion of the period from admission to date specified in the certification section is not authorized by your organization, do not sign the form, but return it to the facility, noting the discrepancy.

Case Manager:

1. Check the date specified in Part III, IV, V against the admission date in Part I.
2. Redetermine eligibility based on the recipient's institutionalized status.
 - a. For recipients younger than 21 or 65 or older, redetermine eligibility in a long-term care coverage group (T track or L track) effective the date specified in the certification (Part III or V).
 - b. For medically needy recipients aged 21 through 64, ***cancel*** eligibility with timely notice due to residency in an institution for mental disease.
3. Retain the original form in the case record.
4. Take ***no action*** for recipients of ***SSI or TANF***.

Health Choice Enrollment Section:

1. Disenroll the recipient from Health Choice effective the date specified in the certification section (Part III, IV or V).
 - a. For Part III or V, use disenrollment code C8.
 - b. For Part IV, use disenrollment code B2 or B1, as appropriate.
2. Retain form for your files.

Discharge Notification - To Be Completed By the Facility:

1. Complete Parts I and II. Indicate the date of discharge and destination in Part VI.
2. The facility's authorized representative must sign and date the form.
3. For recipients under 21 years old, send the original to:

**MA Waiver Unit
6 St. Paul Street, Room 400
Baltimore, Maryland 21202**

4. For recipients over 65 years old, send the original to the Financial Agent or respective local department of social services.
5. Send the second copy to the DHMH HealthChoice Enrollment Section.
6. Retain the last copy for your files.

MARYLAND MEDICAL ASSISTANCE PROGRAM

PHYSICIAN'S STATEMENT OF INCAPCITATION

Date _____

This is to certify that _____ has been under my professional care from _____ to _____

For the treatment of _____.

I certify that he/she is (check one): _____ capable _____ incapable of participating in the application process, and signing the application.

Signature of Physician

Print Name of Physician

Address

Phone Number

**Maryland Medical Assistance Program
Request for Life Insurance Information**

SECTION I (To Be Completed By Case Manager)

Date: _____ **Case Manager** _____

CID# _____ **Telephone Number** _____

District Office (D.O.) _____ **D.O Address** _____

Name of Insurance Company _____

Address _____

Re: Customer Name _____

SSN _____

D.O.B. _____

SECTION II (To Be Completed By Applicant)

I AUTHORIZE THE RELEASE OF INFORMATION TO THE DEPARTMENT OF SOCIAL SERVICES

Signature

Date

NOTICE TO MEDICAID APPLICANT

You are providing personal information (Name, Address, Date of Birth, Income History, Employment History, etc.) in this application for Medicaid benefits. The purpose of requesting this personal information is to determine your eligibility for Medicaid.

If you do not provide this information, the Medicaid Program may deny your application for benefits. You have the right to inspect, amend or correct this personal information. The Medicaid Program will not permit inspection of your personal information, or make it available to others, **except** as permitted by law.

SECTION III (To Be Completed By Insurance Company)

CID# _____
Name: _____

Please Complete Numbers 1-8

TO WHOM IT MAY CONCERN:

Please provide the following information regarding life insurance policies owned by applicant/spouse. When completed and signed, please mail to office address listed on page 1 or fax to _____.

APPLICANT (AP) SSN _____

SPOUSE (SP) SSN _____

- 1. Name of Insured
AP Policy (1) _____ Policy (2) _____ Policy (3) _____
SP Policy (1) _____ Policy (2) _____ Policy (3) _____
- 2. Name of Policy
AP Policy (1) _____ Policy (2) _____ Policy (3) _____
SP Policy (1) _____ Policy (2) _____ Policy (3) _____
- 3. Policy Number
AP Policy (1) _____ Policy (2) _____ Policy (3) _____
SP Policy (1) _____ Policy (2) _____ Policy (3) _____
- 4. Original Face Value
AP Policy (1) _____ Policy (2) _____ Policy (3) _____
SP Policy (1) _____ Policy (2) _____ Policy (3) _____
- 5. Accumulated Face Value
AP Policy (1) _____ Policy (2) _____ Policy (3) _____
SP Policy (1) _____ Policy (2) _____ Policy (3) _____
- 6. Loan(s) Against
AP Policy (1) _____ Policy (2) _____ Policy (3) _____
SP Policy (1) _____ Policy (2) _____ Policy (3) _____
- 7. Has additional insurance been purchased with dividends?
AP Policy (1) _____ Policy (2) _____ Policy (3) _____
SP Policy (1) _____ Policy (2) _____ Policy (3) _____
- 8. Total Cash Value Does this amount include #5 above? Yes No
AP Policy (1) _____ Policy (2) _____ Policy (3) _____
SP Policy (1) _____ Policy (2) _____ Policy (3) _____

Signature of Applicant/Recipient/Representative of Insurance Company

Date

Title

Telephone Number

**MARYLAND MEDICAL ASSISTANCE PROGRAM
CONSENT TO RELEASE INFORMATION**

(To be used by the Long-term Care Facility when releasing newly received information to the Local Department of Social Services including income/assets)

As an applicant/recipient of Medical Assistance, I authorize the release to the Department of Health and Mental Hygiene (The Department) and/or its delegate agencies all data, records, and information by insurance companies, non-profit health service plans, providers of medical care, employers, agencies or organizations necessary for The Department's pursuit of third party reimbursement or verification of my statements provided in this application. I understand that this signed statement serves as written authorization for any of the above persons, agencies, or organizations to release the information requested.

The social security number of every Medical Assistance applicant/recipient will be used to obtain and verify information concerning his/her unearned income, cash benefits, wages and resources. I give my consent for The Department and/or its delegate agencies to compare the information I have given with the records of Federal, State, Local, and private agencies or businesses.

Signature of Applicant/Recipient/Representative

Social Security Number of Applicant/Recipient

CID #

Date

This form is valid for 12 months from the date of signature

NOTICE TO MEDICAID APPLICANTS

You are providing personal information (Name, Address, Date of Birth, Income History, Employment History, etc.) in this application for Medicaid benefits.

The purpose of requesting this personal information is to determine your eligibility for Medicaid. If you do not provide this personal information, the Medicaid Program may deny your application of benefits. You have a right to inspect, amend, or correct this personal information. The Medicaid Program will not permit inspection of your personal information, or make it available to others, except as permitted by federal and state law.

**MARYLAND MEDICAL ASSISTANCE PROGRAM
INCOME AND SHELTER EXPENSE REPORTING FORM
FOR COMMUNITY SPOUSE**

CASE NAME: _____

C.I.D. _____

My monthly income is _____.

My monthly expenses for shelter are _____.

(Please indicate monthly amounts and attach form (s) of verification below.)

INCOME

<u>Source of Income</u>	<u>Monthly Amount</u>	<u>How Verified</u>
Social Security	_____	_____
Veterans Benefits	_____	_____
Pension	_____	_____
Earned Income	_____	_____
Other	_____	_____
Total	\$ _____	_____

SHELTER EXPENSES

<u>Source of Expenses</u>	<u>Monthly Amount</u>	<u>How Verified</u>
Rent	\$ _____	_____
Mortgage Payment	_____	_____
Condo Fees	_____	_____
Property Taxes	_____	_____
Homeowner's Insurance	_____	_____
Heat (if not included in rent)	_____	_____
Water	_____	_____
Gas and Electric	_____	_____
Total	\$ _____	_____

I, the undersigned, declare the information provided above to be accurate and true.

Signature of Spouse

Date

DES 2003 (LTC) Revised 11/03

MARYLAND MEDICAL ASSISTANCE PROGRAM

REPRESENTATIVE'S STATEMENT

PLEASE COMPLETE THE APPROPRIATE SECTION BELOW

I, _____ do hereby consent to allow
_____ to act as my Authorized Representative. In such
capacity he/she shares the responsibility, with me, of providing accurate and timely information to the
Department of Social Services as needed/requested in order to determine Medical Assistance eligibility.

APPLICANT'S SIGNATURE _____ DATE _____

REPRESENTATIVE'S SIGNATURE _____ DATE _____

OR

I, _____ do hereby consent to fully represent
_____. I further realize that, as the full Representative, I am fully
responsible for providing timely and accurate information to the _____ Department of Social
Services as requested/needed.

REPRESENTATIVE'S SIGNATURE _____ DATE _____

DES 2004 (LTC) 11/03

Who can be a Representative?

The representative should be the individual who normally handles the affairs of the institutionalized person. In most instances, that individual will be a relative or legal guardian. However, if neither of these individual exist, then a friend, hospital social worker, nursing home administrator, or other interested party may act on the person's behalf. Whoever decides to act on behalf of the person is considered the representative. This means that the same person who completes and signs the application is also the person who has the responsibility of doing whatever is necessary to establish the person's eligibility. This includes, but is not limited to, making home visits or other contacts necessary to obtain required facts. "Unknown" as an answer to specific questions relating to income and resources is not acceptable.

A representative is also responsible for the accuracy and completeness of the application, for reporting changes to the LDSS and for establishing continuing eligibility. This responsibility continues until such time as a new representative is designated and the LDSS receives written notification of the change. An employee of a LTC facility, hospital, or other agency or organization may not routinely assume the role of a representative by merely filling out the application and mailing it to the LDSS.

While the representative is the primary source of information about the person, the LDSS must not routinely accept information presented by representatives whose source of information is at best questionable.

CONSENT FOR RELEASE OF INFORMATION

**REGARDING AN APPLICATION OR REDETERMINATION FOR
MEDICAL ASSISTANCE LONG -TERM CARE BENEFITS**

This form authorizes the Local Department of Social Services to release information to the Long-Term Care facility.

I, _____, authorize the _____ Department of Social Services to release all necessary information from or about my application or redetermination for Medical Assistance benefits to the following long-term care facility (e.g., nursing home) where I live.

Name of facility	Address
------------------	---------

This information may be released to the following person (s):

Name (please print)	Position
---------------------	----------

Telephone Number	
------------------	--

Name (please print)	Position
---------------------	----------

Telephone Number	
------------------	--

Name of Applicant/Recipient (please print)	CID #
--	-------

Signature of Applicant/Recipient or authorized representative	Applicant/Recipient Social Security Number
---	--

Date _____

This form is valid for 12 months from date of signature.

DES 2005 Revised 11/03

LONG – TERM CARE PATIENT ACTIVITY REPORT

Community Waiver MA

TO: LDSS _____
Address _____

FROM: Name of Facility _____
Address _____

For Agency Use Only
Date Received
Control No.
Due Date
Completed

MMIS Provider ID: _____ CARES Vendor ID: _____

Contact Name: _____ Telephone _____

Provider Type Nursing Facility Chronic/Special Hospital Medical Day Center Other _____

PATIENT INFORMATION

Patient Name: _____ Sex: M F Date of Birth: _____

Medicare Claim No: _____ MD Medicaid No: _____

Patient Representative: _____ Phone: _____

Address: _____

Number and Street

City/State/Zip Code

ACTION REQUESTED- COMPLETE EITHER SECTION A OR B AS APPROPRIATE, PRINT, SIGN AND DATE

A. Begin Payment Admission Date _____ Private Pay Rate _____

Check all that apply (both beginning and ending pay dates must be completed when requested)

NOTE: Actions marked with "*" require Utilization Control Agent/DHMH certification

- 1. *Full MA coverage Begin pay date _____ For MDC only Initial Continued
- 2. Medicare A co- payment Begin pay date _____ End pay date _____
- 3. Bed reservations for Medicare full coverage period Begin date _____ End pay date _____
- 4. *Revocation of Hospice Care and return to NF Care Effective date _____

B. Cancel Payment

- 1. Date of Discharge: _____ Discharged to: Another Facility Community Hospice
- 2. Death- Date of Death: _____

Administrator/Designee Signature _____ Date _____

Print Name of Administrator/Designee _____ Title _____

Level of Care Certification (For UCA/DHMH USE ONLY)

The above named patient is certified for the following level of care (check one): Chronic/ Special Hospital Nursing Facility

Effective Dates _____ through _____

Utilization Control Agent/ DHMH

Authorized Signature

M / D / YYYY

DHMH 257 (Revised 07/13)

INSTRUCTIONS FOR COMLETING THE DHMH 257 (Rev. 4/2011)

TO- Enter the name and address of the designated agency responsible for determining eligibility for benefits. For contact information or other detail, please contact the specific Program area.

FROM: Enter name, address, Medicaid Provider ID and CARES Vendor ID. Check appropriate provider type.

RECIPIENT INFORMATION: Enter full name (first, MI, last) recipient. Enter both Medicare and Medicaid numbers. If no Medicare, enter "none." If approval for Medicaid eligibility is pending, enter "pending."

IF THE RECIPIENT IS A COMMUNITY MEDICAL ASSISTANACE RECIPENT OR WAIVER PARTICIPANT and is expected to stay in the nursing facility or chronic/special hospital for less than 30 days (or up to 80 days Medicare coinsurance), check the "Community MA" or "Waiver" box at the top right of the form.

ACTION REQUESTED- Begin Payment-Enter data fields as instructed below. Enter all dates required on that line. If the column titled "UCA" is checked below, certification by the Department's Utilization Control Agent (UCA) is required.

Nursing Facility (NF) or Chronic/Special Hospital (CSH) Activities		UCA
Initiate NF or CSH benefits, MA only	Line A1	X
Initiate NF or CSH benefits, start Medicare co- payment, convert to full MA	Lines A1 and A2 (both begin and end dates for Medicare co-insurance must be entered)	X
Initiate NF or CSH benefits, Medicare co-payment only (no fill MA)	Line A2 (both begin and end dates for Medicare co-insurance must be entered)	X
Community MA recipient or Waiver participant for temporary NF or CSH placement less than 30 days Medicaid or up to 80 days coinsurance	Check "Community" or Waiver" box at top right, Lines A1 and B1 (check "Community" as discharged destination).	X
Hospice recipient revoking Hospice care and returning to NF care	Line A4	X
Discharge from NF or CSH to another NF or CSH	Line B1, check "Another Provider" box, write name of receiving NF or CSH	
Discharge from NF or CSH to home, or to destination other than NF or CSH if not returning to facility	Line B1, check "Community"	
Died while in NF, CSH, or in acute hospital while on bedhold from NF	Line B2	
Medical Day Care (MDC) Center Activities		
Initiate MDC benefits	Line A1, enter Begin Pay date and check "Initial"	
Continue MDC benefits	Line A1, check "Continued" and enter Begin Pay date	
Discharge	Line B1, check "Discharge" box and enter date of discharge	
Discharge-admitted to NF for long term care	Line B1, check "Another Provider" box, write name of nursing facility if known (otherwise enter "NF")	
Died while a participant	Line B2, enter date of death	

SIGNATURE- Sign and ate the form. The facility staff person completing the form should print his/her name and title.

SUBMISSION- If UCA certification is required, send the Agency and UCA copies to the UCA and retain the provider copy. Otherwise, send the Agency and UCA copies directly to the designated agency and retain the provider copy.

DHMH 257 (Revised 04/11)

Maryland Medical Assistance Medical Eligibility Review Form #3871B

Part A – Service Requested

1. Requested Eligibility Date: _____ 2. Admission Date: _____ 3. Facility MA Provider #: _____

4. **Check Service Type Below:**

Nursing Facility Medical Adult Day Care Wavier for Older Adults

Living at Home Waiver PACE Model Waiver vent only dependent (all other MW use 3871)

Chronic Hospital vent dependent only (all other CH use 3871)

5. **Check Type of Request**

Initial Conversion to MA (NF) Medicare ended (NF) MCO disenrollment (NF)

Readmission-bed Reservation exp. (NF) Transfer new provider (NF) Updated expired LOC Corrected Date

Significant change from Previously denied request Recertification (Waivers/PACE only) Advisory (please include payment)

Part B- Demographics

1. **Client Name:** Last: _____ First: _____ MI _____ Sex: M F
 SS#: _____ - _____ - _____ MA#: _____ DOB: _____

2. **Current Address (check one):** Facility Home

Address 1 _____
 Address 2 _____
 City _____ State _____ Zip: _____ Phone _____

3. **Next of Kin/Representative:**

Last Name _____ First Name: _____ MI _____
 Address 1 _____
 Address 2 _____
 City _____ State _____ Zip _____ Phone _____

4. **Attending Physician:**

Last Name: _____ First Name _____ MI _____
 Address 1 _____
 Address 2 _____
 City _____ State _____ Zip _____ Phone _____

Part C – MR/MI Please Complete the Following on All Individuals:

Review Item	Answer	
	Y	N
1. Is there a diagnosis or presenting evidence of mental retardation/related condition, or has the client received MR services within the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there any presenting evidence of mental illness? Please note: Dementia/Alzheimer's is not considered a mental illness	<input type="checkbox"/>	<input type="checkbox"/>
a. If yes, check all that apply. <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Personality disorder <input type="checkbox"/> Somatoform disorder <input type="checkbox"/> Panic or sever anxiety disorder <input type="checkbox"/> Mood disorder <input type="checkbox"/> Paranoia <input type="checkbox"/> Other psychotic or mental disorder leading to chronic disability		
3. Has the client received inpatient services for mental illness within the past two years	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis? If yes, is the mental illness or psychiatric diagnosis controlled with medication?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
5. Is the client a danger to self or others?	<input type="checkbox"/>	<input type="checkbox"/>

Part D – Diagnoses

Primary diagnosis related to the need for requested level of care	ICD Code	Description
	Descriptions	

Part E – Skilled Services:

Requires a physician's order; requires the skills of technical or professional personnel such as a registered nurse, licensed practical nurse, respiratory therapist, physical therapist, and/or occupational therapist. The service must be inherently complex such that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. Items listed under Rehabilitation and Extensive Services may overlap.

