TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY POLICY
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201

410-767-1463 or 1-800-492-5231 option 2 and request extension 1463

MANUAL: Medical Assistance **EFFECTIVE DATE: April 1, 2007**

RELEASE NO: MR-142 **ISSUED: March 2007**

APPLICABILITY: Changes in long-term care eligibility notices due to the Deficit Reduction Act of 2005; income or deduction changes and additional letters and forms for long-term care eligibility.

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DHR/FIA 1052-LTC Long Term Care Request for Information to Verify Eligibility	After DHMH 4354
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COMMENTS

Chapter 10

Impact on Eligibility and Available Income or Deduction Changes

This Manual Release clarifies requirements regarding the impact of income changes on eligibility and the recipient's available income for the cost of care. An eligibility decision may not be reversed or revised retrospectively after the decision is issued and providers have rendered services (except for recipient-related reasons such as fraud or the recipient's death or move out-of-state). This is because any adverse action impacting eligibility or the recipient's contribution to the cost of care may only take effect prospectively, after timely and adequate written notice is issued to the recipient, any representative, and the long-term care provider. A notice of adverse action must be issued at least 10 days before the action's effective date, in order to provide the opportunity for appeal. This timeframe may only be shortened to 5 days if the adverse action is being taken due to recipient fraud, not just because the recipient or representative neglected to inform the worker of the change within the required 10 business days.

The eligibility worker should initiate an unscheduled redetermination of the recipient's eligibility if the eligibility caseworker is notified of a regular or lump sum increase in the recipient's income. The policies in Chapter 7 of the Manual are followed to prorate any lump sum income that is received. If the recipient remains eligible, the increased income is reflected in the recipient's recalculated available income for the cost of care. Any increase in a recipient's contribution towards the cost of care may only take effect prospectively after adequate notice of the adverse action.

Similarly, any decrease in a recipient's post-eligibility deductions (e.g., spousal maintenance allowance, noncovered services), which results in an increase in the recipient's available income for the cost of care, may only take effect prospectively, after timely and adequate written notice of this adverse action.

Manual Long-Term Care Notices

The Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, made extensive changes to the Medical Assistance (MA) policies for determining long-term care eligibility, covering individuals in a nursing facility or 1915(c) home and community-based services waiver, and penalizing nursing facility or waiver recipients for disposals of assets for less than fair market value (FMV). As a result, this Manual Release revises certain mandatory manual notices for long-term care eligibility. The eligibility worker must suppress the CARES notice, and send the relevant manual notice to the recipient, any representative, and to the nursing facility or waiver provider.

- **DHMH 4235 (LTC) (Revised 4/07)** Notice of Ineligibility Due to Excess Resources: This notice denies long-term care eligibility due to excess resources. The DES 100 form, which explains the decision, is attached to the notice.

- **DHMH 4235A (LTC)** Notice of Non-Coverage of Nursing Facility Services Due to Disposal of Assets for Less Than Fair Market Value: This information was previously

transmitted on the DHMH 4235. A new manual notice more fully explains the imposition of a penalty period due to disposal of assets for less than fair market value, and the recipient's right to request an undue hardship waiver.

- **DHMH 4235B (LTC)** Notice of Non-Coverage of Nursing Facility Services Due to Substantial Home Equity: This new manual notice implements the DRA provision that nursing facility or waiver services are not covered by Medical Assistance if the recipient has equity interest in the home property exceeding $500,000 (after deducting any encumbrances secured by the home).

- **DHMH 4235C (LTC)** Notice of Non-Coverage of Nursing Facility Services Due to Annuity: This new manual notice implements the new DRA provision that nursing facility services are not covered by Medical Assistance if the recipient or the recipient's spouse does not name the State of Maryland as the remainder beneficiary in the preferred position behind only the recipient's spouse and/or the recipient's minor or disabled child. Also, the notice notifies the recipient, any representative, and the nursing facility or waiver provider if a transaction involving an annuity owned by the recipient or the recipient's spouse results in a penalty period, as a disposal of assets for less than fair market value.

In addition to the revised notices and new forms, other forms and notices related to long-term care has been included in Appendix B.

- **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 of less than 30 days.

- **DES/LTC 811** Transfer/Disposal of Assets Worksheet: This worksheet is used to determine when a penalty applies for a disposal or transfer of assets. It is also used to calculate the amount of the penalty and the length of the penalty period.

