Reference Guide for Providers

The DHMH 257 Process

Maryland Department of Health & Mental Hygiene

Office of Eligibility Services

Office of Systems, Operations, & Pharmacy

Office of Health Services

5ŜŏŜYōŜ 2012

REFERENCE GUIDE FOR PROVIDERS: THE DHMH 257 PROCESS

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DHMH 257 QUESTIONS & ANSWERS

257 QUESTIONS AND ANSWERS

257 Q&A topics:

1. **How do I complete the 257 to reflect a Medicare coinsurance time period?**

The most prevalent 257 errors occur when submitting Medicare coinsurance 257 documents. Please see the instructions below to assure that your documents are completed correctly.

Community Coverage/Less than 30-day or up to 80-day Medicare stay

A. Begin Payment:
   - Item #2: Medicare A Co-payment: must include both a begin pay date and an end pay date.

B. Cancel Payment:
   - You must report the discharge status of this patient.
   - If the patient has not been discharged from your facility, the DHMH 257 will be returned for completion of LTC application and conversion of eligibility coverage to LTC.

LTC Coverage/Medicare Coinsurance to Full MA

A. Begin Payment:
   - Item #2: Medicare A Co-Payment: Must include both a begin pay date and an end pay date.
   - Item #1: Full MA coverage: Must include a begin pay date.

Note:
- ***To begin full MA, a DHMH 257 must be signed by UCA for level of care certification.***
- ***In Section A. Begin Payment, any "end pay date" entered must be equal to the discharge date reported in Section B or must be equal to the full MA begin pay date reported in Section A.***
- ***Section B. Cancel Pay should not be completed if your patient still resides in your facility.***

Less Than 30-Day MA Stay

A. Begin Payment:
   - Item #1: Complete for full MA coverage.

B. Cancel Payment:
   - You must report the discharge status of this patient.
   - If the patient has not been discharged from your facility, the DHMH 257 will be returned for completion of the LTC Application and conversion of eligibility coverage to LTC.

Note: The 257 form must be certified by the UCA.

2. When is an IMA-81 letter issued for a 257 with older dates of service?

The Medical Assistance Problem Resolution Unit (MAPR/LTCPR) will only issue an IMA-81 letter if after review of the case it has been determined that there has been agency delay in processing a case. If a 257 is received for older dates of service, but is signed by the UCA with a current date, staff will research the following:

- Was there a retroactive eligibility decision date that places the dates of service in statute at receipt?
- Is there any indication in CARES that the 257 had previously been presented to a caseworker, was processed, but does not appear in MMIS?
    - If the 257 information is in CARES, or if there is history of narration indicating that the facility presented a 257, MAPR staff will correct MMIS to correlate with the CARES system.
    - An IMA-81 retro letter will only be issued if the inquiry to correct MMIS has been received in a timely manner.
    - If the request to correct spans in MMIS has been received over a year after the information was updated in CARES, the IMA 81 letter will not be issued.

3. How do I complete transfers to another facility?

You must report your cancel pay/discharge date in Section B, making sure that your discharge date reflects the date of actual discharge (which is usually the admit date into the new facility). DHR/DHMH staff will end your LTC spans the day prior to the date of discharge reported. The date of admit to the new facility is also their first billable day of service. It is not appropriate for the discharging facility to submit claims for payment of the discharge date.

4. How do we complete a 257 for a patient who resides in our facility but has elected the Hospice benefit?

It is not necessary for the nursing home to submit a discharge 257 in this situation. The Program has put internal procedures in place that will utilize the hospice election document to end nursing home spans the day before the hospice election begin date (or hospice admit).

What do I do if a patient who has elected the hospice benefit decides to revoke their hospice benefit?

At that time the nursing facility will need to complete a new 257 and obtain a UCA certification sign-off. Complete the 257 as follows:

A. Begin Payment:
    - Item #4: Revocation of Hospice care and return to NF care - fill in effective date.

<u>Note</u>: Effective date should be the hospice actual discharge date and the nursing home actual admit date. These dates should be equal.

5. What other instances will cause my 257 to be returned?

- No level of care obtained from UCA to certify necessity to begin full MA
- Incorrect level of care obtained
- Chronic facility with level of care marked as nursing facility

6. Is it necessary to submit multiple 257s when the patient changes levels; either from Medicare coinsurance to full MA, or to full MA back to full Medicare?

For Medicare coinsurance to full MA 257s, please see instructions in question #1. Once full MA LTC spans are established in MMIS for your facility through 999999, it is not necessary for you to report via DHMH 257 when the patient reverts back to full Medicare, and then to full MA again. When billing, make sure your facility does not submit claims for those full Medicare dates of service. We will only need to see another 257 when the patient discharges from your facility; due to death, out to the community, or transferred to another facility.