Table I. Extensive Services (serious/unstable medical condition and need for service)

Review Item (Please indicate the number of days per week each service is required)	# of days services is required/wk. (0-7)
1. Tracheotomy Care: (Please indicate the number of day per week each service is required.)	
2. Suctioning: Not including routine oral-pharyngeal suctioning, at least once a day	
3. IV therapy: Peripheral or central (not including self administration)	
4. IM/SC Injections: At least once a day (not including self-administration)	
5. Pressure Ulcer Care: Stage 3 or 4 and one or more skin treatments (including pressure-relieving bed, nutrition or hydration intervention, application of dressing and/or medications)	
6. Wound Care: Surgical wounds or open lesions with one or more skin treatments per day (e.g., application of a dressing and/or medications daily)	
7. Tube Feedings: 51% or more of total calories or 500cc or more per day fluid intake via tube	
8. Ventilator Care: Individual would be a ventilator all or part of the day.	
9. Complex respiratory services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	
10. Parenteral Feeding or TPN: Necessary for providing main source of nutrition	
11. Catheter Care: Not routine foley	
12. Ostomy Care: New	
13. Monitor Machine: For example, apnea or bradycardia	
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime or perform self care or treatment skills for recently diagnosed conditions (must be ordered by a physician)	

Table II. Rehabilitation (PT/OT/Speech Therapy services) Must be current ongoing treatment.

Review Item (Please indicate the number of days per week each service is required.)	# of days service is required/wk. (0-7)
15. Extensive Training for ADLs: (restoration, not maintenance) including walking, transferring, swallowing, eating, dressing and grooming.	
16. Amputation/Prosthesis Care Training: For new amputation	
17. Communication Training: For new diagnosis affecting ability to communication	
18. Bowels and/or Bladder Retraining Program: Not including routine toileting schedule	

Part F – Functional Assessment

Review Item	Answer	
	Y	N
Cognitive Status (Please answer Yes or No for EACH item.)		
1. Orientation to Person; Client is able to state his/her name	<input type="checkbox"/>	<input type="checkbox"/>
2. Medication Management: Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	<input type="checkbox"/>	<input type="checkbox"/>
3. Telephone Utilization: able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	<input type="checkbox"/>	<input type="checkbox"/>
4. Money Management: Can manage banking activity, bill paying writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	<input type="checkbox"/>	<input type="checkbox"/>
5. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person	<input type="checkbox"/>	<input type="checkbox"/>
6. Brief interview for mental status (BIMS). Was the examiner able to administer the complete interview? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent).	If yes, Score: _____ If No, check one of the following: <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Applicant is rarely/never understood <input type="checkbox"/> Language Barrier <input type="checkbox"/> Refused <input type="checkbox"/> Other (specify) _____	
Behavior (Please answer Yes or No for EACH item.)	Answer	
	Y	N
7. Wanders (several times a day): Moves with no rational purpose or Orientation, seemingly oblivious to needs or safety	<input type="checkbox"/>	<input type="checkbox"/>
8. Hallucinations or Delusions (at least weekly): Seeing or hearing nonexistent objects or people, or a persistent false psychotic belief regarding the self, people, or objects outside of self.	<input type="checkbox"/>	<input type="checkbox"/>
9. Aggressive/abusive behavior (several times a week): Physical and verbal attacks on other including but not limited to threatening others, hitting, shoving, scratching, punching, pushing, biting, pulling hair or destroying property.	<input type="checkbox"/>	<input type="checkbox"/>
10. Disruptive/socially inappropriate behaviors including but not limited to making disruptive sounds self-abusive acts, inappropriate sexual behavior, disrobing in public, smearing/throwing food/feces, hoarding, rummaging through others' belongings constantly demanding attention, urinating in inappropriate places.	<input type="checkbox"/>	<input type="checkbox"/>
11. Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self, biting, scratching, picking behaviors, putting inappropriate object into any body cavity, (including ear, mouth, or nose) head slapping or banging.	<input type="checkbox"/>	<input type="checkbox"/>

Client Name _____

Communication (Please answer Yes or No for EACH item.)	Answer	
	Y	N
12. Hearing impaired even with use of hearing aid: Difficulty hearing when not in quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice or totally deaf.	<input type="checkbox"/>	<input type="checkbox"/>
13. Vision impaired even with correction: Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind.	<input type="checkbox"/>	<input type="checkbox"/>
14. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier).	<input type="checkbox"/>	<input type="checkbox"/>

Review Item	
FUNCTIONAL STATUS: Score as Follows 0= independent: No assistance or oversight required 1= Verbal cueing, oversight, encouragement 2= Limited assistance: Requires hands on physical assistance 3= Extensive assistance: requires full performance (physical assistance and verbal cueing) by another for more than half of the activity 4= Total care: Full activity done by another	Score Each Item (0-4)
15. Mobility: Purposeful mobility with or without assistive devices.	
16. Transferring: The act of getting in and out of bed, chair or wheelchair. Also, transferring to and from toileting, tub and/or shower.	
17. Bathing (or showing): Running the water, washing and drying all parts of the body, including hair and face.	
18. Dressing: The act of laying out clothes, putting on and removing clothing, fastening of clothing and footwear, includes prostheses, orthotics, belts or pullovers.	
19. Eating: The process of putting foods and fluids into the digestive systems (including tube feedings).	
20. Toileting: Ability to care for body functions involving bowel and bladder activity, adjusting clothes, wiping, flushing of waste, use of bedpan or urinal, and management for any special devices (ostomy or catheter). This does not include transferring (see transferring item 16 above).	
CONTINENCE STATUS: Score as Follows 0= Independent: Totally continent, can request assistance in advance of need, accidents only once or twice a week or is able to completely care for ostomy. 1= Dependent: Totally incontinent, accidents three or more times a week, unable to request assistance in advance of need, continence maintained on toileting schedule, indwelling, suprapubic or Texas catheter in use or unable to care for own ostomy.	Score Each Item (0-1)
21. Bladder Continence: Ability to voluntarily control the release of urine from the bladder.	
22. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel.	

Part G – Certification

1. Signature of Person Completing Form: _____ Date: _____

Printed Name: _____

I certify to the best of my knowledge the information on this form is correct.

2. Signature of Health Care Professional: _____ Date: _____

Printed Name: _____

**MARYLAND MEDICAL ASSISTANCE PROGRAM
WORKSHEET FOR INSTITUTIONALIZED PERSONS**

Cost of Care/Available Income

Cost of Care Determination

	Effective _____	Effective _____	Effective _____
Private Per Diem	\$ _____	\$ _____	\$ _____
Days Per Month	× _____	× _____	× _____
Monthly C.O.C.	\$ _____	\$ _____	\$ _____

Available Income Determination

	Effective _____	Effective _____	Effective _____
Monthly Income:			
Social Security	\$ _____	\$ _____	\$ _____
V.A.	_____	_____	_____
Pension	_____	_____	_____
Other _____	_____	_____	_____
Other _____	_____	_____	_____
Total Monthly Income	\$ _____	\$ _____	\$ _____
Deductions:			
Personal Needs	\$ _____	\$ _____	\$ _____
Health Insurance	_____	_____	_____
Medicare	_____	_____	_____
Other _____	_____	_____	_____
Total Deductions	- _____	- _____	- _____
Available Income	\$ _____	\$ _____	\$ _____

Eligibility Decision

- Available income less than cost of care. Eligible for MA and cost of care. Issue 206N-showing income. Complete 1159C, LIEN WORKSHEET, if the institutionalized person has income home property.
- Available income is equal to cost of care. Eligible for MA card only. Issue 206N showing available income. Complete 1159C, LIEN WORKSHEET, if the institutionalized person has home property.
- Available income greater than cost of care. For applications, proceed to side 2. For recipients close case.

Spend-Down

Available income is greater than cost of care. Ineligible for cost of care.

Consideration Period _____ to _____

Income:

Total Monthly Income \$ _____ x _____ = \$ _____

Allowances:

Personal Needs \$ _____ x _____ = \$ _____

Spousal/Dependent _____ x _____ = _____

Residential _____ x _____ = _____

Total Allowances - _____

Available Income \$ _____

Cost of Care:

Private Per Diem \$ _____

Days in period x _____

Projected Cost of Care - _____

Excess Available Income \$ _____

Medical Expenses:

Date _____	Amount \$ _____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- Spend-down met on _____. Eligible for MA card only. Complete 1159C, LIEN WORKSHEET, if the institutional person has home property.
- Application preserved for the period _____ to _____.

Case Manager

Date

**MARYLAND MEDICAL ASSISTANCE PROGRAM
NOTICE OF INELIGIBILITY FOR NON-FINANCIAL REASONS**

Date of Notice _____

C.I.D. Number _____

Dear _____:

This is to notify you that based on the application you filed on _____ you have been determined ineligible for the reason(s) checked below:

____ You are not a resident of the State of Maryland.

____ You do not meet the citizenship or alien requirements.

____ You did not provide the required information or verifications. Specify: _____

If you send this information before _____, you will not have to file another application. This agency will re-activate your application and determine your eligibility.

____ Other-Specify: _____

____ The income and assets of _____ are within scale for long-term care Medical Assistance. However, Medical Assistance payment for long-term care services (e.g., nursing facility) cannot be authorized until a DHMH 257 form certifying an appropriate level of care has been received from the Utilization Control Agent. Once we receive that form, you will receive a notice with the decision about your Medical Assistance eligibility.

This decision is based on COMAR 10.09. _____. If you have questions, please contact the case manager at the telephone number below. If you do not agree with this decision, you have the right to request a hearing within 90 days of this notice. The procedures for requesting a hearing are on the back of this letter. You also have the right to reapply.

Sincerely,

Case Manager

Department of Social Services

Telephone Number

SUMMARY OF PROCEDURES FOR FAIR HEARINGS

If you are dissatisfied with the decision of the Local Department of Social Services, you have the right to appeal that decision to the Office of Administrative Hearings by writing to:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

You may obtain the necessary forms from the local department and if you wish, someone there will assist you in filing an appeal. Your appeal must be filed within 90 days from the notice date on the other side of this letter. If you request a hearing within 10 days of the date of this notice, your Medical Assistance benefits may continue until a decision is issued on your case. **However, if you receive extended benefits pending a decision on your appeal and the Administrative Law Judge decides that the decision of the Local Department of Social Services was correct, you will be required to pay back the amount the Department paid for medical services you received during the appeal process.** This will not be required if it is determined that your request for a hearing resulted from a bonafide belief that the decision of the Local Department of Social Services was in error.

The appeal hearing will be scheduled by the Office of Administrative Hearings at a place and time that is convenient to you. You will be expected to be present or, if for some reason you cannot be present, you must notify the Office of Administrative Hearings of the identity of the person who will attend in your place. You may represent yourself or, if you wish, you may be represented by legal counsel or by a relative, friend or other person although it is not required that someone else represent you. You may bring any witness you desire to help you establish pertinent facts and explain your circumstances. A reasonable number of persons of the general public may be admitted to the hearing if you desire this. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific reason for your wanting to appeal. The Hearing Officer will decide whether or not the action of the local department was correct in its interpretation of the law and regulations. This decision will be sent to you as soon as possible, but not later than 90 days after receipt of your request for a hearing, unless there is a delay because you request that the hearing be postponed.

You may obtain free legal aid help through the Legal Aid Bureau in many areas of the State. Consult your telephone directory for the address and telephone number of the Legal Aid Office nearest you, or contact your Case Manager at the Local Department of Social Services for this information. You may also qualify for free legal representation. To see if you qualify, contact the Maryland Volunteer Lawyer Services at 1-800-510-0050.

DHMH 4210 (LTC) – Revised 7/13

**MARYLAND MEDICAL ASSISTANCE PROGRAM
NOTICE OF ELIGIBILITY**

Re: _____
Name

Date: _____

Client Identification Number: _____

LTC Facility: _____

Dear _____:

This is to notify you that the individual identified above has been determined eligible for Medical Assistance (MA) for the period _____ through _____. The MA card will be sent to the Long Term Care Facility. A portion of the patient's income must be paid directly to the Facility, and you must contact the Facility to establish the time and manner of payment.

(NOTE: The Department of Social Services and the LTC facility must be notified of any increase in the patient's current income benefits and/or any new benefits received. The increased amount must be paid to the facility when received, whether or not a notice of increased payment requirement is received from the Department of Social Services or the facility has billed for it.)

The portion of income to be paid to the Long Term Care Facility has been calculated as follows:

	Effective _____	Effective _____	Effective _____
Social Security	\$ _____	\$ _____	\$ _____
Veterans Benefits	_____	_____	_____
Pension _____	_____	_____	_____
Other _____	_____	_____	_____
Total Income	\$ _____	\$ _____	\$ _____
Personal Needs	_____	_____	_____
Health Insurance	_____	_____	_____
Medicare	_____	_____	_____
Other _____	_____	_____	_____
_____	_____	_____	_____
Total Deductions	- _____	- _____	- _____
Cost of Care	\$ _____	\$ _____	\$ _____

If these amounts are not correct, you must contact the Department of Social Services immediately and, if necessary, the Department will adjust these amounts.

Any change in income, resources, health insurance premiums, medical expenses, living arrangements, persons living in the home, etc., must be reported within 10 working days to the Department of Social Services. The recipient, representative, and Long Term Care Facility are responsible for reporting such changes. Any of these changes could affect eligibility and income paid for the cost of care. This decision is based on COMAR 10.09.24__. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached.

Sincerely,

Case Manager

Department of Social Services

Telephone

DHMH 4233 (LTC) - Revised 3/08

White-Customer/Authorized Representative Copy Yellow- Long Term Care Facility Copy Pink- Case Record Copy

HOW TO REQUEST A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- Call the telephone number on the other side of this notice to ask for a conference.
- Request a hearing by:
- Calling 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- Visiting your local department office and requesting a hearing; or
- Mailing or giving a request for a hearing in writing to your local department office, or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- **If you don't want to fill out the form to request the hearing:**
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than 90 days after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than 10 days after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision that you are appealing, at least 6 days before your hearing.

DHMH 4233 (LTC) - Revised 3/08

MARYLAND MEDICAL ASSISTANCE PROGRAM

NOTICE OF INELIGIBILITY DUE TO EXCESS RESOURCES OR DISPOSAL OF RESOURCES

Date: _____

Re: _____
Name

CURRENT _____

RETRO _____

CID #

Dear _____,

This is to notify you that based on the application filed on _____,
the above named person has been determined ineligible for Medical Assistance for the reason(s) checked below:

- Resources exceed the Medical Assistance standard of \$ _____. The amount of excess resources is \$ _____. When the excess resources have been used for necessary personal or health care needs, you may reapply. When you reapply, you will be required to verify how the resources have been used. Keep all receipts for this purpose.
- Resources have been transferred or otherwise disposed of for less than fair market value. This results in a period of ineligibility for cost of care payments from _____ to _____. However, you are eligible for medical services covered under the red & white Medical Care Program Identification Card.

The following resources have been considered:

Type of Resource	Amount
_____	\$ _____
_____	_____
_____	_____
_____	_____
_____	_____

This decision is based on COMAR 10.09._____. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this letter. You have the right to reapply.

Case Manager

Department of Social Services

Telephone Number

DHMH 4235 (LTC) Revised 07/13

White-Customer/Authorized Representative Copy Yellow-Long Term Care Facility Copy Pink-Case Record Copy

HOW TO REQUEST A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- Call the telephone number on the other side of this notice to ask for a conference.
- Request a hearing by:
- Calling 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- Visiting your local department office and requesting a hearing; or
- Mailing or giving a request for a hearing in writing to your local department office, or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- If you don't want to fill out the form to request the hearing:
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than 90 days after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than 10 days after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision that you are appealing, at least 6 days before your hearing.

DHMH 4235 (LTC) Revised 07/13

MARYLAND MEDICAL ASSISTANCE PROGRAM

Explanation of Ineligibility Due to Excess Resources

IMPORTANT – PLEASE READ CAREFULLY

Case Name: _____

C.I.D. Number: _____

Date: _____

We have determined that **you** (or the Medical Assistance recipient that you represent) **have more resources than allowed**.

The excess amount is \$ _____. For this reason, you are determined to be **ineligible** for Medical Assistance. You will remain ineligible for Medical Assistance for each month that your resources exceed the allowable amount as of the first day of the month.

If your eligibility is being terminated, your Medical Assistance benefits will be restored if you use the excess amount to reimburse the Medical Assistance Program for payments it has made on your behalf. If you reduce your resources in this way before _____, your Medical Assistance benefits will be restored without loss of coverage. If you do otherwise, you will lose Medical Assistance coverage for the months in which your resources exceed the standard. If you decide to reimburse the Program, it is not necessary that you contact your Case Worker. Simply mail a check (no cash) along with the enclosed forms to:

Division of Recoveries and Financial Services
P. O. Box 13045
Baltimore, Maryland 21203

You and your Case Worker will receive a receipt of the payment.

If you decide not to pay your excess resources to the Medical Assistance Program, your Medical Assistance benefits will not be restored automatically. You must reapply at the local department of social services. A Case Worker will decide if you are again eligible and, if so, when your eligibility begins. Inform your Case Worker if you reduce your resources, such as by buying a burial plan, paying for repairs to your home, or purchasing personal items. However, giving away your resources for less than fair market value (e.g., by gifts to family or friends) may be considered a disposal, which results in a penalty period during which Medical Assistance will not pay for nursing facility services.