- **DES/LTC 812** Home Equity Value Worksheet: This worksheet is to be completed to evaluate the equity value of the home property.

- **DES/LTC 813** Manual MMIS Instructions for Screen 4/Screen 8: This form is sent to the Division of Recipient Eligibility Programs (DREP) when a penalty exists or the home equity value exceeds $500,000. DREP codes MMIS screen 4 or screen 8 (waivers) to prevent payment for LTC or waiver services.

- **DES/LTC 814** Trust/Document Review Request: This form is used to request a review of trust or other document from the Division of Eligibility Services.

- **DES 1000** Certification of Institutionalization & Health Choice Disenrollment **or** Notification of Discharge From Long -Term Care: 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.

- **DHMH 257** Long –Term Care Patient Activity Report: This form is used to notify the LDSS of any action that is required regarding a Medical Assistance payment to the LTCF.

- **DHMH 259** Medical Care Transaction Form: 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 an admission to another.

- **DHMH 3871B** Medical Eligibility Review Form: 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 is submitted to the attending physician.

- **DHMH 4236** (LTC) Notice of Ineligibility Due to Excess Income: This notice is used to advise the applicant/recipient of his/her ineligibility for Medical Assistance due to excess income.

- **DHMH 4239** (LTC) Discharge From Long Term Care: This notice is used when a recipient is discharged from a long-term care facility. It provides the income calculation for the portion of available income to be paid to the LTCF for the month of discharge, and also advises the recipient if Medical Assistance will continue or be terminated.

- **DHMH 4241-A** (SSI-LTC) Notice to Review Medical Assistance Eligibility for SSI-LTC: This notice is sent to SSI recipients to advise the recipient that their Medical Assistance eligibility under SSI needs to be reviewed and they have 10 business days to report any changes in their circumstances.

- **DHMH 4246** (LTC) Notice of Medical Review Decision – Home Property: The Utilization Control Agent (UCA) completes this form. The UCA determines if an individual is able to resume living in his/her home property to determine if the home property is an excludable resource.

- **DHMH 4354** - Resource Evaluation for Married Applicants Institutionalized on or after 9/30/89 Assessment: This form is used to assess the resources of a married applicant and the spouse for: the month of institutionalization, the month of application, to determine the spousal share, and to identify the resources to be transferred to the community spouse.

- **DHR/FIA 1052**-LTC Long Term Care Request for Information to Verify Eligibility: This form is used by the Medical Assistance caseworker to request information necessary to determine medical Assistance eligibility for the applicant or recipient.

- **206-C** Interface Correction Report: This form is sent to the Division of Recipient Eligibility Programs (DREP) to correct changes on MMIS that were unable to be transmitted from CARES.

- **C-TAD** Certification / Turnaround Document: This form is sent to the Division of Recipient Eligibility programs (DREP) to establish MA eligibility on MMIS screen 1 or to change the eligibility data on screen 1.

If you have any questions about these policies or procedures, contact the DHMH Division of Eligibility Policy and MCHP at 410-767-1463 or 1-800-492-5231 (select option 2 and request extension 1463). Questions regarding CARES processing should be directed to Cathy Sturgill at 410-238-1247 or via email at csturgil@dhr.state.md.us.

- 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 or 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.

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

2. The Program has paid, on the recipient's behalf, medical expenses at least equal to the amount of the excess resources.

3. 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, 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.

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 eligibility caseworker 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 eligibility caseworker 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 Chapter 7 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 eligibility caseworker 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 long-term care provider 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 caseworker must give timely notice of adverse action. The MA/LTC assistance unit will trickle to spenddown (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 spend-down of the excess income is met (coverage group L99). Effective the first day of the month after ineligibility due to “spenddown”, the individual is responsible for the full cost of care in the long-term care facility.

If an individual reapplies after the “spenddown” 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.

Change in Deductions

When the eligibility caseworker 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 notified otherwise. The caseworker 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 long-term care provider 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 retrospectively, in order to benefit the recipient.
- An increase in the recipient's contribution towards the cost of care may not take effect retrospectively, just prospectively after timely and adequate notice of this adverse action.

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.

Discharge to the Community

When an institutionalized individual is discharged to the community, the month of discharge is an institutional month. The caseworker 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 Chapter 9) 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 issued December 2001, and Policy Alert 10-09 Supplement issued April 2002.).