If you have questions about these instructions, you may call _____ at _____
Case Worker Telephone Number

DES 100(LTC) –Revised 12/08: Attachment to DHMH 4235

MARYLAND MEDICAL ASSISTANCE PROGRAM

NOTICE OF NON-COVERAGE OF NURSING FACILITY SERVICES DUE TO DISPOSAL OF ASSETS FOR LESS THAN FAIR MARKET VALUE

Date _____

Re: _____

Name

CID #

Dear _____,

This is to notify you that based on the application/redetermination filed on _____, you are determined ineligible for Medical Assistance coverage of nursing facility services. This is because income and/or assets have been transferred or otherwise disposed for less than fair market value.

However, you are eligible for medical services covered under the red and white Medical Care Program Identification Card. Your eligibility for Medical Assistance:

began effective _____.

will continue unless you receive a cancellation notice.

The transfers considered are listed below:

Asset	Date Transferred	Value	Amount Transferred
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

The total amount transferred for less than fair market value was \$ _____.

This results in a penalty period of _____ months and _____ days, which begins on _____ and expires on _____.

You are not covered by Medical Assistance for nursing facility services until the penalty period expires, at which time you may have to complete a new application. If you cannot access these funds and the penalty would cause you to be deprived of medical care, food, clothing, shelter, or other necessities so that your health or life would be endangered, contact the case worker below to find out about requesting an "undue hardship waiver."

This decision is based on COMAR 10.09.24. _____.

If you do not agree with this decision, you have the right to request a hearing within 90 days of the date on this notice. The procedures for requesting a hearing are attached. If you have any questions about this letter, please call your Case Manager at the number below.

Case Manager

Department of Social Services

Telephone Number

DHMH 4235A (LTC) Revised 12/08

White-Customer/Authorized Representative Copy Yellow-Long Term Care Facility Copy Pink-Case Record Copy

HOW TO REQUEST A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- Call the telephone number on the other side of this notice to ask for a conference.
- Request a hearing by:
- Calling 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- Visiting your local department office and requesting a hearing; or
- Mailing or giving a request for a hearing in writing to your local department office, or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- If you don't want to fill out the form to request the hearing:
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than 90 days after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than 10 days after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision that you are appealing, at least 6 days before your hearing.

MARYLAND MEDICAL ASSISTANCE PROGRAM

NOTICE OF NON-COVERAGE OF NURSING FACILITY SERVICES
DUE TO SUBSTANTIAL HOME EQUITY

Date _____

Re: _____

Name

CID #

Dear _____,

This is to notify you that based on the application/redetermination filed on _____, you are determined ineligible for Medical Assistance coverage of nursing facility services. This is because you did not meet the Program's requirements related to home equity. **However, you are eligible for medical services covered under the red and white Medical Care Program Identification Card.** Your eligibility for Medical Assistance:

began effective _____.

is re-approved and will continue unless you receive a cancellation notice.

You reported that you have \$ _____ in equity interest in your home property (after deducting any encumbrances secured by the home). So long as your home equity exceeds the current home equity limit by any amount, Medical Assistance will not pay for your nursing facility services.

If you cannot access these funds and the non-coverage of nursing facility services would cause you to be deprived of medical care, food, clothing, shelter, or other necessities so that your health or life would be endangered, contact the case worker below to find out about requesting an "undue hardship waiver."

This decision is based on COMAR 10.09.24. _____.

If you do not agree with this decision, you have the right to request a hearing within 90 days of the date on this notice. The procedures for requesting a hearing are attached. If you have any questions about this letter, please call your Case Manager at the number below.

Case Manager

Department of Social Services

Telephone Number

DHMH 4235B (LTC) Revised 12/08

White-Customer/Authorized Representative Copy Yellow-Long Term Care Facility Copy Pink-Case Record Copy

HOW TO REQUEST A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- Call the telephone number on the other side of this notice to ask for a conference.
- Request a hearing by:
- Calling 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- Visiting your local department office and requesting a hearing; or
- Mailing or giving a request for a hearing in writing to your local department office, or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- If you don't want to fill out the form to request the hearing:
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than 90 days after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than 10 days after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision that you are appealing, at least 6 days before your hearing.

**MARYLAND MEDICAL ASSISTANCE PROGRAM
NOTICE OF NON-COVERAGE OF NURSING FACILITY SERVICES
DUE TO ANNUITY**

Date: _____

Re: _____

Name

CID #

Dear _____,

This is to notify you that based on the application/redetermination filed on _____, you are determined ineligible for Medical Assistance coverage of nursing facility services. This is because you did not meet the Program's requirements related to annuities. However, you are eligible for medical services covered under the red and white Medical Care Program Identification Card. Your eligibility for Medical Assistance:

began effective _____.

will continue unless you receive a cancellation notice.

Since you did not meet the following requirements related to annuities, Medical Assistance will not pay for your nursing facility services:

____ 1. You did not name the State of Maryland as the remainder beneficiary for an annuity owned by yourself (or your spouse), behind only any spouse or minor or disabled sons or daughters that you have. Because of this, you will not be covered by Medical Assistance for nursing facility services until the State of Maryland is named as a remainder beneficiary in the correct position for the total amount of Medical Assistance expenditures on your behalf.

____ 2. You are considered to have transferred assets for less than fair market value because on _____:

You (or your spouse) purchased an annuity and did not name the State of Maryland as the remainder beneficiary, behind only any spouse or minor or disabled sons or daughters that you have.

You (or your spouse) purchased an annuity, added money to an annuity, withdrew money from an annuity, or changed payments from an annuity that made your money unavailable or for which you did not receive fair market value.

You purchased an annuity, added money to an annuity, withdrew money from an annuity, changed payments from an annuity, or made another change to an annuity's payments or principal and the annuity either does not meet certain requirements of the Internal Revenue Code to be excluded from consideration or does not meet all of the following Medical Assistance requirements: is irrevocable, non-assignable, and actuarially sound and provides for payments, with no deferral and no balloon payments, in approximately equal amounts through the annuity's term to you or any spouse or minor or disabled child that you have.

Because of the action specified in #2 above, you are considered to have transferred assets for less than fair market value in the amount of \$_____. This results in a penalty period of _____ months and _____ days, which begins on _____ and expires on _____.

You are not covered by Medical Assistance for nursing facility services until the penalty period expires, at which time you may have to complete a new application. If you cannot access these funds and the penalty would cause you to be deprived of medical care, food, clothing, shelter, or other necessities so that your health or life would be endangered, contact the case worker below to find out about requesting an "undue hardship waiver."

DHMH 4235C (LTC) Revised 12/08 (1 of 3)

White-Customer/Authorized Representative Copy Yellow-Long Term Care Facility Copy Pink-Case Record Copy

Note: You are required to inform the case manager named below of any change in your income or resources within 10 days of the change. This includes notifying your case worker when you (or your spouse) purchase, sell, or make any change to an annuity, such as changing the ownership or the amount of payments.

This decision is based on the requirements set forth in the Deficit Reduction Act of 2005 (Public Law 109-171) Section 6012, as codified in 42 U.S.C. 1396p, and/or COMAR 10.09.24.____.

If you do not agree with this decision, you have the right to request a hearing within 90 days of the date on this notice. The procedures for requesting a hearing are attached. If you have any questions about this letter, please call your Case Manager at the number below.

Case Manager

Department of Social Services

Telephone Number

cc: Representative _____
Long Term Care Facility _____

DHMH 4235C (LTC) Revised 12/08 (2 of 3)
White-Customer/Authorized Representative Copy Yellow-Long Term Care Facility Copy Pink-Case Record Copy

HOW TO REQUEST A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- Call the telephone number on the other side of this notice to ask for a conference.
- Request a hearing by:
- Calling 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- Visiting your local department office and requesting a hearing; or
- Mailing or giving a request for a hearing in writing to your local department office, or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- If you don't want to fill out the form to request the hearing:
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than 90 days after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than 10 days after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision the you are appealing, at least 6 days before your hearing.

MARYLAND MEDICAL ASSISTANCE PROGRAM

NOTICE OF INELIGIBILITY DUE TO EXCESS INCOME

Re: _____
Name

Date: _____
CID# _____

Dear _____,

This is to notify you that based on the application filed on _____, the above named person has been determined ineligible for Medical Assistance due to excess income. The income for the period _____ to _____ has been calculated as follows:

Source of Income	Monthly Amount	Amount for Period
Social Security	_____	\$ _____
Veterans Benefits	_____	_____
Pension	_____	_____
Other _____	_____	_____
		Total Income \$ _____

Deductions

Personal Needs Allowance	_____	\$ _____
Spousal/Dependent Allowance	_____	_____
Residential Allowance	_____	_____
Cost of Long Term Care	_____	_____
Other Medical Expenses	_____	_____
		Total Deductions - \$ _____
		Total Available Income - \$ _____
		Cost Of Care - \$ _____
		Excess Income for Period - \$ _____

If medical expenses are incurred that will not be covered by health insurance or other sources and these expenses equal or exceed the amount of excess income, eligibility for Medical Assistance may be established under the spend-down provision. Enclosed is a sheet that tells you how to keep records of medical expenses. If incurred medical expenses equal the amount of excess income within the time period specified above, you should immediately report this to the Department of Social Services.

This decision is based on COMAR 10.09.____. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this letter. You have the right to reapply.

Sincerely,

Caseworker Telephone Number

Department of Social Services

cc: Representative _____
Long Term Care Facility _____

DHMH 4236-LTC (Revised 12/08)

HOW TO REQUEST A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- Call the telephone number on the other side of this notice to ask for a conference.
- Request a hearing by:
- Calling 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- Visiting your local department office and requesting a hearing; or
- Mailing or giving a request for a hearing in writing to your local department office, or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- If you don't want to fill out the form to request the hearing:
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than 90 days after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than 10 days after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision that you are appealing, at least 6 days before your hearing.

**MARYLAND MEDICAL ASSISTANCE PROGRAM
DISCHARGE FROM LONG TERM CARE**

Date: _____

Re: _____
Name

Client ID

Dear _____,

The Department of Social Services has been notified that the above named person has been discharged from the Long Term Care Facility. The portion of available income to be paid to the facility for the month of discharge has been recalculated as follows:

Effective _____

Social Security	\$ _____	
Veterans Benefits	_____	
Pension	_____	
Other	_____	
Total Income		\$ _____
Medical Assistance Standard	_____	
Income Disregard	_____	
Other	_____	
Total Deductions		— _____
Available Income to be Paid to Cost of Care		\$ _____

Eligibility has been reviewed because of this change in living arrangement and the following decision has been made:

- Medical Assistance will continue and you will be notified when another redetermination of eligibility will be required.
- Medical Assistance will be cancelled effective _____ because income exceeds the Medical Assistance standards.
- Medical Assistance will be cancelled effective _____ because _____.

This decision is based on COMAR 10.09._____. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this letter. You have the right to reapply.

Sincerely,

Case Worker

Department of Social Services

Telephone

cc: Recipient/Representative
Long Term Care Facility

DHMH 4239 (LTC) 7/13

HOW TO REQUEST A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- Call the telephone number on the other side of this notice to ask for a conference.
- Request a hearing by:
- Calling 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- Visiting your local department office and requesting a hearing; or
- Mailing or giving a request for a hearing in writing to your local department office, or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- If you don't want to fill out the form to request the hearing:
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than 90 days after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than 10 days after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision that you are appealing, at least 6 days before your hearing.

**MARYLAND MEDICAL ASSISTANCE PROGRAM
NOTICE OF CHANGE IN AVAILABLE INCOME**

Date: _____

Re: _____
Name

Client ID Number

LTC Facility

Dear _____:

Based on a review of Medical Assistance eligibility for the person named above, the portion of income to paid to the Long Term Care Facility has been recalculated as follows:

	Effective _____	Effective _____	Effective _____
Social Security	\$ _____	\$ _____	\$ _____
V.A.	_____	_____	_____
Pension	_____	_____	_____
Other	_____	_____	_____
Total Income	\$ _____	\$ _____	\$ _____
Personal Needs	\$ _____	\$ _____	\$ _____
Health Insurance	_____	_____	_____
Medicare	_____	_____	_____
Other _____	_____	_____	_____
_____	_____	_____	_____
Total Deductions -	_____	- _____	- _____
Cost of Care:	\$ _____	\$ _____	\$ _____

If these amounts are not correct, you must contact the Department of Social Services immediately and, if necessary, the Department will adjust these amounts.

Any change in income, resources, health insurance premiums, medical expenses, living arrangements, persons living in the phone, etc., must be reported within 10 working days to the Department of Social Services. The recipient, representative, and Long Term Care Facility are responsible for reporting such changes. Any of these could affect eligibility and income paid for the cost of care.

This decision is based on COMAR 10.09.24__. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached.

Sincerely,

Case Manager

Department of Social Services

Telephone Number

SUMMARY OF PROCEDURES FOR FAIR HEARINGS

If you are dissatisfied with the decision of the Local Department of Social Services, you have the right to appeal that decision to the Office of Administrative Hearings by writing to:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

You may obtain the necessary forms from the local department and if you wish, someone there will assist you in filing an appeal. Your appeal must be filed within 90 days from the notice date on the other side of this letter. If you request a hearing within 10 days of the date of this notice, your Medical Assistance benefits may continue until a decision is issued on your case. **However, if you receive extended benefits pending a decision on your appeal and the Administrative Law Judge decides that the decision of the Local Department of Social Services was correct, you will be required to pay back the amount the Department paid for medical services you received during the appeal process.** This will not be required if it is determined that your request for a hearing resulted from a bonafide belief that the decision of the Local Department of Social Services was in error.

The appeal hearing will be scheduled by the Office of Administrative Hearings at a place and time that is convenient to you. You will be expected to be present or, if for some reason you cannot be present, you must notify the Office of Administrative Hearings of the identify of the person who will attend in your place. You may represent yourself or, if you wish, you may be represented by legal counsel or by a relative, friend or other person although it is not required that someone else represent you. You may bring any witness you desire to help you establish pertinent facts and explain your circumstances. A reasonable number of persons of the general public may be admitted to the hearing if you desire this. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific reason for your wanting to appeal. The Hearing Officer will decide whether or not the action of the local department was correct in its interpretation of the law and regulations. This decision will be sent to you as soon as possible, but not later than 90 days after receipt of your request for a hearing, unless there is a delay because you request that the hearing be postponed.

You may obtain free legal aid help through the Legal Aid Bureau in many areas of the State. Consult your telephone directory for the address and telephone number of the Legal Aid Office nearest you, or contact your Case Manager at the Local Department of Social Services for this information. You may also qualify for free legal representation. To see if you qualify, contact the Maryland Volunteer Lawyer Services at 1-800-510-0050.

**MARYLAND MEDICAL ASSISTANCE PROGRAM
NOTICE TO REVIEW MEDICAL ASSISTANCE ELIGIBILITY
FOR SSI LONG TERM CARE**

Date: _____

RE: _____

Client ID #: _____

Dear _____:

This is to notify you that it is time to review Medical Assistance eligibility for the above-named recipient. Please answer fully the questions below:

1. **Does the recipient still reside in a nursing home?** Yes (*go to #3*) No (*go to #2*)
2. **What was the date of discharge or death?** ___/___/___ (*Please stop here and return this form to the local department. If deceased, please send a copy of the death certificate.*)
3. **What is the name of that nursing home?** _____
4. **Who is the recipient's current authorized representative?**

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Other Phone: _____

5. **What kind of income does the recipient receive? (Please attach proof(s) of income)**
 SSI SSDI Veteran's Other _____

6. **What assets does the recipient own? (bank accounts, life insurance, property, etc.) (Please attach proof(s) of income)**

Please return photocopies of those items with this letter to the local department before _____.

All Medical Assistance recipients are required to report to their caseworker any changes concerning their circumstances within 10 business days of the change. This includes, but is not limited to, changes in income, resources, living arrangements, and home property.

Sincerely,

Case Manager

Department of Social Services

Telephone Number

DHMH 4241A (SSI/LTC) – Revised 12/08

White–Customer/Authorized Representative Copy Yellow–Long Term Care Facility Copy Pink–Case Record Copy

**MARYLAND MEDICAL ASSISTANCE PROGRAM
PHYSICIAN REPORT**

Date: _____

PART I. INSTITUTIONALIZED PERSON'S IDENTIFICATION

(To be completed by the Local Department of Social Services)

1. _____
Name CID#

2. _____
Name of Facility Telephone Number

_____ Address

3. _____
Representative Name Telephone Number

_____ Address

4. _____
Case Manager Department of Social Services Telephone Number

_____ Address

PART II. STATEMENT BY ATTENDING PHYSICIAN

1. The anticipated length of stay in a Long Term Care Facility for the above named patient is:
(check the appropriate box)

Remainder of Life * Six Months or Less * More Than Six Months

* (give expected month and year of discharge _____)

2. The medical reasons for this expectation are:

(use back for additional space)

3. This person's ability to resume community (non-institutional) living requires the following support systems:

Medical Day Care Home Health Care Personal Care

Other _____ No support system(s) will be needed

Specify

I certify that I am the attending physician of the above name person and that the statements I have made concerning this person are based on my professional assessment of his/her medical condition and are supported by the person's medical record.

Signature of Physician Printed Name of Physician Date

_____ Address

Notice to Medicaid Applicants

You are providing personal information (Name, Address, Date of Birth, Income History, Employment History, etc.) in this application for Medicaid benefits.

The purpose of requesting this personal information is to determine your eligibility for Medicaid. If you do not provide this personal information, the Medicaid Program may deny your application for benefits. You have a right to inspect, amend, or correct this personal information. The Medicaid Program will not permit inspection of your personal information, or make it available to others, except as permitted by federal and state law.

DHMH 4245 Revised 7/13

**MARYLAND MEDICAL ASSISTANCE PROGRAM
NOTICE OF MEDICAL REVIEW DECISION – HOME PROPERTY**

Date: _____

Re: _____

Name

Case Number

Dear _____:

This is to inform you that a medical review was held on to decide if there is reasonable expectation that the above named person will be able to resume living in his/her home property. The review was based on medical information provided by his/her attending physician and the Long Term Care Facility. The decision is checked below:

- The above named person can reasonably be expected to be discharged from the Long Term Care Facility to resume living in his/her home property.
- The above name person cannot reasonably be expected to be discharged from the Long Term Care Facility to resume living in his/her home property. The Division of Medical Assistance Recoveries will contact you concerning the placing of a lien on this person's real property.

The person's medical condition will be reviewed every six months or when a change is indicated, and you will be notified if the above decision is changed. The Medical Assistance Program's authority to make this decision is based on COMAR 10.09.24.15A-2(2). If you do not agree with the medical review decision, you have the right to request a hearing. The procedures for requesting a hearing are on the back of this letter.

Sincerely,

Utilization Control Agent

Telephone Number

cc: Recipient
Division of Medical Assistance-Recoveries

Local Department of Social Services

DHMH 4246 (LTC) Revised 12/08
White-Authorized Representative Yellow-Division of Recoveries Pink-Case Record Blue-Applicant/Recipient

**MARYLAND MEDICAL ASSISTANCE PROGRAM
HOME EXCLUSION – STATEMENT OF INTENT**

Date: _____

PART I. INSTITUTIONALIZED PERSON'S IDENTIFICATION

(To be completed by the Local Department of Social Services)

1.	Name	Client ID	
2.	Name of Facility	Telephone Number	
Address			
3.	Representative's Name	Telephone Number	
Address			
4.	Case Manager	Department of Social Services	Telephone Number
Address			

PART II. STATEMENT OF INTENT TO RESUME LIVING IN HOME PROPERTY

Read this entire section before answering the question below. The person's representative may answer the question.

If "no" is checked, the equity value of the person's home may be a countable resource which could cause the person to be ineligible for Medical Assistance. If "yes" is checked, the person's home property will not be a countable resource; however, the State may place a lien on the home and other real property.

Does the institutionalized person ever intend to live in his/her home property located at _____ again?

Yes No

Signature of Applicant or Representative _____ Date _____

**MARYLAND MEDICAL ASSISTANCE PROGRAM
DECLARATION OF JOINT BANK ACCOUNT
OWNERSHIP INTEREST**

(e.g., Savings and Checking Accounts, Money Market Accounts, Certificates of Deposit)

I. Type of Account _____ Account No. _____

Name of Bank or Financial Institution _____

Address _____

<u>Name of Owners</u>	<u>S.S. #</u>	<u>Relationship to A/R</u>	<u>Ownership Interest</u>
-----------------------	---------------	----------------------------	---------------------------

- 1. _____
- 2. _____
- 3. _____

Total Amount in Account _____

II. Type of Account _____ Account No. _____

Name of Bank or Financial Institution _____

Address _____

<u>Name of Owners</u>	<u>S.S. #</u>	<u>Relationship to A/R</u>	<u>Ownership Interest</u>
-----------------------	---------------	----------------------------	---------------------------

- 1. _____
- 2. _____
- 3. _____

Total Amount in Account _____

We, the undersigned, declare the statements made above to be accurate and true. We, also understand that this declaration may be subsequently changed or rescinded only if such action results in an increase in funds for _____

Name of Applicant/Recipient

If there are additional accounts, use an additional form.

Signature of Applicant/Recipient (or Representative)	Date
--	------

Signature of Co-Owner	Date
-----------------------	------

Signature of Co-Owner	Date
-----------------------	------

Resources Evaluation

For Married Applicants Institutionalized on or after 9/30/89

Case Name _____

CID Number _____

I. Assessment

Month of Institutionalization _____

Owner*	Type	Verification	Full Value	Unavailable Excluded Value	Countable Value
			\$	\$	\$
				A. Total Assessed Resources (as of Month of Institutionalization)	\$
				B. 1/2 of line A	\$
				C. Enter the lesser of line B or maximum spousal share (MA-8)	\$

*Legend
 J=Joint
 SP=Spouse
 AP=Applicant

III. Attribution of Resources

A. Total from Section II. \$ _____

B. Enter the following amounts:

Amount from Section I Line C \$ _____

Minimal Spousal Share (MA -8) \$ _____

Amount per Hearing or Court Order \$ _____

C. Enter greatest amount from Section III Line B - _____

D. Resources Attributed to Applicant \$ _____

Schedule MA-2 \$ _____

Excess Resources \$ _____

Resources Exceed Standard: Ineligible

Resources Within Standard: Proceed to Section IV

IV. 90 Day Post-Eligibility Transfer Period

Value of resources owned by applicant in the month of application

(List Resources from Section II)

Owner*	Type	Verification	Full Value	Unavailable Excluded Value	Countable Value
			\$	\$	\$

A. Total Resources Owned by Applicant (From Section III line A) \$ _____

B. Amount from Section III Line D - _____

C. Amount to be transferred to Community Spouse \$ _____

Caseworker

Telephone Number

MARYLAND DEPARTMENT OF HUMAN RESOURCES
Family Investment Administration
Long Term Care Medical Assistance
Request for Information to Verify Eligibility

Local Department Address: _____	Date: _____ Case Name: _____ Address: _____ _____ CID#: _____ (Please use this number on all correspondence) Case Manager: _____ Telephone Number: _____
--	---

Ms./Mr. _____ for _____

After you give us a signed application, we have 30 days to make a decision about eligibility for Long Term Care Medical Assistance. To make that decision, we must have the verifications checked NEED. Please mail or bring them to our office at the address above by _____.
Questions? Call your case manager at the number above.

Key: N/A – Not Applicable OK – Already have or do not need NEED – Please provide

I. BASIC REQUIREMENTS

- | N/A | OK | NEED | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Signed, dated application (DHR/FIA CARES 9709) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Face-to-Face Interview |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consent to Release Information – nursing home to DSS worker (DES 2002 form) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consent to Release Information – DSS worker to nursing home (DES 2005 form) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Voter Registration Form 784 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DHMH 257 (Medical certification initiated by Nursing Home) |

II. DEMOGRAPHIC DATA

- | N/A | OK | NEED | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Proof of Social Security Number (SSA 1099, SSA letter, or other SSA verification) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medicare card |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alien status (alien registration card passport) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Proof of disability (DHMH 4204, DHR/FIA 402B, DHR/FIA 161 – for applicants 21-64 years old who have not been determined blind or disabled by the US. Social Security Administration) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Marriage Certificate/Divorce decrees |

III. MONTHLY INCOME

- | N/A | OK | NEED | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Social Security Benefits (award letter, 1-800-772-1213) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Private Pension (gross benefit/deductions, if any) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Application for any private/public benefit which the applicant may be entitled |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other (annuities, alimony, royalties, income from loans, etc.) _____ |

(PLEASE GO TO PAGE 2)

DHR/FIA 1052-LTC Page 1 (Revised 12/08)

White – Customer copy

Yellow – Long Term Care Facility Copy

Pink – Case Record Copy

Copy also to: _____ at _____

Case Name:	CID:
-------------------	-------------

IV. ASSETS

Checking, Savings, Certificate of Deposits, Stocks, Bonds, Mutual Funds, Trusts, LTC Insurance, etc;
 (for the month of application and any additional statements specified)

N/A	OK	NEED	NAME	ACCT.#	COMMENTS (which months, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Closed Accounts – final statement (accounts which were active/open at any time in the past 36 months)

N/A	OK	NEED	TYPE	ACCT.#	COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Life Insurance – Form DES 2001, letter from the Insurance Company (stating original face value, current cash value, dividend value, loans against policy), **or copy of policy with amortization table** for current cash value

N/A	OK	NEED	<u>Company Name</u>	<u>Policy Number</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Home Property/Other Property

N/A	OK	NEED	Primary/other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mortgage Agreement <input type="checkbox"/> DHMH 4255 Physician’s Report <input type="checkbox"/> Deed(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> State Property Tax Assessment <input type="checkbox"/> DHMH 4255 Statement of Intent

Funeral Arrangements

N/A	OK	NEED	Bank Account Statements/Irrevocable and Itemized Contracts: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

V. ALLOWANCES

Health Insurance

N/A	OK	NEED	Other Health Insurance (ID card – front and back, actual premium bill or cancelled check)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Residential Allowance

N/A	OK	NEED	DHMH 4245 Physician’s Report
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Spousal Allowance

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Income and Expense Reporting Form for Community Spouse
--------------------------	--------------------------	--------------------------	--

ADDITIONAL INFORMATION NEEDED (see attachment)

When I sign below it means I understand I must provide the information and verifications checked on this form. I may have to provide additional documentation, if indicated in the review of the material I provide. I understand this application is good for only six months from the date I applied and I will have to file a new application if I do not provide all required verification in that time period.

SIGNATURE

**MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAID MANAGEMENT INFORMATION SYSTEM**

CERTIFICATION / TURNAROUND DOCUMENT

Action Code:

TYPE OF CHANGE

ADD INDIVIDUAL **REISSUE TAD** **CANCEL** **RECERTIFY**
CHANGE **REISSUE CARD** **REOPEN** **COVERAGE**

ORIG-ID:

***CURR-ID:**

***NAME**

***HOH NAME:**

***ADDR:**

ADDR:

***CITY:**

***STATE: MD**

***ZIP:**

PHONE:

***RES-CNTY:**

CITZ-IDEN:

DIST-OFF:

***HOH/CASE-NUM:**

CARES-IRN:

SSN:

MEDICARE -NUM:

***APPL DATE:**

***DEC-DT:**

***BIRTH:**

***RACE:**

***SEX:**

HOSP-NUM:

DT-OF-ENTRY:

UNIT:

DEATH:

VCN:

ISSUE-DT:

***REQUIRED FOR ADD**

REQUIRED FOR OMB

ELIGIBILITY SPAN

BEGIN DATE	END DATE	COV GROUP	COV TYPE	CAT	SCP	SPLIT AMT	CIT	CN-RSN

REASON FOR DOCUMENT: MARYLAND KIDS COUNT TRANSACTION NOT PASSED TO MMIS-II
 OUTSIDE OF CARES

MESSAGE: SEE ATTACHED CARES PRINTS.

SIGNATURE: _____ PHONE: _____ DATE: _____

Request for Non-Covered Services Pre/Post-Eligibility Deductions

To: Office of Eligibility Services
Department of Health & Mental Hygiene
201 West Preston Street, Room SS-10
Baltimore, Maryland 21201-2399

Date Received by DHMH

From: _____ Local Department of Social Services

D.O. # _____

Date Request Sent _____

Please **complete** the following information: New Request Resubmission
Case Manager _____ Contact Number _____
Case Name _____ Client ID Number _____
Application Date _____ Current Certification Period _____
Penalty Period (if applicable) From _____ To _____

Retro Period _____

Has an eligibility determination been made for the **retro period**? Yes No
(A determination **must** be made for the retro months requested before submitting this form*)

Retro Eligibility Determination

1 st Month _____	<input type="checkbox"/>	Approved	Denied	<input type="checkbox"/>
2nd Month _____	<input type="checkbox"/>	Approved	Denied	<input type="checkbox"/>
3rd Month _____	<input type="checkbox"/>	Approved	Denied	<input type="checkbox"/>

Attach a copy of denial notices for all current and retro months. *This does not apply to Waiver cases.

Type of Expense

(Place a check mark next to the appropriate type.)

<input type="checkbox"/> Dental Bill	<input type="checkbox"/> Hearing Aid Bill
<input type="checkbox"/> Vision Bill	<input type="checkbox"/> Podiatry Bill
<input type="checkbox"/> Pharmacy Bill	<input type="checkbox"/> Nursing Home Bill
<input type="checkbox"/> Other (Please Specify): _____	Months being requested: _____

OES 001 (LTC) Revised 08/13 All other versions are obsolete. All information MUST be completed.

Maryland Medical Assistance Program
Notice of Eligibility for the Post-Eligibility Medical Expense Deduction

Re: _____
(Name)

Date: _____

(Client ID #)

Dear _____:

This is to notify you that based on the medical bills, totaling \$_____, that you submitted on _____, you are determined eligible for the Post-Eligibility Medical Expense Deduction in the amount of \$_____. You are determined ineligible in the amount of \$_____. The attached report shows every expense item, if you are eligible for the deduction, and the amount of the deduction that you are eligible to receive. If you were not eligible for the service, it will indicate the reason for your ineligibility.

- The amount of \$ _____ will be deducted from the amount you are responsible to pay the nursing home for the month of _____. The amount of the deduction is less than your monthly contribution to the nursing home cost of care. This is a onetime only deduction.
- The amount of \$ _____ will be deducted from your nursing home cost of care contribution beginning the month of _____ and will continue until the month of _____. If there are no changes to your countable monthly income, we anticipate \$ _____ of the allowable deduction will remain at the end of your current consideration period. The remaining amount will be applied to the consideration period that immediately follows.

The decision is based on the requirements found in COMAR 10.09.24.10. If you do not agree with this decision, you have the right to request a hearing within 90 days of the date on this notice. The procedures for requesting a hearing are attached. If you have any questions about this letter, please call your Case Manager at the number below.

Case Manager

Department of Social Services

Telephone Number

Cc: Representative

Long Term Care Facility

OES 011 (LTC)

White-Customer/Authorized Representative Copy Yellow-Long Term Care Facility Copy Pink-Case Record Copy

SUMMARY OF PROCEDURES FOR FAIR HEARINGS

If you are dissatisfied with the decision of the Local Department of Social Services, you have the right to appeal that decision to the Office of Administrative Hearings by writing to:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

You may obtain the necessary forms from the local department and if you wish, someone there will assist you in filing an appeal.

Your appeal must be filed within 90 days from the notice date on the other side of this letter. If you request a hearing within 10 days of the date of this notice, your Medical Assistance benefits may continue until a decision is issued on your case. **However, if you receive extended benefits pending a decision on your appeal and the Administrative Law Judge decides that the decision of the Local Department of Social Services was correct, you will be required to pay back the amount the Department paid for medical services you received during the appeal process.** This will not be required if it is determined that your request for a hearing resulted from a bonafide belief that the decision of the Local Department of Social Services was in error.

The appeal hearing will be scheduled by the Office of Administrative Hearings at a place and time that is convenient to you. You will be expected to be present or, if for some reason you cannot be present, you must notify the Office of Administrative Hearings of the identity of the person who will attend in your place. You may represent yourself or, if you wish, you may be represented by legal counsel or by a relative, friend or other person although it is not required that someone else represent you. You may bring any witness you desire to help you establish pertinent facts and explain your circumstances. A reasonable number of persons of the general public may be admitted to the hearing if you desire this. At least six (6) days before the hearing, the local department will send you a letter containing pertinent information, including the specific reason for your wanting to appeal. The Hearing Officer will decide whether or not the action of the local department was correct in its interpretation of the law and regulations. This decision will be sent to you as soon as possible, but not later than 90 days after receipt of your request for a hearing, unless there is a delay because you request that the hearing be postponed.

You may obtain free legal aid help through the Legal Aid Bureau in many areas of the State. Consult your telephone directory for the address and telephone number of the Legal Aid Office nearest you, or contact your Case Manager at the Local Department of Social Services for this information. You may also qualify for free legal representation. To see if you qualify, contact the Maryland Volunteer Lawyer Services at 1-800-510-0050.

1000.13 Policy Alerts

a. Eligibility for Institutionalized Persons: Application of Available Income to Cost of Care Policy Alert (10-01)

Federal law limits monthly pension payments to \$92 for Medical Eligible recipients of a VA pension who have no dependent and who reside in nursing home participating in Medicaid. Effective immediately, the \$92 VA pension is to be excluded from income and no part of it is to be applied to the person's cost of care in months following the month of admission.

As calculation Request CR-656 state, veterans and their representative should be aware that accumulation of this pension income may lead to excess resources and subsequent ineligibility, and that local departments should inform them of this when notifying them of the change in available income.

b. Change in Alimony Law Policy Alert (10-02)

The new law states that a judge may not award alimony based on a separation due to institutionalization. The court must also consider whether an award of alimony will cause the institutionalized spouse to become eligible for Medical Assistance earlier than if the award were not made. The effective date of the new law is July 1, 1992. If a worker encounters any alimony awards on or after the above date which appear to be in conflict with this new law, please contact the Division of Eligibility Services so that the case can be referred to the Attorney General's office for appropriate action.

c. Release of Information Policy Alert (10-03)

It is the practice of most Long Term Care Facilities to ascertain the payment method prior to admitting a patient. Facilities collect financial information to try to determine how long a patient will be "private pay" prior to going on Medical Assistance. Some LTCF administration have expressed their concern that applicants for Medical Assistance are not making complete disclosures of assets to Medical Assistance. LTCF administrators are willing to share the information with local departments; however they must have the applicant's consent to release information.

For any LTC case where a patient has been admitted as private pay or where the reported assets are, in any way, inconsistent with other information the worker must have such a consent form signed by the A/R or representative. The form should be completed in duplicate, one copy maintain in the case record and the original mailed by the local department to the LTCF.