- 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.

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

Appendix B
Table of Contents
Long-Term Care (LTC) Forms and Notices

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 601A (LTC)** – Spousal and Family Allowance Worksheet

    - This worksheet is used in determining the monthly maintenance allowance for a spouse (see pages 1000-27 – 1000-30) or the monthly maintenance allowance for a family (see pages 1000-30 – 1000-31).

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 pages 1000-32 – 1000-33).

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 (see pages 1000-11- 1000-16).

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

    - This worksheet is used to determine when a penalty applies for a 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 caseworker 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 $500,000.00, by any amount, the

caseworker must complete and fax the DES/LTC 813 to the Division of Recipient Eligibility Programs (DREP).

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

   - This form is sent to the Division of Recipient Eligibility Programs (DREP) when a penalty exists or the home equity value exceeds $500,000. 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 case manager at the LDSS.

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

    - The caseworker uses this form when it is necessary for the 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 caseworker 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)**

    - This 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 is sent along with the DHMH 3871B form to the UCA. The DHMH 257 and the DHMH-3871B forms are returned to the LTCF and the LTCF 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 an 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 rev.4/95** – 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 the 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.

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

    - This worksheet is used by the eligibility caseworker 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 noncovered services over multiple months. The caseworker 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 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

    - This manual eligibility approval notice is used, and the CARES notice is suppressed, when it is difficult to get CARES to put the correct information on the system-generated notice, such as when more than one column is completed for deductions to available income that change (e.g. deductions for noncovered services).

22. **DHMH 4235 (LTC) Revised 4/07** – Notice of Ineligibility Due to Excess Resources **This form obsoletes form 4237 and all previous editions of form 4235**.

    - This manual notice is used to advise the applicant/recipient (A/R), representative, and long-term care facility of the A/R's ineligibility for MA because the A/R'S resources exceed the allowable resources standard as of a specified date(s). The caseworker 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 and DES 100 attachment 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.

23. **DES 100 (LTC)** Revised April 2007 – Explanation of Ineligibility Due to Excess Resources – attachment to DHMH 4235

    - This is **an attachment to the DHMH 4235** notice. It indicates that the applicant or recipient 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 (see MA Manual pages 800-11 – 800-15).

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 informs the A/R and representative of their right to contact the case worker and request an "undue hardship waiver". 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.

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 limit of $500,000. 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 for 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) Revised 3/07** – 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 MA case worker 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 long-term care facility 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. For example, suppress the CARES notice when more than one column is completed for changes in deductions that affect the monthly available income for the cost of care (e.g. deductions for noncovered services).

30. **DHMH 4241-A Revised 3/07** – 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. It is used to evaluate home property and the residential maintenance allowance.

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 pages 800-18c – 800-18e). It is used to evaluate the consideration of home property and the residential maintenance allowance.

34. **DHMH 4343** – Declaration of Joint Bank Account Ownership Interest

- This form is completed and signed by the applicant/recipient 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 pages 800-47 – 800-57).

35. **DHMH 4354 (Revised 3/07)** – Resource Evaluation for Married Applicants Institutionalized on or after 9/30/89

- 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.

36. **DHR/FIA 1052-LTC (7/02)** – Long Term Care Request for Information to Verify Eligibility **(SAMPLE)**

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

37. **206-C** – Interface Correction Report

- This form is sent to the Division of Recipient Eligibility Programs (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; to document multiple spans for MMIS screen 4 (Long-Term Care Spans), etc.

38. **C-TAD** – Certification / Turnabout Document

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

To: DHMH Medical Care Operations Administration
201 West Preston Street, SS12
Baltimore, Maryland 21201

From: _____
Local Department

_____

Name of Recipient _____ M.A. I.D. _____
First M.I. Last

Name of Facility _____ MMIS Provider ID _____

Requested Begin Pay Date _____ Date of Discharge _____

☐ Recipient Certified under Spenddown.
Excess income remaining on first day of eligibility: $_____

_____

Worker Signature: _____ Date _____

Telephone No. _____

DES 501 (Revised 12/98)

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,

   ____ 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

DES/LTC 811 (4/07)

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 ÷ (4300.00) MA-6 Average Cost of Care =