Consent to Release Information Form

I understand that as an Applicant /Recipient of Medical Assistance. I authorize the release to the Department of Health and Mental Hygiene (The Department) and/or its delegate agencies of all data, records, and information by insurance companies, non-profit health services plans, providers of medical care, employers, agencies or organization necessary for The Department's pursuit of third party reimbursement or verification of my statements provided in this application. I understand that this is signed statement serves as written authorization for any of the above person, agencies, or organizations to release the information requested.

The social security number of every Medical Assistance applicant/recipient will be used to obtain and verify information concerning his/her unearned income, cash benefits, wages and resources. I give my consent for The Department and/ or its delegate agencies to compare the information I have given with the records of Federal, State, local and private agencies or businesses.

Signature of Applicant

Date

d. Policy Alert 10-04: Assignment of Support Provision

Introduction

The assignment of support provision is intended to enable an institutionalized person to qualify for Medical Assistance without consideration of spousal assets when the community spouse has refused to make the assets available to the institutionalized person. As a condition of this provision, the institutionalized spouse must cooperate in taking criminal action for non-support and must sign an agreement that any support paid will be given to the State as reimbursement for the care provided.

Policy and Procedures

An institutionalized person will not be determined ineligible for Medical Assistance due to the counting of spousal asset if all of the following conditions are met:

- (1) The institutionalized person, or that person's guardian or attorney in fact, has no legal authority to withdraw, liquidate or otherwise access the asset; and
- (2) Payments for cost of care are not being made; and
- (3) The institutionalized person, or that person's guardian or attorney in fact, agrees to cooperate with the State in bringing criminal action for non-support against the community spouse; and
- (4) All support rights have been assigned to the State.

Condition 1: No access to assets

When there is more than one asset being considered, this provision only applies to those specific assets to which the applicant has no access. If there are other assets to which the applicant does have access, those assets are to be considered.

The institutionalized spouse does not have access if all of the following circumstances exist:

- (a) The institutionalized person has no ownership interest in the asset and the person, or the person's guardian or attorney in fact, has no legal authority to withdraw, liquidate or otherwise access the asset; and
- (b) The community spouse has refused to pay for the cost of care and payments for any health care has not been made by or on behalf of the institutionalized spouse prior to the month of application, or during or after the month of application, and
- (c) The institutionalized spouse, or that person's person guardian attorney in fact, has not assisted in making the asset inaccessible.

The "no access" condition is unlikely to be met when the community spouse is the guardian or attorney in fact for the institutionalized spouse.

Item (c) above is not met if both husband and wife are represented by the same legal counsel on any matter related to obtaining Medical Assistance or spousal support. The presumption is that an attorney could not act as an advocate for the institutionalized spouse while assisting the community spouse in depriving the institutionalized spouse of support and/or access to spousal assets. This means that if

husband and wife have the same lawyer, the institutionalized spouse cannot be protected by the assignment of support provision.

Actions that constitute assisting in making an asset inaccessible include but are not limited to removal of the institutionalized person's name from an asset, placing any asset in which the institutionalized person has an ownership interest into a trust, converting any ownership interest of the institutionalized spouse from fee simple to life interest, transferring assets to the community spouse and adding a joint owner or trustee to an asset owned solely or in part by the institutionalized spouse. The LDSS must determine if any of these actions have taken place within 60 months prior to the month of application or anytime during or after the month of application.

If an institutionalized spouse has taken any of the actions described above but can demonstrate, to the Department's satisfaction, that there was no intent to make assets inaccessible that the action was for a purpose unrelated to Medical Assistance eligibility and that denial of eligibility would result in undue hardship then the institutionalized spouse will not be considered to have assisted in making the asset inaccessible. The LDSS must refer all requests for such consideration to the Division of Eligibility Services and the decision to grant to request may only come from this office.

Factors that will be considered in determining if there was intent or anticipated need for Medical Assistance will include the persons' health, age and financial status at the time for the action, and whether or not the action was typical or routine for persons not applying for Medical Assistance. For example, a man and a woman, both 45 years old, marry. She places his name on her accounts soon after the wedding. One year later, she is disabled in an auto accident and is institutionalized. He withdraws all of the funds and places them in an account in his name only and refuses to make the funds available to his wife. In this example, placing her husband's name on her bank accounts was a typical action, given the circumstances. Her age, health and financial status at the time she took this action did not suggest the need for long term care or Medical Assistance. Because of this she will not be considered to have assisted in making the assets inaccessible.

The 30 month look period for assistance in making assets inaccessible is not to be confused with 60 month look back period for disposal of assets, meaning that while some of these actions do not constitute a disposal of assets (eg. Inter-spousal transfers), they would preclude protection of eligibility under the assignment of support provision. Furthermore, while the look back period for disposals is limited to 60 months, the 30 month figure used in this provision is provided as a reasonable guideline, meaning that, while the LDSS is not required to investigate beyond this period, it may do so if there is reason to believe such action has taken place at an earlier time in anticipation of incurring LTC expenses; for example if there is an unusual distribution of the spouses' ownership interest (90%/10%. 100%/0) or any other circumstance that may indicate that the inaccessibility was consented to by the institutionalized spouse.

Condition 2: Cooperation in Non-Support Action and Assignment of Court Ordered Support to the State

To meet this condition, two circumstances must exist:

1. The institutionalized person, guardian or attorney in fact must take all required steps to obtain support, including agreeing to cooperate in criminal prosecution of the community spouse.
2. All support rights have been assigned to the State by the institutionalized spouse.

Circumstance 1 may be waived if the Department determines that denial of eligibility would work an undue hardship on the applicant. The LDSS must refer all requests for consideration of undue hardship through the Division of Eligibility Services and the determination of a hardship case may come only from this office.

An example of undue hardship would be a case where a couple has been separated for many years, the applicant has failed in the attempt to locate the spouse, and there is no reasonable method of ascertaining spousal resources. Both the length of separation and attempts to locate must be documented. Condition number one (no access) is presumed to be met since the community spouse, and likewise his or her assets, cannot be located. Condition 2 pursuit of criminal action, is waived since the spouse cannot be located to take court action against. In this case, protection under the assignment provision may be provided based on undue hardship.

A second example of undue hardship is where the pursuit of criminal action might reasonably be expected to result in harm to the applicant. If there is a documented history of spousal abuse by the community spouse, the institutionalized spouse may claim good cause for failing to pursue criminal action. Under these circumstances, protection under the assignment provision may be provided based on undue hardship.

Consequences for the Community Spouse

In the case where eligibility is granted because spousal resources have not been counted under the Assignment of Support Provision, there are certain actions that will be taken by the Department. They are:

1. The name of the community spouse will be referred to the State's Attorney for possible criminal prosecution;
2. The name of the community spouse will be referred to other governmental agencies, as appropriate; and
3. The community spouse will be held responsible for all payments made on behalf of the institutionalized spouse, including both administrative costs and payments for care.

Assignment of Support Rights

The purpose of the Assignment of Support Rights is to provide a means of determining eligibility for an applicant whose spouse will not cooperate with the application process. The conditions in COMAR 10.09.24.10-1D (3) must be met, including the willingness of the institutionalized person or their representative to cooperate with the State in bringing criminal action against the community spouse for non-support and assigning all support rights to the State.

The CM should research the electronic systems that are available (e.g., CARES, MMIS, MABS, Department of Motor Vehicles, and Social Security Administration), to obtain information about the community spouse. The databases may provide an address for the community spouse or information regarding the community spouse's eligibility for benefits. This information will assist the CM in determining if the Assignment of Support Rights and Notary Certification forms should be sent to the DHMH Office of Eligibility Services (OES).

When the CM determines the applicant is eligible for long term care, information regarding the applicant and the non-cooperative community spouse is sent to OES. This information is to include: the Cover Letter for Assignment of Support Rights, the Assignment of Support Rights, the Notary Certificate and a copy of the Information obtained about the community spouse from the database verifications indicated above. When no data are found, please indicate in the NOTES section of these over letter which databases were reviewed. Information on the cover letter about the applicant is sufficient. Incomplete information will be returned to the CM with the cover document. The Assignment of Support Rights, Right of Elective Share (Returned Information).

Following are the situations in which these forms should **not** be sent to Eligibility Services:

1. The community spouse receives SSI.
2. The community spouse's address is unknown.
3. The community spouse receives Medical Assistance (without a spend-down).
4. The case is denied for any reason. The forms would be kept in the record and sent only when the applicant is determined eligible.
5. The community spouse is incarcerated.
6. The community spouse is deceased. (The Right of Elective Share should be pursued for the applicant).

Right of Elective Share

Assets transferred to a spouse must remain in that spouse's name or be exchanged for fair market value to remain free of penalty. If the community spouse for whom an Assignment of Support Rights is in force or was completed dies, the LDSS should contact OES.

Following are the procedures to follow when the community spouse is deceased:

- a) When the spouse dies, his assets that pass to his heirs as a result of a will are not subject to a penalty. However, Maryland law provides that a surviving spouse is entitled to a share of the decedent's estate, regardless of the provisions of the will. To claim this share, the surviving spouse or his representative simply files a request for the share with the Probate Court. The request for this share must be made within nine months of the date of death of the late spouse.

Require verification that a claim has been filed with Probate Court by the applicant, requesting the share to the estate to which he is entitled. Advise the representative of the timely reporting obligation.

- b) Create a CARES Alert to review the case 60 days from the date that you receive the Probate Court documentation. If the document has not been received contact the authorized representative by mail requesting the information. If there has not been a disposition by the Probate Court, create an Alert for another 60 days and follow standard procedures. When received, the inheritance is considered lump sum income. If the lump sum causes ineligibility, any amount remaining at the time a subsequent application is filed is considered a resource. At the re-application, the applicant/representative will need to document the use of the inheritance and regular income during the period of ineligibility, since penalties for disposal are applicable to income, as well as resources.
- c) If an applicant or recipient fails to exercise the Right of Elective Share, this is considered a disposal of assets subject to penalty. COMAR 10.09.24.08-1 defines “assets” as including resources or income to which a person is entitled but which the person does not receive due to the action of the person, his or her spouse, or representative. The Medical Assistance Manual, Disposals Made After August 10, 1993, (located in Section 800) clarifies that a failure to act may be considered an action which would result in a penalty.

Forms and Mailing Address

Attached is the form used for the Assignment of Support Rights, and a Notary Certification form to be completed by the Notary Public and imprinted with the Notary’s seal. There is also a cover letter to use when submitting these forms to OES, and a form that is used by OES to specify the reason the request is being returned to the CM. Mail the forms when the applicant is determined eligible. If the forms do not need to be sent to Eligibility Services, retain them in your record.

Mail the forms and the printouts to:

Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston Street Room SS10
Baltimore, MD 21201

ASSIGNMENT OF SUPPORT RIGHTS

I, _____, do hereby assign, relinquish and transfer to the State of Maryland, Department of Health and Mental Hygiene, Medical Assistance Program all of my rights, privileges, and claims to any support required to be provided to me by my (husband/wife), _____,
For the period for which I am receiving Medical Assistance benefits for institutional care in a long term care facility.

This assignment is irrevocable and can terminate only upon my discontinuance of Medical Assistance benefits. However, the assignment for the period during which I received Medical Assistance benefits will remain in full force and effect until the Medical Assistance funds that were expended on my behalf during the period of my institutionalization are paid or otherwise reimbursed to the Medical Assistance Program.

I also hereby agree to cooperate with the State in bringing criminal action for nonsupport against my (husband/wife) _____, under Family Law Article, §§10-201 and 202, Annotated Code of Maryland.

DATE

SIGNATURE

Notary Certificate

STATE OF _____

COUNTY _____

I HEREBY certify that on the _____ day of _____ 20 _____, before me, the subscriber, a
(Month)

notary public of the state of _____, in and for

the _____, personally

[Insert the name of the city or county for which the notary is appointed]

appeared the above named signatory and duly executed the foregoing assignment of support rights.

As witnessed my hand and notary seal,

(Notary Public Signature)

Printed Name

[Notary Seal]

My commission expires: _____
(Date)

**DOCUMENTATION RETURNED TO THE LDSS CASE MANAGER FOR ASSIGNMENT
OF SUPPORT RIGHTS, RIGHT OF ELECTIVE SHARE**

Meets a situation described indicated in Policy Alert 10-4, Supplement in which there should not be referred to Eligibility Services.

FAILED TO PROVIDE:

- Cover letter with all items completed.
- Assignment of Support Rights letter.
- Notary Certificate
- Documentation (printouts) for the absent spouse or verify searches failed to produce any data about the absent spouse.

Comments: _____

Respectfully,

Program Specialist
Office of Eligibility Services

e. Hospice Care in a Long-Term-Care Facility (Policy Alert 10-6)

A resident of a long-term-care facility who has an illness that is expected to be terminal within six months may elect to receive hospice care. Hospice care includes some services not typically provided by nursing homes and not usually covered by Medical Assistance, such as spiritual counseling and social work services. A person receiving hospice care does not receive certain other services which would prolong life.

Hospice providers are responsible for coordinating the patient's care and insuring that all appropriate services are rendered. The amount the hospice provider is paid by Medical Assistance is based on the services the individual patient requires. A person who elects hospice care must receive treatment related to the terminal illness through the hospice provider only. The hospice provider is then responsible for making payments to all providers treating the patient's terminal illness, including the nursing home.

When a person is a resident in a LTCF and elects hospice care, eligibility is determined as for any other institutionalized person. A DHMH 257 approved by the UCA is required to verify admission to the LTCF and a level of care of at least intermediate.

When a person is determined eligible for Medical Assistance and hospice care is elected, there are procedures in place to prevent further payments by Medical Assistance to the LTCF and to authorize payments to the hospice provider. These procedures will be carried out by the hospice provider, the LTCF and DHMH. No action other than the usual ongoing case maintenance is required by the LDSS.

Hospice care is also provided to those who reside in their own homes or in hospice facilities. Eligibility for these persons continues to be determined under community M.A. rules.

f. Recipients Admitted to Long Term Care Facilities and Institutions for Mental Disease (IMDs) (Policy Alert 10-7)

If a MCO-enrolled recipient requires care from a nursing home, chronic care, or chronic rehab facility, the MCO must make the placement and cover the first 30 consecutive days of care. The MCO must obtain approval for the placement from the Utilization Control Agent (UCA). When an MCO properly places a recipient into long-term care and obtains appropriate approval from the UCA, the MCO submits a disenrollment request to DHMH. If the MCO does not take the required steps to obtain the UCA approval, any unapproved time may not be counted towards fulfilling the MCO's 30-day obligation. This means the MCO may be responsible for paying for more than the first 30 days of care.

When an MCO enrollee requires mental health services, clinical evaluation and assessment of services needed will be provided by the enrollee's MCO. However, Maryland Health Partners, the Administrative Services Organization (ASO), authorizes all specialty mental health services. The MCO is not responsible for payment of any specialty mental health services, including inpatient admissions to an IMD.

MCO-Enrolled Recipients Admitted to Nursing Homes, Rehab Facilities, or Chronic Facilities

LDSS CMs are not required to track the 30 days for which the MCO is responsible. This is handled through procedures arranged with the MCO and DHMH. LDSS CMs may continue to determine eligibility based on the dates submitted on the DHMH 257. MMIS-II includes edits which will not allow MCO enrollment dates and long-term care spans to overlap, and ensure that the recipient in long-term care is disenrolled from the MCO on the appropriate date. The LDSS must complete an unscheduled redetermination when a recipient is considered institutionalized to allow the long-term care facility to bill the Medical Assistance Program on a fee-for-service basis after the 30-day period for which the MCO is responsible. A long-term care application and DHMH 257 are required.

Upon receipt of the DHMH 257, with an approved level of care determination by the UCA, the CM must take the following action to effect a change from community MA to long-term care MA:

- If the recipient is the Head of Household (HOH), select “L” (Add-A-Program). If the recipient is not the HOH, select “J” to rescreen the case, making the recipient the HOH (“SE”). Go in through “O” Interview and enter the appropriate valid value code, i.e. “IC”, “CC”, etc. under “Living Arrangement” on the “DEM1” screen for the new AU. Update the “ADDR” screen to reflect that the individual is residing in a long-term care facility and include information on the authorized representative on the “AREP” screen. Evaluate countable assets to ascertain whether a disposal has taken place within the applicable look-back period.
- Complete the “INST” screen, including:
 - Institution Type;
 - CARES Vendor ID (Prov ID);
 - Date of Admission (Entry Date);
 - Level of Care (Level Auth); and
 - The requested begin pay date (LTC Payment Auth Date).
- After completing the Interview, go to “DONE”. This will simultaneously close out the community AU and allow you to process the new long-term care AU. Then Process (“P”) and Finalize (“Q”) the case.

The long-term care facility must bill the MCO for the first 30 days and then bill the Medical Assistance Program on a fee-for-service basis for the subsequent days.

When the case is processed in CARES, a long-term care span will be created on the MMIS-II system through the interface process.

Recipients Admitted to Institution for Mental Disease (IMDs)

An Institution for Mental Disease (IMD) means a hospital, nursing facility, or other medical institution of more than 16 beds that is primarily engaged in providing diagnosis, treatments, or care of individuals with mental diseases or substance abuse problems. IMDs include such long-term care facilities as psychiatric hospitals, residential treatment centers (RTCs), Regional Institutes for Children and Adolescents (RICAs), intermediate care facilities-alcoholic (ICF-As), and residential drug-free treatment programs.

An individual must meet technical eligibility, living arrangement and financial eligibility, before he or she may be determined eligible to receive Medical Assistance benefits. A person's living arrangement essentially refers to his or her residency in the community, as opposed to residency in an institution, which includes IMDs. Different financial criteria are applied based on a person's status as a community resident or as institutionalized.

There are several eligibility factors which determine when a person is considered institutionalized. The applicable policy is based upon the person's age, i.e., persons under 21 years old, persons who are 21 through 64 years old, and persons 65 or older. Once a person is considered institutionalized, the person retains that status until discharged from the facility. The rules are as follows:

- 1) Persons under 21 years old. Children are considered institutionalized as of the first day of the first full calendar month of admission to an IMD.
- 2) Persons 21-64 years old. Non-aged adults are considered institutionalized as of the 30th consecutive day of residency in an IMD, or as of the 60th cumulative day of residency in an IMD during a calendar year.
- 3) Persons 65 or more years old. An aged person is considered institutionalized as of the first day of admission to the IMD if the admission last for 30 days or more.

For children (under 21 years old) and elderly adults (65 or more years old), being considered institutionalized has the same effect. On the date the person is considered institutionalized, the following applies:

- MA eligibility is re-determined based on long-term care rules.
- If enrolled in Health Choice, the person must be disenrolled from the MCO as of the date that the institutionalization status is considered to begin.
- If an individual enters an IMD before age 21, he or she may remain MA eligible as an institutionalized person in the IMD up to his or her 22nd birthday or until care in the IMD is no longer required. If a recipient is discharged from an IMD and then is readmitted and institutionalized at age 21 or older, the recipient loses MA eligibility and MA does not cover the IMD services. Therefore, MA covers a recipient's IMD services until the earlier of the date that the recipient:
 - No longer requires the services
 - Is unconditionally discharged; or
 - Reaches age 22.

For adults between the ages of 21 and 64, admission to the IMD for a continuous period of institutionalization causes the person to become ineligible for MA. When a non-aged adult is considered institutionalized in an IMD, the following applies:

- If enrolled in Health Choice, the person must be disenrolled from the MCO effective the date that the institutionalized status is considered to begin.
- For recipients of Supplemental Security Income (SSI) or Temporary Cash Assistance (TCA), their MA eligibility is not terminated unless their eligibility for the cash program ends. However, MA is prohibited from paying for the cost of their IMD services.

- For medically needy and other MA recipients who are not automatically eligible, their MA eligibility must be terminated with timely notice.

MCO-enrolled recipients requiring specialty mental health services (e.g. IMD services) receive those services through the Administrative Service Organization (ASO) contracted by DHMH's Mental Hygiene Administration to assist the local Core Service Agencies (CSAs) with specialty mental health systems management. The ASO handles service preauthorization and claims payment for all MA recipients requiring mental health services, whether or not they are enrolled in Health Choice. The ASO also administers mental health services for persons who do not qualify for MA but cannot afford to pay for their own care.

The DES 1000, "Certification of Institutionalized and Health Choice Disenrollment" is a four-part snapshot form. It is used by IMDs to notify the Health Choice Enrollment Section in DHMH and the MA CM (Financial Agent, LDSS MA CM, or DHMH Division of Eligibility Waiver Services) of a recipient's admission to or discharge from an IMD. The authorizing agent for this form is the ASO, rather than DHMH's Utilization Control Agent (UCA) for other long term care services. .

Procedures

When a MA CM or financial agent is notified through the DES 1000 of an IMD admission:

- The admission date specified in Part III, IV, or V of the DES 1000 is compared with the admission date in Part 1;
 - The recipient's age is determined; and
 - It is confirmed that the recipient is institutionalized in an IMD.
1. For a recipient admitted for a long-term care stay in an IMD who is a child (younger than 21) or an elderly adult (aged 65 or older)
 - A completed and signed MA long-term care (LTC) application is obtained from the recipient or representative.
 - The MA CM or financial agent initiates an unscheduled redetermination. Eligibility is determined in a LTC coverage group—"L" Track for SSI recipients or adults, or "T" track for children or TCA adults.
 - The date that the person is considered institutionalized is specified in Part III or V of the DES 1000.
 - The ASO's authorizing signature on the DES 1000 is used as the level of care certification, rather than the DHMH 257.

The MA CM or Financial Agent uses the following CARES procedures to complete the unscheduled redeterminations;

- a) For a recipient who is on the only member receiving benefits in his or her existing community MA assistance unit (AU).
 - Go in through "O" Interview
 - The "ADDR" screen should reflect that the individual is residing in a long-term care facility (IMD).
 - Include information on the authorized representative on the "AREP" screen.

- Enter the appropriate valid value code “MD” (Mental Disease Facility) under “Living Arrgmt” on the “DEM1” screen for the new AU.
 - Evaluate countable assets to ascertain whether a disposal has taken place within the applicable look-back period.
 - Complete the “INST” screen, including:
 - Institution type: Use “NH” (Nursing Home);
 - CARES Vendor ID (Prov ID);
 - Date of Admission (Entry Date);
 - Level of Care (Level Auth). Use “U” (Under 21 Psychiatric) for children under 21 years old or “L” (LTC Hospital) for adults aged 21 or older; and
 - Requested Begin-Pay Date (LTC Payment Auth Date).
 - After completing the Interview, go to “Done”. This will simultaneously close out the community AU and allow you to process the new LTC AU.
 - Process (“P”) and Finalize (“Q”) the case.
- b) For a recipient who is in an existing community MA AU with other members receiving benefits (e.g., spouse, parents, children):
- Select “J” (Screening) to rescreen the case.
 - Select “Long Term Care” from the “KIND” screen.
 - When you get to the “INCH” screen, “PF20” to find a match for the recipient.
 - Continue to follow the procedures outlined in a) above. The recipient must be entered as Head of household (“SE”). This will terminate the recipient’s eligibility in the community MA Case.
 - If a child is a member of an active TCA AU when institutionalized in an IMD, the child may remain in both the TCA AU and the MA- LTC AU.
(Follow TCA policies that address when a child who is placed out-of-home must be removed from the TCA AU)
 - Eligibility must be redetermined for the remaining members of the MA Community AU.
2. For a recipient institutionalized in an IMD who is 21 years old:
- If the recipient was admitted before age 21 and remains in the IMD for a continuous period of institutionalization, the recipient is covered by MA for IMD service until earlier of the date that the recipient: (a) is determined by the ASO to no longer need IMD services, (b) is unconditionally discharged from the IMD, (c) reaches age 22, or (d) loses MA eligibility for other reasons.
 - If the recipient is 21 years old when admitted or when an institutionalized person in an IMD reaches age 22, the procedures in #3 or #4 below are followed.
- 3.
- Individuals between age 22 through 64 are not MA eligible if they are institutionalized in an IMD. Therefore, their MA eligibility must be cancelled with timely notice. The date that the individual is considered institutionalized is specified in Part IV of the DES 1000. The MA CM or financial agent uses the following CARES procedures to terminate MA eligibility:
- Complete the unscheduled redetermination i.e. rescreen, etc. following the procedures given in #1b) above. The person must be entered as Head of Household (“SE”).

- ON the “DEMI” screen, enter valid value code “MD” (Mental Disease Facility.) This will generate the Closure code “220”-“Failed Age Requirement.”
 - Use freeform text to indicate the reason for the case closure on the Notice of Denial.
4. For a recipient admitted for a long-term care stay in an IMD who is between 22 and 64 years old and is MA eligible as a recipient of SSI or TCA: Eligibility for MA is retained unless eligibility for the cash assistance program ends. However, MA is prohibited from paying for the cost of their IMD services.

Procedures after eligibility determination for a recipient institutionalized in an IMD:

- All cases activity should be documented in the CARES narrative.
- Retain the original DES 1000 in the case record.
- When a recipient transfers from one IMD to another, a new DES 1000 form should be received by the MA CM to confirm admission to the new facility. “Transfer” should be checked in Part VI of the DES 1000.
- When recipient is transferred from an IMD to an acute, sub-acute, or rehabilitative hospital (not a long-term care facility) and then returns to the IMD, the hospitalization is not considered a discharge and does not interrupt the recipient’s institutionalization in the IMD. Since hospitalization does not impact the recipient’s MA long-term care eligibility, a DES 1000 is not used.
- When a recipient is discharged from an IMD, to the community, the facility should send a DES 1000 to notify the MA CM (DEWS, financial agent, or LDSS) and the DHMH Health Choice Enrollment Section. The recipient’s eligibility should be redetermined for community MA. If the recipient is being discharged from an IMD for persons under 21 years old, the policies and procedures in Policy Alert 10-9 and its Supplement are followed to redetermine eligibility for community MA.

PLEASE CHECK REQUESTED ACTION:
 **CERTIFICATION OF INSTITUTIONALIZATION & HEALTHCHOICE
 DISENROLLMENT**
 NOTIFICATION OF DISCHARGE FROM LONG-TERM CARE

TO: DHR/LDSS CM
 District Office: _____
 Address: _____

TO: DHMH HealthChoice
 Enrollment Section, Room L-9
 201 W. Preston Street
 Baltimore, Maryland 21201

Part I. Recipient Identification

Last Name _____ First _____ M.I. ____ D.O.B. _____
 M.A. Number _____ Social Security Number _____ - _____ - _____
 Date of Admission to the Facility _____

Part II. Facility Identification

Name _____ CARES Vendor ID Number _____
 Address _____ MMIS Provider ID Number _____
 _____ Facility Phone Number _____
 _____ Facility Contact Person _____

Part III. Recipient Under 21 Years Old

To be completed after *one full calendar month* in the facility.

This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on _____ / 1 / _____ .

Part IV. Recipient Aged 21 Through 64

To be completed after *the 30th consecutive day* in the institution **or** after the *60th cumulative day during a calendar year* in an institution.

This certifies that this individual has been institutionalized in the above facility

For 30 consecutive days, effective _____

For 60 days during the calendar year, effective _____

Part V. Recipient 65 Years Old or Older

To be completed after the *30th consecutive day* in the facility.

This certifies that this individual was admitted to the above facility on _____

and is considered institutionalized on that date.

Part VI. Discharge Information For Recipients Under 21 & Over 65 Years of Age

To be completed *upon discharge from the facility*.

This certifies that this individual was *discharged from the above facility* on _____ to

Home _____
 LTCF _____
 Other _____

Facility Certification: Signature _____ Date _____ Phone _____

Administrative Services Organization Authorization:

Signature _____ Date _____ Phone _____

DES 1000 Revised 01/09 White – LDSS/DEWS Yellow- DHMH Pink- IMD Blue-

INSTRUCTIONS

Facility:

1. Complete Part I and II for all Medical Assistance recipients admitted to your facility.
2. Follow the instructions in section III, IV and V to determine *when* to complete and submit this form for each recipient.
3. The facility's authorized representative ***must*** sign and date the form.
4. Submit the entire, completed, signed form to the Administrative Services Organization (ASO) for their signature.
5. When the ASO returns the signed form to you:
 - a. Send original to the Medical Assistance CM
 - b. Send the second copy to the DHMH HealthChoice Enrollment Section
 - c. Retain the last copy for your files.

Administrative Services Organization:

1. Review form to determine that the period from the date of admission through the effective dates specified in the certification (Part III, IV, or V) is an authorized inpatient stay at this facility.
2. If the period is fully authorized, sign the form, retain the last copy for your files, and return the original and all other copies to the facility.
3. If any portion of the period from admission to date specified in the certification section is not authorized by your organization, do not sign the form, but return it to the facility, noting the discrepancy.

CM:

1. Check the date specified in Part III, IV, V against the admission date in Part I.
2. Redetermine eligibility based on the recipient's institutionalized status.
 - a) For recipients younger than 21 or 65 or older, redetermine eligibility in a long-term care
 - b) coverage group (T track or L track) effective the date specified in the certification (Part III or V). For medically needy recipients aged 21 through 64, ***cancel*** eligibility with timely notice due to residency in an institution for mental disease.
3. Retain the original form in the case record.
4. Take ***no action*** for recipients of ***SSI or TANF***.

HealthChoice Enrollment Section:

1. Disenroll the recipient from HealthChoice effective the date specified in the certification section (Part III, IV or V).
 - a. For Part III or V, use disenrollment code C8.
 - b. For Part IV, use disenrollment code B2 or B1, as appropriate.
2. Retain form for your files.

Discharge Notification - To Be Completed By the Facility:

1. Complete Parts I and II. Indicate the date of discharge and destination in Part VI.
2. The facility's authorized representative must sign and date the form.
3. For recipients under 21 years old, send the original to:

**Division of Eligibility Waiver Services (DEWS)
6 St. Paul Street, Room 400
Baltimore, Maryland 21202**

4. For recipients over 65 years old, send the original to the Financial Agent or respective local department of social services.
5. Send the second copy to the DHMH HealthChoice Enrollment Section.
6. Retain the last copy for your files.

IMDs

<u>FACILITY</u>	<u>PHONE NUMBERS</u>
** Walter P. Carter	410- 209-6200
**Crownsville Hospital	Main 410- 729-6000
**Eastern Shore Hospital	410- 221-2300
**Thomas B. Finan Center	301- 777-2200
**RICA-Baltimore	Main 410-368-7800
**RICA-Southern	301-372-1800
**The John L. Gildner RICA (Also known as RICA-Rockville)	301-251-6800
**Spring Grove Hospital	410-402-6000
**Springfield Hospital	410-795-2100
**Upper Shore CMHC	410-778-6800
	1-888-216-8110
**Maryland Psychiatric Research Center	410-455-7101
Chestnut Ridge Hospital	304-293-4000
*Taylor Manor Hospital	410-465-3322
*Devereux Hospital & Child Ctr.	407-812-4555
*Mapleton Psychiatric Inst.	215-296-6821
*Kennedy Krieger Institute (psychiatric admissions only)	410-502-8885
Rockford Center IMD	302-996-5480
*The Psychiatric Inst. of Washington	202-965-8550

NOTE: This listings reflects information known as of the month of issuance. For questions concerning the DES 1000 process for facilities without an asterisk, you may contact the Mental Hygiene Administration at 1-877-4MD-DHMH, Extension 6655. For questions concerning Provider numbers, please contact Provider Enrollment at 1-877-4MD-DHMH, Extension 5340.

***DES 1000s Processed by DHMH Medical Assistance Waiver Unit.**

****DES 1000s Processed by DHMH Financial Agents.**

IMDS

<u>FACILITY</u>	<u>PHONE NUMBERS</u>
Hall-Brooke Hospital	1-800-543-3669
*Sheppard Enoch Pratt Hospital	410-938-3000
*Chesapeake Youth Ctr. Inc.-Cambridge (RTC)	410-221-0288
*Chesapeake Youth Center-Cambridge (Hospital)	410-221-0288
*Brook Lane Psych Ctr.	301-733-0330
*The Jefferson School (RTC)	301-624-8400
*Edgemeade-Upper Marlboro (RTC)	301-888-1330
*Edgemeade at Focus Point (RTC)	410-987-6200
Chesapeake Youth Center, Inc. –Hickey (RTC)	410-221-2300
*Devereux Mapleton Center	610-942-5900
*Devereux Brandywine Ctr.	610-942-5900
*The Pines RTC	757-474-3310
First Hospital Corporation (Acute Hospital)	
*Woodbourne Center, Inc. (RTC)	410-433-1000
Crittenton (RTC-Out of State)	816-765-6600
*Villa Maria (RTC)	410-252-4700
*Good Shepherd Center (RTC)	410-247-2770
*The Mann Residential Treatment Center (RTC)	410-938-3427
*Potomac Ridge Behavioral Health/Adventist Health Care	301-251-4500
Edward W. McCready Mem. Hospital	Extension 3273

*DES 1000s Processed by DHMH Medical Assistance Waiver Unit

**DES 1000s Processed by DHMH Financial Agents.

g. Redetermination Procedures for SSI Recipients Entering Long-Term Care (Policy Alert 10-08)

When it is anticipated that an individual receiving Supplemental Security Income (SSI) will remain in a long-term care facility (LTCF) for more than thirty days, the CM must confirm with the individual, or his or her representative, that the change of address and living arrangement have been reported to the Social Security Administration (SSA). Upon admission to the LTCF, SSA will reduce the SSI-only individual's monthly income to the \$30.00 SSI Personal Needs Allowance. Any other income received by an SSI recipient must be verified.

The form DHMH 257, which either requests a begin date for Medicare co-payment or satisfies Utilization Control Agent (UCA) authorization for nursing facility services, is required. Non-SSI individuals admitted to LTCFs who are eligible for community Medical Assistance, must file an application for long-term care Medical Assistance. This requirement is non-mandatory for the SSI individual. However, it is strongly recommended that a Medical Assistance long-term care (LTC) application is completed to satisfy administrative and post-eligibility requirements and to establish eligibility for Medical Assistance cost of care payments. The application ensures that:

- A representative is identified if necessary;
- Home property is evaluated for continued excludability and applicability of a lien;
- Disposals of resources for less than fair market value are identified and properly treated; and
- Any additional income is evaluated for availability toward the cost of care, spousal or family allowance, residential maintenance allowance, or dependent allowance.

Please refer to Policy Alert 10-7 for procedures concerning the appropriate action to take when MCO-enrolled recipients move from community Medical Assistance to long-term care and when recipients enter one of the Institutions for Mental Diseases (IMDs).

Failure To File A Long-Term Care Application

Failure to file a long-term care application does not result in termination of eligibility, since an SSI recipient is categorically needy. However, if the long-term care application is not filed, and the information necessary to make an eligibility determination is not available to the CM, the long-term care case cannot be completed. Return the form DHMH 257 to the LTCF if an application has not been filed, since the applicant's eligibility determination for long-term care cannot be made without the application and necessary verifications.