Length of Computed Penalty - Month(s): _____

Partial Month Uncompensated Value ÷ $141.00 =

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

Penalty Begin Date: _____

Penalty End Date: _____

Case Worker: _____

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 $500,000, 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 $500,000 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 Worker_____ **District Office** _____ **Telephone Number** _____

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

TRUST/DOCUMENT REVIEW REQUEST

To: Division of Eligibility Services
Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

Date: _____

From: _____ Telephone: _____

RE: ☐ Trust Documents

☐ _____

Case Name: _____

Local DSS: _____

Case Worker Name: _____ Telephone: _____

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 _____

_____

Reply: _____

_____

_____

_____

Reviewer _____ Date Returned _____

Telephone _____

PLEASE CHECK REQUESTED ACTION:
[ ] CERTIFICATION OF INSTITUTIONALIZATION & HEALTHCHOICE DISENROLLMENT
[ ] NOTIFICATION OF DISCHARGE FROM LONG-TERM CARE

TO: DHR/LDSS/LHD Case Manager
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 _____

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***.

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:

Ms. Nellie Allen, Supervisor, 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.

LONG – TERM CARE PATIENT ACTIVITY REPORT

For LDSS Use Only
Date Received:
Control No:
Due Date:
Completed:

① **TO:** _____
Local Department of Social Services

_____
Number and Street

_____
City / State / Zip Code

② **FROM:** _____ _____
Name of Facility — MMIS PROVIDER ID

_____
Number and Street

_____ _____ _____
City / State/ Zip Code — Contact Person — Telephone

③ **Type of Activity:** ☐ Begin Payment ☐ Change ☐ Cancel Payment

---

Patient Information

④ **Patient Name:** _____ Sex: ☐ M ☐ F D.O.B.: _____
First M.I. Last — Mo / Day / Yr

⑤ **Medicare Claim No.** _____ ⑥ **Md. Medicaid No.** _____

⑦ **Patient Rep.** _____ _____
First M.I. Last — Telephone No.

Address _____ _____
Number and Street — City / State / Zip Code

Action Requested

⑧ **Begin Payment:** ☐ Initial Placement ☐ Transferred from Another Facility

☐ Other: (Specify) _____ ⑨ **CARES Vendor ID** _____

⑩ **Admission:** _____ ⑪ **Begin Pay:** _____ ⑫ **Private Per Diem Rate:** $ _____
Mo / Day / Yr — Mo / Day / Yr

⑬ **Cancel Payment:** ☐ Death Date of Death: _____
Mo / Day / Yr

☐ Transferred to Another Facility Date of Discharge: _____
Mo / Day / Yr

☐ Returned to Community Date of Discharge: _____
Mo / Day / Yr

☐ Other: (Specify) _____

Discharged To: _____ _____ _____
Facility Name — Number and Street — City / State / Zip Code

⑭ _____ _____
Signature of Facility Administrator — Mo / Day / Yr

Level of Care

⑮ ☐ Initial Determination Eff. Date(s) _____ through _____
Mo / Day / Yr — Mo / Day / Yr

⑯ Check Level of Care: ☐ Chronic/Spec. Hosp. ☐ Intermediate ☐ SNC/ECF

☐ Day Care ☐ Home Health

⑰ ☐ Change in Level of Care to Less than Intermediate: Effective Date _____

⑱ _____ _____ _____
Utilization Control Agent — Authorized Signature — Mo / Day / Yr

Medical Care Transaction Form

① TO: Department of Health & Mental Hygiene
Medical Care Operations Administration
201 West Preston Street, SS-18
Baltimore, Maryland 21201
☐ Nursing Home Section ☐ Chronic Care Section

③ Re: Name: _____

M.A. No. _|_|_|_|_|_|_|_|_|_|_

② FROM: _____
Nursing Home/Chronic Facility

_____
Street Address

_____
City State Zip Code

⑦ * UCA USE ONLY
Level of Care Eff. _____|_____|_____
Mo. Day Yr.
☐ Intermediate ☐ Skilled
☐ Chronic
_____
Utilization Control Agent
_____ _____
Authorized Signature Date

④ Cancel Pay Effective _____|_____|_____:
Mo. Day Yr.
☐ Discharge to Medicare
☐ Expiration of Bed Reservation
☐ No longer Intermediate or Skilled Care
☐ No Longer Chronic Care
☐ Bed hold during Medicare period from _____ through _____

⑤ Begin Pay Effective _____|_____|_____:
Mo. Day Yr.
☐ Medicare Co-pay
☐ * Medicare Ended
☐ * Readmitted after Expiration of Bed Reservation
☐ * Admitted to Chronic Care
☐ * Admitted to Skilled or Intermediate Care

⑥ _____ _____ _____
Signature of Facility Administrator MCOA Date Telephone Number

DHMH 259

Client's Name _____

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:**

a. ☐ Nursing Facility b. ☐ Medical Adult Day Care c. ☐ Older Adults Waiver
d. ☐ Living at Home Waiver e. ☐ PACE

Part B – Demographics

1. **Client Info:** a. Last Name _____ b. First Name _____ c. MI _____
d. Sex: M F (circle) e. SS#: _____ -_____ -_____
f. MA#: _____ g. DOB: _____
(Permanent Address) h. Address 1 _____
i. Address 2 _____
j. City _____ k. State _____ l. Zip _____
m. Phone (_____)_____ - _____

2. **Current location of Individual if in Facility:**
a. Name of Facility _____
b. Address 1 _____
c. Address 2 _____
d. City _____ e. State _____ f. Zip _____

3. **Next of Kin/Representative:**
a. Last Name _____ b. First Name _____ c. MI _____
d. Address 1 _____
e. Address 2 _____
f. City _____ g. State _____ h. Zip _____
i. Phone (_____)_____ - _____

4. **Attending Physician:**
a. Last Name _____ b. First Name _____ c. MI _____
d. Address 1 _____
e. Address 2 _____
f. City _____ g. State _____ h. Zip _____
i. Phone (_____)_____ - _____

Client's Name _____

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?	☐	☐
2. Is there any presenting evidence of mental illness? Please note: Dementia/Alzheimer's is not considered a mental illness.	☐	☐
a. If yes, check all that apply. _____ Schizophrenia _____ Personality disorder _____ Somatoform disorder _____ Panic or severe anxiety disorder _____Mood disorder _____ Paranoia _____ Other psychotic or mental disorder leading to chronic disability		
3. Has the client received inpatient services for mental illness within the past two years	☐	☐
4. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis?	☐	☐
a. If yes, is the mental illness or psychiatric diagnosis controlled with medication?	☐	☐
5. Is the client a danger to self or others?	☐	☐

Part D – 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	# of days service is required/wk. (0-7)
1. Tracheotomy Care: (Please indicate the number of days 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 500 cc or more per day fluid intake via tube	
8. Ventilator Care: Individual would be on a ventilator all or part of the day	
9. Complex respiratory services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous 02 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)	

Client's Name _____

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 communicate	
18. Bowels and/or Bladder Retraining Program: Not including routine toileting schedule	

Part E - Functional Assessment

Review Item	**Answer**	
Cognitive Status (Please answer Yes or No for EACH item.)	**Y**	**N**
1. Orientation to Person: Client is able to state his/her name	☐	☐
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.	☐	☐
3. Telephone Utilization: able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
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.	☐	☐
5. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐
6. Mini-Mental Results: Was the entire Folstein Mini-Mental test completed? (If all questions are not answered, answer NO.) 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: ☐ Visual Loss ☐ Hearing Loss ☐ Loss of Motor Ability ☐ Language Barrier ☐ Refused ☐ Less than 8th Grade Education	
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.	☐	☐
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.	☐	☐
9. Aggressive/abusive behavior (several times a week): Physical and verbal attacks on others including but not limited to threatening others, hitting, shoving, scratching, punching, pushing, biting, pulling hair or destroying property.	☐	☐
10. Disruptive/socially inappropriate behavior (several times a week): Interferes with activities of others or own activities through 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.	☐	☐
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.	☐	☐

Client's 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.	☐	☐
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.	☐	☐
14. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier.	☐	☐

Review Item	
FUNCTIONAL STATUS: Score as Follows	
0 = Independent: No assistance or oversight required 1 = Supervision: 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 showering): 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, pullovers.	
19. Eating: The process of putting foods and fluids into the digestive system (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 of 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 F - Certification

1. a. Signature of Person Completing Form: _____

b. Date: _____

c. Printed Name: _____

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

2. a. Signature of Health Care Professional: _____

b. Date: _____

c. Printed Name: _____

MARYLAND MEDICAL ASSISTANCE PROGRAM
NOTICE OF INELIGIBILITY DUE TO EXCESS RESOURCES

Date: _____

Re:_____ ☐ Current_____
Name

_____ ☐ Retro_____
CID #

Dear_____,

This is to notify you that, based on the application/redetermination filed on _____, you are determined **ineligible** for Medical Assistance. You are not eligible because your resources exceed the maximum allowable amount of **$2,500.00** as of _____. The amount of excess resources is $_____.