Excess Resources

If resources are found to be overscale, delay LTC certification until SSA has verified that SSI eligibility will continue. Send a manual notice indicating the reason for delay in processing the application as: awaiting response from SSA regarding continued SSI eligibility.

If notified by SSA that the individual remains eligible for SSI, certify in the appropriate long-term care category. If notified by SSA that the individual is no longer eligible for SSI, enter the resource amount onto the appropriate CARES asset screen. Allow the system to determine eligibility. If resources exceed the \$2000 SSI resource standard, but are within the \$2500 MA medically needy resource standard, the person may be certified as LTC medically needy (L98). Include in the narrative the case action taken, including information received from the SSA.

Evaluation of SSI Recipient's Income

The income of SSI-only recipients certified for LTC MA (L01) is reduced to the SSI Personal Needs Allowance of \$30.00 per month. These individuals will never have income to contribute toward the cost of care in the LTCF. Also, there will never be income available for spousal, family, dependent, or residential maintenance allowances.

However, any "other income" (e.g., Social Security benefit, pension, etc.) will be considered beginning the second month of institutionalization. These individuals will be in the L98 coverage group, and will receive a \$40.00 per month Personal Needs Allowance and any other applicable deductions. Any remaining income will be contributed toward the monthly cost of care.

Penalty Period Imposed

Individuals who are eligible for coverage in the L01 or L98 coverage groups, except that a current penalty period exists due to the disposal of assets for less than fair market value, are not eligible for Program payment toward cost of care in the LTCF. Normally, CARES transmits the resource information to MMIS Screen 4, and a long-term care span is created that allows providers to bill for services rendered. In the case of a penalty being imposed, the MMIS Screen 1 will reflect eligibility in the L01 or L98 coverage group. However, Screen 4 will not reflect the long-term care span that is necessary for provider billing. When the asset- disposal information is entered onto the CARES "TRANS" Screen, a system edit precludes CareS from transmitting the resource information necessary to create a long-term care span onto the MMIS Screen 4. These individuals are however, entitled to receive the Medical Care Program card to cover medical expenses. Under these circumstances, after the penalty period has been calculated and entered onto CARES:

- Send a manual Notice of Ineligibility for Medical Assistance long-term care due to the transfer or disposal of assets for less than fair market value. Include the amount of the transfer or disposal and the duration of the penalty period.
- Include in the Notice that he or she is ineligible for Program assistance with payment toward the cost of care in the LTCF, however, he or she is eligible and will receive the Medical Care Program card to cover medical expenses.
- Include COMAR citations and appeal rights.

Please note: The CM must set an Alert to ensure that the case is reviewed and Program payment toward the cost of care begins when the penalty period is ended if the individual's eligibility continues beyond the penalty period.

Scheduled Redeterminations

Redetermination packets will be automatically sent out every year for recipients in the L98 coverage group. For recipients in the L01 category, the CM should set an Alert at least once a year to review the case for any changes, e.g., change of nursing facility residence, sale of home property if a lien has been placed, change of representative, new assets, death, etc.. When the alert is received, take the following action:

- Send a manual letter to the Representative informing him or her that it has been a year since the recipient's case was last evaluated for LTC eligibility.
- Include in the letter that the LDSS needs to be informed of any changes concerning nursing facility residences, or changes that might affect the recipient's LTC eligibility, i.e., sale of home property if a lien has been placed, new assets, death, etc.

Please refer all questions concerning this Policy Alert to the DHMH Division of Eligibility Services at (410) 767-1463.

Redetermination Procedures for SSI Recipients Entering Long-Term Care (Policy Alert 10-08 Supplement)

Procedures To Be Followed If There Are Excess Resources

When an individual who is active in the Medical Assistance (MA) coverage group S02 enters a Long-Term Care Facility, the case is pended in L01 while the CM waits to receive verifications. If verifications indicate that resources exceed the \$2000 SSI resource standard, but are within the \$2500 Medical Assistance medically needy resource standard, the case worker will certify the individual as LTC medically needy (L98). The CM must Add- A- Program for L98, complete the eligibility process for the L98, close the active S02, and deny the pending L01. CARES will not trickle from L01 to L98 because of the SSI income. Update the narrative to reflect all case action.

If the person is no longer eligible for SSI, remove the SSI income from the pending L01 on the UINC screen and code the SSI closing information on the bottom of the UINC screen. At the bottom of the UINC screen, indicate SI for Appl Type, T for the status, and the termination date from the SDX on-line inquiry. CARES will trickle to Medicaid coverage group L98. Complete the application process.

h. Redetermination Procedures for Children Under the Age of 21 Being Discharged from Institutions for Mental Disease (IMDs), Regional Institutes for Children and Adolescents (RICAs), or Residential Treatment Centers (RTCs) (Policy Alert 10-09)

Federal and State regulations provide for the prompt redetermination of (MA eligibility when there is a change in an individual's circumstances, i.e., disability, living arrangements, income, resources, etc, which could result in the loss of eligibility. Federal and State guidelines also stipulate that MA eligibility must continue until it has been determined that an individual no longer meets the criteria for continued eligibility. This Policy Alert sets forth procedures, effective immediately, which are to be followed to facilitate the transition when a recipient under 21 years of age is discharged to the community from an IMD, RICA, or RTC. Upon the discharge of recipients under 21 years of age from IMDs, RICAs, and RTCs, the facilities have been instructed to give the parents or guardians the children's Medical Care Program Identification cards so that they may access Medical Assistance services. The facilities have also been instructed to provide the parents or guardians with a supply of any needed prescriptions for the children to last through the end of the month.

Rather than closing the Medical Assistance (MA) case upon the child's discharge, the CM must allow MA eligibility to continue for at least 90 days, so there will be time for an unscheduled redetermination using MA community rules.

Procedures to be followed by the CMs for Canceling Long-Term Care Eligibility and Establishing Community Case

Medical Assistance eligibility may not be terminated based on a child's discharge from the facility. The child's MA eligibility must continue until it has been determined eligibility no longer exists. The CM at the local department of social services (LDSS) must make this determination through the redetermination process. To facilitate this process and the child's transition from long-term care Medical Assistance to the community, use the following procedures:

Procedures for Financial Agents and MA Waiver CMs

- The Financial Agent or MA Waiver CM, as the worker of record, must change the redetermination end date to allow the case to go into the CARES automatic redetermination cycle so that the MA CM at the LDSS can redetermine eligibility.
- Financial eligibility tests are not required until the redetermination is initiated.
- Income and assets will be considered beginning the month following the redetermination.
- The Financial Agent or MA Waiver CM should use the following procedures when a copy of the DES 1000 form is received from as IMD/RICA/RTC, indicating that a recipient under 21 years of age has been discharged:

1. In the Historical month enter the discharge date onto the "INST" Screen. This will generate a transaction to effect closure of the long-term care span on MMIS Screen 4 as of the discharge date, and will also allow the child to continue to receive necessary specialty mental health services and other MA services on a fee-for-service basis. DO NOT change the information on the "DEM1" or "DEM2" Screens. However, the "ADDR" Screen should be changed to reflect the discharge address indicated on the DES 1000.

2. Leave the child in the “T” track. **Remember:** Leave the child as the head of household and use the discharge address indicated on the DES 1000 form as the community address. Income and assets will not be considered for the child until the redetermination is completed by the LDSS CM.
3. On the “MISC” screen adjust the redetermination end date to 90 days from the first day of the month following the month in which the Financial Agent or MA Waiver Division CM became aware of the discharge, to allow inclusion into the CARES automatic redetermination cycle.

Please Note:

- If the discharge date is during the first nine (9) months of the child’s certification period, the redetermination end date must be adjusted according to number 3 above to allow inclusion into the CARES automatic redetermination cycle.
 - If the discharge takes place in the last three (3) months of eligibility, the Financial Agent or MA Waiver CM must initiate the redetermination in the month following the month in which he or she became aware of the discharge. Complete the redetermination and adjust the “REDET END DATE” to 90 days from the “REDET BEGIN DATE.”
 - Following this procedure will ensure that CARES begins a “new redetermination cycle”, and in doing so, will generate a new redetermination packet to the discharge address. Since the child is still in the “T” track, the CARES 9708 application will be sent, even if the child is discharged back home.
 - If the AU has closed on CARES during the previous month, due to failure to complete the redetermination process, the Financial Agent or MA Waiver CM should “J” Screen the closed AU number from the first day of the month in which eligibility ended. Complete the application process and, in finalization, adjust the “REDET END DATE” to 120 days from the “REDET BEGIN DATE” to allow inclusion into the automatic redetermination cycle.
4. Transfer the case to the appropriate LDSS’s MA District Office.
 5. Set an Alert to notify the LDSS CM that the above action has been completed and forward the case to the District Office for follow-up.
 6. Be sure to narrate all case action.

Procedures for LDSS MA CMs

1. For quality assurance purposes, the LDSS CM must set an Alert to review the transferred “T” track case by at least 30 days before the end of the 90-day certification period.
2. If the redetermination application is returned by the child’s parent or representative, determine whether the child is living at home. If so, mail a CARES 9701 to the parent/representative, specifying and highlighting the sections to complete, which are not included on the CARES 9708. Complete the application process, applying all applicable rules for assistance unit composition (HOH, etc.).

3. In the application month the “FINL RESP” code for the child must be entered as “NM” to avoid dual participation and insure eligibility is determined correctly for any other AU members.
4. If the redetermination application is not received, the LDSS CM must update the narrative and allow CARES to close the AU due to failure to complete the redetermination. The procedures in Policy Alert 12-04 for tardy redeterminations apply if an application for continued eligibility is returned within four (4) months of the redetermination due date, or if a new application is filed within that time frame.
5. When determining community eligibility, technical and financial eligibility factors must be met for all household members for whom benefits are requested. If the LDSS CM determines that the child is eligible for MCHP and there is no associated case, change the D.O. and transfer the open case to the appropriate local health department (LHD). If the LDSS CM determines that the child is eligible in another community category or there is an associated case, the AU remains active in the LDSS.
6. If it is determined that eligibility no longer exists, the assistance unit must receive timely and adequate notification, and the right to request a hearing.

NOTE: ALL CASE ACTIVITIES MUST BE FULLY NARRATED IN CARES.

i. Maryland Home and Community Based Service Waivers Applicants Who Reside In a Long-Term Care Facility (Policy Alert 10-11)

Medical Assistance (MA) recipients in a long-term care facility (LTCF) who have applied for a home and community based services waiver and meet all other medical, technical, and financial waiver requirements may not be enrolled in the waiver until they are discharged from the LTCF to a community-based setting. The DHMH Division of Eligibility Waiver Services (DEWS) is responsible for processing the MA waiver application and pending it in CARES. The following procedures will be used for institutionalized MA recipients who apply for a waiver. If the applicant has received a “Notice of Ineligibility” for MA waiver eligibility from DEWS, the applicant must re-apply if the applicant wants waiver eligibility to be reconsidered.

For pending waiver applicants, if the waiver administering agency (the State agency or other designated entity responsible for administration of the waiver) determines that the applicant meets all the non-financial waiver eligibility requirements except that the applicant still resides in a LTCF, the waiver administering agency will send an “advisory” Authorization to Participate (ATP) to DEWS. This ATP will specify that it is an advisory ATP because the applicant still resides in a LTCF. Upon receipt of the advisory ATP, DEWS will determine MA waiver eligibility.

If the applicant is not MA waiver eligible, DEWS will send the applicant a waiver denial notice, specifying the reason(s) for MA waiver ineligibility.

If DEWS determines that the applicant appears to be MA waiver eligible based on the information provided so far, DEWS will send the applicant a waiver eligibility advisory opinion. The notice will inform the applicant that he/she may qualify for the waiver without reapplying, if he/she moves from

the LTCF to the community within 6 months of the waiver application date (i.e. the date that the MA waiver application was received).

The Waiver CM will follow up with the LTCF to establish the discharge date, and will assist the applicant with the necessary arrangements for community living. When the applicant is ready to leave the LTCF, the waiver administering agency will send an “authorization” ATP to DEWS, specifying the discharge date from the LTCF, confirming approval of waiver enrollment, and proposing a waiver enrollment date (usually the discharge date from the LTCF). The waiver administering agency will send a revised ATP to DEWS if the discharge date changes.

If the applicant moves out of the LTCF to a community home within 6 months of the application date, a new MA application is not necessary. The LTCF should send the discharge DHMH 257 to DEWS rather than to the local department of social services (LDSS) which has the MA long-term care case. If the applicant is MA eligible for the waiver, DEWS will close the MA LTC case and open the MA waiver case. DEWS will send the waiver approval notice to the applicant/representative, specifying the effective date for waiver enrollment, with a copy to the local waiver CM and the waiver administering agency.

If the applicant does not move out of the LTCF within 6 months of the application date, the DEWS CM will send a denial notice to the applicant, giving as the reason that the MA application expired after 6 months. The applicant’s representative, waiver CM, waiver administering agency and other appropriate parties should be copied. If the applicant is still interested in the waiver, the applicant will need to re-apply. A new application date and consideration period will be established by DEWS upon receipt of the new application.

j. Deduction of Non-covered Medical or Remedial Services from an Institutionalized Person's Available Income for the Cost of Care (Policy Alert 10-12)

Certain deductions are allowed when calculating an institutionalized person's available income for the cost of care in a long-term care (LTC) facility or waiver program. One of the allowable deductions is for the individual's unpaid, incurred expenses for necessary services recognized under State law as medical or remedial care but not covered by the State's Medical Assistance (Medicaid) program.

In two circumstances, non-covered services may be used as a deduction from a recipient's contribution towards the cost of care (patient resource amount):

A. The individual was enrolled as a Medicaid LTC or waiver recipient for the date of service, but the necessary medical or remedial services are not covered under the Medicaid State Plan.

For example, services that are only covered by Maryland Medicaid for children younger than 21 years old (e.g. private duty nursing, eyeglasses, dental care, dentures, or hearing aids) may be deducted from an adult LTC or waiver recipient's available income for the cost of care. Deductions for non-covered assisted living services may not include room and board, just expenditures for the types of medical or remedial services covered for waiver enrollees

B. The recipient is not Medicaid-eligible for the service date, and the service was received:

- During the three-month period prior to the month of the current application; or
- During any period between the month **of the current application** and the first month of current eligibility.

For example, unpaid bills for nursing facility services received by a recipient during ineligible months in the three month period prior to the month of the current application (e.g., when the recipient was still resource over scale) may be deducted from the recipient's available income for the cost of care.

Note: Although there is no retroactive period associated with a waiver application, waiver applicants residing in Assisted Living Facilities are entitled to have unpaid medical bills incurred during the three months prior to the month of the current application deducted from their available income for the cost of care.

1. When the applicant or authorized representative indicate they have unpaid medical bills at application, first the CM determines the A/R's eligibility for Medicaid Long Term Care (MA-LTC). *Note: If the A/R indicates they have unpaid medical bills at application that were incurred in the last three months, an eligibility determination must be made for these months prior to sending a request to DHMH to determine any pre/post- eligibility medical expense deductions.*
2. When the recipient or authorized representative indicates they have unpaid medical bills at redetermination, first the CM redetermines eligibility for Medicaid Long Term Care (MA-LTC).

3. As soon as the A/R is determined eligible, the CM requests and/or collects the bills from the applicant/authorized representative and then:

a) Verifies that the items or services:

- Occurs during one of the two time periods in section B above;
- As of the first day of the month of application the bill must have been unpaid and remained obligation of the applicant/recipient (A/R) to pay, as verified by a detailed bill, or statement from the provider. Bills for medical or remedial services received prior to the three-month period may not be deducted from the recipient's available income for the cost of care;
- The dates of service are not more than three months prior to application;
- Are recognized under Maryland law as a medical or remedial service; and
- Were medically necessary (e.g. would be reimbursed by Maryland Medicaid if the individual and/or service were covered).

b) Requests the necessary verifications. The provider's bill, invoice or statement must:

- Be an itemized bill, statement, contract or invoice, for items or services furnished during the three months prior to the application month or for an ineligible month between the application month and the first month of current eligibility;
- Specify the date(s) of service;
- Describe the services received in detail, **including procedure codes** when applicable;
- Specify the provider's charge for each service received (e.g. give separate charges for nursing facility services and for non-medical services such as beauty parlor/barber services, cable, telephone or security alarms and monitors);
- Specify any payments received or third party liability for the services (e.g. payments from the A/R or others on the A/R's behalf prior to the month of application, and any third party payments from health insurance, Medicare, LTC insurance, etc.); and
- Give the provider's name, address, and telephone number.

4. To determine the allowable deduction, the CM must complete all fields on the OES 001 and send a copy of the CARES STAT Screen for all denied months, and a copy of the detailed current bill, invoice or contract to:

DHMH
Attn: Non-Covered Services
201 West Preston Street, Room SS-10
Baltimore, MD 21201

5. When the CM receives DHMH's approval to deduct a specified total amount for the non-covered services, the CM manually calculates the A/R's available income for the cost of care, to assure that it is calculated correctly. Use the DHMH 1159 (LTC) Worksheet for Institutionalized Persons- Cost of Care/Available Income. Enter the allowable deduction for non-covered services as "Other" under deductions on the worksheet.