You are:

- ❑ **denied** Medical Assistance eligibility for _____ based on the application filed on _____.
- ❑ **terminated** from Medical Assistance eligibility effective: _____.

The following resources were considered:

Type of Resource	**Amount**
_____	$_____
_____	_____
_____	_____
_____	_____
_____	_____

The total amount of your countable resources is: _____

You may reapply when your resources no longer exceed the maximum allowable amount as of the first day of the month. Your resources may be used for necessary personal or health care needs (e.g., burial plan, nursing facility or other medical bills, home repairs), but may not be given away or otherwise disposed for less than fair market value. When you reapply, you will be required to verify how the resources were used. Keep all receipts for this purpose.

This decision is based on COMAR 10.09.24.08. 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 caseworker at the number below.

_____
Case Worker

_____
Department of Social Services

_____
Telephone Number

Attachment: DES 100
cc: Representative _____
Long Term Care Facility _____

DHMH 4235 (LTC) Revised 4/07

HOW TO HAVE 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
- 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 bona fide 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

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 _____

Case Worker

at _____.

Telephone Number

cc: Authorized Representative _____

Long-Term Care Facility _____

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 caseworker below to find out about requesting an "undue hardship waiver."

This decision is based on the requirements set forth in the Deficit Reduction Act of 2005 (Public Law 109-171) Section 6011 and Section 6016, 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 caseworker at the number below.

_____
Case Worker

_____
Department of Social Services

_____
Telephone Number

cc: Representative _____

Long Term Care Facility _____

HOW TO HAVE 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
- 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 bona fide 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 **$500,000** 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 the requirements set forth in the Deficit Reduction Act of 2005 (Public Law 109-171) Section 6014, 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 caseworker at the number below.

_____
Caseworker

_____
Department of Social Services

_____
Telephone Number

cc: Representative _____

Long Term Care Facility _____

HOW TO HAVE 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
- 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 <u>until</u> 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 <u>and</u> the annuity <u>either</u> does not meet certain requirements of the Internal Revenue Code to be excluded from consideration <u>or</u> does not meet <u>all</u> 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."

Note: You are required to inform the caseworker named below of any change in your income or resources within 10 days of the change. This includes notifying your caseworker 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 caseworker at the number below.

_____
Caseworker

_____
Department of Social Services

_____
Telephone Number

cc: Representative _____

Long Term Care Facility _____

DHMH 4235C (LTC)
April 2007

HOW TO HAVE 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
- 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 INELIGIBILITY DUE TO EXCESS INCOME

Date:_____

Re: _____ CID# _____
Name

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 3/07)

HOW TO HAVE 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
- 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 bona fide 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)

HOW TO HAVE 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
- 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 bona fide 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 TO REVIEW MEDICAL ASSISTANCE ELIGIBILITY FOR SSI LONG TERM CARE

Date _____

Re: _____
Name

_____
CID #

Dear _____:

This is to notify you that it is time to review Medical Assistance eligibility for the above named person. The file was last reviewed on, _____.

All Medical Assistance recipients are required to report to their case worker 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.

Please contact your caseworker at the number listed below for a brief review of your current eligibility status.

Sincerely,

_____
Caseworker

_____
Department of Social Services

_____
Telephone Number

cc: Representative/Recipient
Long Term Care Facility

DHMH 4241-A (SSI/ LTC) *(Revised 3/07)*

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)

HOW TO HAVE 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
- 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 bona fide 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.

B.

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. ½ of line A	$
C. Enter the lesser of line B or maximum spousal share (MA-8)	$

*Legend
J = Joint
SP = Spouse
AP = Applicant

Case Name _____

CID Number _____

II. <u>Current Resources</u> **Month of Application _____**

Owner*	Type	Verification	Full Value	Unavailable/ Excluded Value	Countable Value
			$	$	$
			A. Total Assessed Resources (as of Month of Application)		$

*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	
☐	☐	☐	**Signed, dated application** (DHR/FIA CARES 9709)
☐	☐	☐	**Face-to-Face Interview**
☐	☐	☐	**Consent to Release Information** – nursing home to DSS worker (DES 2002 form)
☐	☐	☐	**Consent to Release Information** – DSS worker to nursing home (DES 2005 form)
☐	☐	☐	**Voter Registration Form 784**
☐	☐	☐	**DHMH 257** (Medical certification initiated by Nursing Home)

II. DEMOGRAPHIC DATA

N/A	OK	NEED	
☐	☐	☐	**Proof of Social Security Number** (SSA 1099, SSA letter, or other SSA verification)
☐	☐	☐	**Medicare card**
☐	☐	☐	**Alien status** (alien registration card passport)
☐	☐	☐	**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)
☐	☐	☐	**Marriage Certificate/Divorce decrees**

III. MONTHLY INCOME

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

(PLEASE GO TO PAGE 2)

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, etc; (for the month of application and any additional statements specified)

N/A	OK	NEED	NAME	ACCT.#	COMMENTS (which months, etc.)
☐	☐	☐			
☐	☐	☐			
☐	☐	☐			
☐	☐	☐			
☐	☐	☐			
☐	☐	☐			

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

N/A	OK	NEED	TYPE	ACCT.#	COMMENTS
☐	☐	☐			
☐	☐	☐			

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	Company Name	Policy Number
☐	☐	☐		
☐	☐	☐		

Home Property/~~Other~~ Property

N/A OK NEED Primary/other: _____

☐ ☐ ☐ ☐ Mortgage Agreement ☐ DHMH 4255 Physician's Report ☐ Deed(s)

☐ ☐ ☐ ☐ State Property Tax Assessment ☐ DHMH 4255 Statement of Intent

Funeral Arrangements

N/A OK NEED

☐ ☐ ☐ Bank Account Statements/Irrevocable and Itemized Contracts: _____

_____

V. ALLOWANCES

Health Insurance

N/A OK NEED

☐ ☐ ☐ Other Health Insurance (ID card – front and back, actual premium bill or cancelled check)

Residential Allowance

N/A OK NEED

☐ ☐ ☐ DHMH 4245 Physician's Report

Spousal Allowance

☐ ☐ ☐ 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

206 – C I N T E R F A C E C O R R E C T I O N R E P O R T

SECTION: **Skilled** **Chronic** **Intermediate**

RECIPIENT ID: **NAME:**

----------LONG TERM CARE SPANS ----------

BEGIN / EFFECTIVE DATE	CANCEL/DISCHARGE DATE	TRANSACTION TYPE	MMIS PROV-ID	TERM CD	OASDI	RESOURCE
1.						
2.						
3.						
4.						
5.						
6.						

CASE MANAGER
NAME : _____
DIST. OFF : _ _____
PHONE : _____

NOTE TYPE - N IS BEGIN FULL MA, A IS MEDICARE CO-PAY
OTHERWISE, LEAVE TYPE BLANK

PROVIDER # - 9 DIGIT MMIS FACILITY #
TERM CODE – EITHER 8 (DEATH) OR 4 (OTHER)
OASDI - Gross Social Security Amount
Resources - Available Income

_____ / / _____

Signature **Date**

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION / TURNAROUND DOCUMENT

ACTION CODE:

ADD INDIVIDUAL		TYPE OF CHANGE: REISSUE TAD		CANCEL		RECERTIFY	
CHANGE	X	REISSUE CARD		REOPEN		COVERAGE	

ORIG-ID:

***CURR-ID:**

***NAME**

***HOH NAME:**

***ADDR:**

ADDR:

***CITY:**

***STATE:** *MD* ***ZIP:**

PHONE:

***RES-CNTY:**

CITZ-IDEN: **DIST-OFF:**

***REQUIRED FOR ADD**

***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 QMB

ELIGIBILITY SPAN

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

REASON FOR DOCUMENT: **MARYLAND KIDS COUNT OUTSIDE OF CARES**

TRANSACTION NOT PASSED TO MMIS-II X

MESSAGE: *SEE ATTACHED CARES PRINTS.*

SIGNATURE: _____ **PHONE** _____ **DATE:** _____