- If the amount approved by DHMH for the non-covered service deduction *is less than* the A/R's monthly available income without the non-covered service deduction, use the amount approved by DHMH as the deduction.
- If the non-covered service deduction approved by DHMH *exceeds* the A/R's monthly available income, use the A/R's monthly available income without the non-covered service deduction as the monthly deduction for the non-covered services. Then, the available income is reduced to \$0. All of the A/R's net countable income, after any other deductions are subtracted (e.g. spousal maintenance allowance, personal needs allowance), is allowed as the deduction for non-covered services, so that the recipient may pay the provider's bill in full as quickly as possible.
- Complete more than one column on the DHMH 1159D worksheet if you expect a change in income, cost of care, or deductions- e.g., the recipient's income will change due to a cost of living increase, or the deduction for Medicare premiums will end in the 3rd month of Medicaid eligibility when Medicare Buy-In begins.
- Estimate how many months the deduction for non-covered services will continue until the monthly deductions total the deduction approval by DHMH. Establish a way (e.g. CARES "745" alerts, tracking system) to assure that the monthly deductions continue until the total is reached, and that the monthly amount is adjusted as necessary when the recipient's net countable income and/or other deductions change over time.

6. Enter the required information onto the INST screen of CARES. The monthly deduction for non-covered services is entered in the field for "UNCVRD MED AMT". Complete the INST screen for the current month, any ongoing month with a change, and any historic month with a change.

7. Check the MAFI screen of CARES for each impacted month to assure that it has the correct information and calculations. Make any necessary corrections to assure that the available income is correct on CARES for each month, and will transmit correctly to MMIS recipient screen 4 as the "patient resource amount". The line for "Non-covered Med Exp" on the MAFI screen represents the sum of three fields from the INST screen: "UNCVRD MED AMT" for the non-covered services, "MEDB PREM AMT" for non-covered Medicare premiums, and "UNCOVERED INS PREMIUM AMT" for other non-covered insurance premiums.

8. If a change or correction is necessary to MMIS Recipient Screen 4 that cannot be processed through the CARES-MMIS interface, submit the 206C form to the DHMH LTC Reconciliation Unit (e.g. to change the available income/resource amount for one or more historic months).

9. Suppress the CARES notice. Issue the manual DHMH 4240 (LTC) Notice of Change in Available Income and OES 011 (LTC) Notice of Eligibility for the Post-Eligibility Medical Expense Deduction to the recipient, any designated representative and the LTC facility (if the consent to release of information is signed). Complete the DHMH 4240 (use additional notices as necessary) to inform the recipient of the allowed deductions and the available income for the current month and for any subsequent months with a change. Under "other" specify the allowable deduction.

Attach to the OES 011 (LTC) Notice of Eligibility for the Post-Eligibility Medical Expense Deduction a copy of the A/R's Non-Covered Service Report sent by DHMH.

10. Set a "745" alert in CARES as a reminder to recalculate the recipient's available income for any anticipated change in the recipient's income (e.g. January 1st COLA increase in Social Security income) or other deductions (e.g. annual increase in health insurance premium or the community spouse's rent). Also, set a "745" alert for the date the deduction for non-covered services is estimated to end, i.e. when the full amount approved by DHMH will have been deducted.

11. Fully narrate in CARES. Include the requested amount of non-covered service deduction, the amount approved by DHMH, the type of service, the provider, and the anticipated ending month for the deduction.

12. If the recipient's income or a deduction changes, follow the above procedures for manual calculation of the non-covered service deduction and the available income and for entry into CARES. Suppress the CARES notice and send the manual DHMH 4240 (LTC) Notice of Change in Available Income to recipient, any designated representative, and the LTC facility.

Time Frame for Deducting Non-covered Services from a Recipient's Available Income for the Cost of Care in a LTC Facility or Waiver

- The deduction may not begin before the month that the expense is incurred by the recipient.
- When an applicant indicates they have pre-eligibility medical expenses and acceptable documentation is provided (bills, receipts, contract), the CM submits the OES 001 Request for Non-Covered Services to DHMH if the applicant is found eligible. If a deduction is approved by DHMH, the CM allows the deduction beginning in the first month of eligibility.
- When a recipient requests a deduction for non-covered services during periods of eligibility, the CM must immediately submit the request to DHMH. If DHMH approves a deduction, the CM begins the deduction the month the request and required documentation were submitted, as this is an interim change.
- If there is a contract for regular payments for an item or service, the monthly obligation may be allowed for the period specified in the contract.
- If the non-covered service deduction request approved by DHMH, after allowing other deductions, exceeds the recipient's net countable income for the month, the excess portion of the deduction for non-covered services may be carried forward into additional month(s). If necessary, it may be carried into subsequent 6-month period(s) under consideration. The deductions continue until the monthly amounts deducted for the non-covered service total the amount approved by DHMH for the deduction.
- Unpaid bills for medical services incurred during the 3 months prior to the month of the current application may be considered for a non-covered service deduction if the bills are for services received during the consideration period associated with an earlier application:

- that was denied due to a technical factor;
 - that was denied due to excess resources; or
 - that expired more than six months after the application month.
- If the LTC provider needs to submit a claim more than 12 months after the service date due to agency (DHMH/DHR) delay or a change in the recipient's available income calculated by the agency, the CM sends the DHR/IMA 81 Administrative Error Letter to the provider and a copy to the recipient. The provider submits the DHR/IMA 81 letter with the claim, so that DHMH will not apply the 12-month billing limitation when processing the claim.

Example 1:

Customer files a MA-LTC application January 3, 2010. No information is returned to determine eligibility. On the 30th day the application is denied and notice is sent to all required parties. The application is placed in a preserved status for the remainder of the 6 month consideration period, which ends June 30, 2010. On July 6, 2010, the customer submits a new application for MA-LTC coverage. The customer states that they have unpaid medical bills for 3 months prior to the month of the **new** application. Since these bills were incurred during a **prior expired consideration period**, they cannot be considered for retroactive coverage in connection with the new application. However, the bills must be submitted to DHMH for a determination of the request for deduction of non-covered medical or remedial services.

Example 2:

DHMH approves a deduction of \$450 for dental care received by a recipient. According to the MAFI screen for the current month (based on the CM's entries on UINC, ERN1, and ERN2 screens), the recipient's total available income before deducting these non-covered services is \$1,400. The recipient has no deductions for Medicare premiums or private health insurance. After the deduction for non-covered dental services, the recipient's available income is reduced to \$950. The CM enters \$450 under "UNCVRD MED AMT" on the INST screen for the month the request was submitted. The CM checks the MAFI screen for the current month. The CM makes the necessary corrections if MAFI does not have \$450 for "Non-covered Med Exp" and \$950 for the "Available Income Amt." The CM ensures that the non-covered service is only deducted for the applicable month, not for ongoing months when the available income should return to \$1,400. The CM suppresses the CARES change notice and issues the DHMH 4240 (LTC) change notice and the OES 011 (LTC) and DHMH Non-Covered Service Report to the recipient, representative (if applicable) and the LTC facility, to inform them of the recipient's approved deduction for the dental expense and of the change in the recipient's available income for the cost of care for that one month. The CM fully narrates in CARES.

Example 3:

DHMH approves a deduction of \$9,000 for nursing facility services received by a newly approved recipient during two ineligible months prior to the month of application. The CM uses the DHMH 1159D work sheet to re-calculate the available income. The recipient has monthly income of \$1,400 and deductions for a personal needs allowance of \$74, a spousal maintenance allowance of \$400, and the Medicare Part B premiums of \$96.40 for the first two months of Medicaid eligibility. Therefore, the recipient's available income is \$829.60, before deducting nursing facility non-covered services. This means that, for the 1st and 2nd month of current eligibility, the deduction for non-covered services (the unpaid private-pay nursing facility bills) is \$829.60 and

the available income is \$0. Beginning with the 3rd month of current eligibility, there is no deduction for Medicare premiums. Therefore, the deduction for non-covered services increases to \$926.00 and the available income remains at \$0. The CM determines that it will take 10 months of non-covered services deductions to total the recipient's incurred expenses for nursing facility services.

The CM enters the information in CARES and suppresses all CARES approval notices and issues the DHMH 4240 (LTC), the OES 011 (LTC) and a copy of the DHMH Non-Covered Service Report to the recipient, representative (if applicable) and the LTC facility. These documents inform them of the eligibility decision, the number of months the non-covered services deduction will be in effect, the available income of \$0, and each approved deduction including the monthly deduction for the unpaid nursing facility bill. Two columns are completed on the notice--one for the first two months of eligibility and the second column for the 3rd and ongoing months. The CM fully narrates in CARES.

The CM sets a "745" alert in CARES to recalculate the recipient's available income for the 10th month of eligibility (the last month of deductions for the recipient's nursing facility bills). Also, "745" alerts are established to adjust the deduction amounts and/or available income for any other month that a change to other deductions or income is anticipated. Beginning with the 11th month of eligibility, there will be no deduction for non-covered services. In the 9th month, the CM records the manual calculations on the DHMH 1159D (LTC) worksheet, enters the necessary information on CARES, and issues the manual DHMH 4240 (LTC) change notice with two columns completed for the 10th month and for the 11th and ongoing months. Again the CM sends copies of these forms to the recipient, representative (if applicable) and the LTC facility. The CM narrates in CARES.

Example 4:

A recipient is in the 2nd year of the 20 months necessary to pay off a bill of \$12,000 for nursing facility services received during ineligible months in the retroactive period. The recipient's monthly Social Security income is \$664. Since the recipient has no deductions besides the personal needs allowance of \$74 and the non-covered services, the monthly amount deducted for non-covered services is \$590 and the available income is \$0.

The CM sets a "745" alert to recalculate the available income when the recipient's Social Security check increases on January 1st. When the CM finds out what the COLA will be (in this example the COLA will be 4.1%, so the recipient's income will increase to \$692), they recalculate the deduction for non-covered services as \$618 to keep the available income as \$0. CARES will automatically issue the COLA letter in early December informing the customer that the available income for the cost of care will be \$28. The CM issues the manual DHMH 4240 (LTC) change notice to the recipient, informing them that the deduction for non-covered services is actually \$618 and that the available income for the cost of care is still \$0.

Note: Remember to use current rates for the Medicare premiums and the personal needs allowance.

Questions regarding this issuance should be directed to the DHMH Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231, option 2, extension 1463.

Request for Non-Covered Services Pre/Post-Eligibility Deductions

To: Office of Eligibility Services
Department of Health & Mental Hygiene
201 West Preston Street, Room SS-10
Baltimore, Maryland 21201-2399

Date Received by DHMH

From: _____ Local Department of Social Services

D.O. # _____

Date Request Sent _____

Please **complete** the following information: New Request Resubmission

Case Manager _____ Contact Number _____

Case Name _____ Client ID Number _____

Application Date _____ Current Certification Period _____

Penalty Period (if applicable) From _____ To _____

Retro Period _____

Has an eligibility determination been made for the **retro period**? Yes No

(A determination **must** be made for the retro months requested before submitting this form*)

Retro Eligibility Determination

1st Month _____ Approved Denied

2nd Month _____ Approved Denied

3rd Month _____ Approved Denied

Attach a copy of denial notices for all current and retro months. *This does not apply to Waiver cases.

Type of Expense (Place a check mark next to the appropriate type.)

- Dental Bill
- Hearing Aid Bill
- Vision Bill
- Podiatry Bill
- Pharmacy Bill
- Nursing Home Bill
- Other (Please Specify): _____
- Months being requested: _____

OES 001 (LTC) Revised 08/13 All other versions are obsolete. All information MUST be completed.

m. Prescription Drug Costs and Post-Eligibility for Institutionalized Persons Policy Alert (10-13)

Background

Beginning January 1, 2006, individuals enrolled in Medicare may receive prescription drugs through Medicare Part D (see DHR/FIA Action Transmittal 06-06). For the most part, coverage of prescription drugs is no longer available under Medicaid. Chapter 10 in the Medicaid Manual addresses the deduction of a long-term care recipient's incurred expenses for health insurance premiums or for non-covered medical or remedial services from the recipient's available income for the cost of care. See also Policy Alert 10-12, issued in this Manual Release. Following is information about how Medicaid eligibility case workers are to consider pharmacy charges and Medicare Part D costs in the Medicaid post-eligibility calculations for institutionalized persons.

Medicare Part D Premiums

Dual eligibles for full Medicare and Medicaid benefits are entitled for premium-free Medicare Part D enrollment. However, they may choose to enroll in an enhanced prescription drug plan. Those who enroll in an enhanced plan are responsible for the portion of the premium that is attributable to the enhancement. When an institutionalized Medicaid recipient is enrolled in an enhanced Medicare plan, the portion of the premium that remains the individual's responsibility is an allowable deduction in the post-eligibility calculation for the recipient's contribution to the cost of care.

Co-pays, Deductibles, and Coverage Gap

Dual eligibles that are institutionalized and enrolled in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) are not responsible for the payment of Medicare Part D deductibles or co-pays, nor are they subject to a coverage gap in their Medicare Part D benefits. A Medicare Advantage plan generally provides all health care, including prescription drug coverage. (These rules do not apply to individuals eligible under a 1915(c) home and community-based services waiver). Listed below are the various circumstances that may apply to institutionalized persons who are dual eligibles:

1. Individuals who were dual eligibles and institutionalized as of January 1, 2006 were auto-enrolled into a PDP or, if in a Medicare Advantage Plan that offers a drug plan, into the MA-PD. For institutionalized dual eligibles, the drug plans may not require co-pays or deductibles and may not impose any coverage gap.
2. For individuals who were dual eligibles prior to institutionalization, and who were subject to co-pays, the drug plan may continue to charge those co-pays until the plan is notified of the individual's institutionalized status. If the state identifies the individual as an

institutionalized dual eligible for past months on the state's monthly file sent to Medicare, the plan will reimburse the individual for any co-pays incurred during those months.

3. For individuals who were enrolled in Medicare Part D, but who were not eligible for Medicaid at the time of institutionalization, the plan may continue to charge co-pays, deductibles, and costs incurred during a coverage gap until the plan is notified by the state of the individual's status as an institutionalized dual eligible. If the state identifies the individual as an institutionalized dual eligible for past months on the state's monthly file sent to Medicare, the plan will reimburse the individual for co-pay, deductibles, and costs incurred during a coverage gap for those months.
4. Individuals who qualify for Medicare Part D but are not enrolled in a drug plan, and are not Medicaid eligible at the time of institutionalization, will be fully responsible for their drug costs until their Medicaid eligibility is determined and their Medicare Part D auto-enrollment is processed as an institutionalized person. The plan will be responsible for drug charges as of the effective date of the enrollment. The plan will not charge deductibles or co-pays, or apply a coverage gap to those persons enrolled as institutionalized dual eligibles.

In the first three circumstances above, when Medicaid post-eligibility is calculated for the individual's cost of care contribution, there should be no deductions for prescription co-pays, deductibles, or coverage gaps. This is because, if these costs are incurred, the individual is not ultimately responsible for these charges.

In the last circumstance above, the individual will remain responsible for Medicare Part D covered drugs purchased prior to the effective date of the Part D enrollment. In this circumstance, the cost of these drugs is allowable as a deduction for non-covered services in the Medicaid post-eligibility calculation.

Creditable Coverage under Part

Individuals who were dual eligibles, institutionalized, and receiving Medicare benefits may also have health and prescription benefits through a union or employer retirement plan. Most of these plans providing prescription drug coverage to Medicare beneficiaries must disclose whether their coverage is "creditable prescription drug coverage" through a Disclosure Notice.

Because this coverage is considered creditable, these institutionalized individuals may have decided to continue their prescription coverage through their union or employer retirement plan. In these cases, they are deemed to have creditable coverage under Part D and do not have to join a Medicare Prescription Drug Plan. Therefore, any documented out-of-pocket payments for premiums, co-pays, and deductibles associated with their retirement plan prescription benefits

must be allowable deductions in the Medicaid post-eligibility calculation for the recipient's cost of care contribution. They must, however, provide documentation of the out-of-pocket payments and a copy of the Disclosure of Creditable Coverage Notice from the employer or union retirement plan for the allowable deduction.

Non-Formulary Part D Drugs

PDPs and MA-PDs are required to develop transition plans for institutionalized individuals. Plans may allow for limited coverage of drugs that are not part of the plan's formulary. Each PDP/MA-PD's transition plan may vary. Plans must issue a periodic (at least monthly) statement to each beneficiary explaining all benefits paid and denied. Medicare Part D drugs that are not covered by the plan may not be covered by Medicaid and so, absent other drug coverage, would remain the individual's responsibility. These charges may be allowable deductions in the Medicaid post-eligibility calculation for the cost of care contribution. Medicaid eligibility caseworkers should use the following rules to determine whether to deduct prescription charges as non-covered services:

- When a plan denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the plan's decision on any exception requested. If the drug charge appears on the statement as a denial, and the beneficiary did not request an exception, do not allow the charge as a deduction for non-covered services.
- If the drug charge appears on the statement as a denial, and an exception was requested by the beneficiary but was denied, allow the charge as a deduction for non-covered services.

Institutionalized persons should be advised to maintain their statements and other related documentation needed for consideration of pharmacy expenses as non-covered services. This procedure will help ensure that legitimate costs for drugs not covered by the plan are correctly allowed in post-eligibility. By relying on the plans' statements and exception notices, eligibility case workers do not need to know each plan's formulary, or the non-formulary drugs covered under a transition plan or under the exception process.

Non-Part D Covered Drugs

Certain drugs are not covered under Medicaid Part D. State Medicaid programs have the option of covering these excluded drugs. Maryland Medicaid covers excluded drugs for Medicaid recipients, including institutionalized persons.

Questions regarding this issuance should be directed to the DHMH Division of Eligibility Services at 410-767-1463 or 1-800-492-5231 option 2 and request extension 1463.