7. When should I complete a 257 to report a cancel pay in Section B?

- If your patient leaves your facility:
  - Discharge to community
  - Transfer to another facility

- Date of death

Note: ***It is imperative that cancel pay 257s are submitted by LTC facilities. Lack of cancel pay documents cause denial of community services and disruption to continuity of care for the patient.***

8. What happens to the 257 if the case has been denied for reasons other than lack of information?

The 257 will be returned to the sender along with the 726.

Reasons for return:

- Your case has been forwarded to another jurisdiction
- Because we have not yet received an application for Medical Assistance/Long Term Care for the patient
- It has not been authorized by the Utilization Control Agent
- The client has been determined ineligible for Medical Assistance/Long Term Care
- Other reason as identified

ADDENDUM - BEDHOLD/HOSPITAL LEAVE

Note: ***As of July 1, 2012, hospital leave is a non-covered service in the Maryland Medical Assistance Program. Please refer to the Programs' Nursing Home Transmittal No. 241 issued 7/12/2012 regarding this policy change and follow the appropriate instructions below.***

9. How do I complete the 257 to reflect a full Medicare hospital leave/bed reservation time period?

For *on or after* July 1, 2012

As of 7/1/12, there is no need to notify the Program of a hospital admission for a patient on straight MA, and the Program no longer requires a cancel pay after 15 days. Do not submit a discharge 257 unless the recipient is deceased, discharged to community, or is transferred to another facility from the hospital.

For hospital leave/bed reservations *prior to* July 1, 2012

A. Begin Payment:
   - Item #3: Bed reservations for full Medicare coverage period. Fill in the begin pay date field and the end pay date field.

B. Cancel Payment:
   - If your patient remains in the hospital and exceeds the 15 day bed reservation maximum, check "discharge to", fill in the discharge date field, and under discharge to another provider, write "hospital leave exceeded 15 day maximum."
   - If the patient returns to the facility into a Medicare co-payment time period, complete the 257 as instructed in question #1.
   - If the patient returns to the facility into a full MA time period, complete a new DHMH 257 and forward to UCA for certification signatures.

POLICY

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 241
July 12, 2012

TO: Nursing Home Administrators

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

SUBJECT: Reimbursement of Hospital Bedhold

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Effective July 1, 2012, the Maryland Medicaid Program will no longer reimburse nursing facilities for hospital bedhold – payments to reserve the bed for recipients admitted to acute care hospitals who intend to return to the nursing facility. This change was approved by the General Assembly as a cost containment measure; however, the end of this reimbursement changes nothing about either residents' rights to be re-admitted to the facility or residents' rights with regard to involuntary discharge from nursing facilities.[1] The Program expects that most recipients in nursing facilities will return to their same bed and same room when discharged from the hospital, and that discontinuation of paid bedhold will not otherwise materially change current practice with regard to hospital transfers and re-admissions.

This transmittal provides guidance on notice and readmission requirements, claims submission for months during which a Medicaid recipient is hospitalized, determination of continuing medical eligibility, and other matters relating to the discontinuation of paid hospital leave for Medicaid recipients in nursing facilities.

Notice and Readmission Requirements

The three most important things to know with regard to the end of Medicaid-reimbursed hospital leave are:

[1] The provisions of COMAR 10.07.09.12D and E still apply to the return of a Medicaid recipient to the nursing facility after a hospitalization. Regulation .12D emphasizes the resident's right to be readmitted to the facility even if his or her absence exceeds the current 15-day paid bedhold, and .12E includes as an involuntary discharge the refusal of a facility to take back a resident (including one with pending Medicaid eligibility) after a hospital stay. Consequently, the same 30-day written notice is required.

- Nursing facilities are still obligated to have and to provide to all residents a written bedhold policy.
- Medicaid recipients have the right to return to the first available gender-appropriate bed in a semi-private room at the facility. (In most instances, this will be to their current room and bed.)
- Notifying a transferring resident that he or she is being discharged permanently or refusing to re-admit a resident after a hospital stay both constitute an involuntary discharge. Both require a thirty-day written notice, and appeal rights apply.

In accordance with federal Medicaid regulations [42 CFR 483.12(b)] and parallel State regulations codified at COMAR 10.07.09 as the Residents' Bill of Rights, nursing facilities must notify residents and representatives/family members in writing of their policies regarding bedhold before a transfer takes place, and provide written notice again at the time of a transfer. State regulations at COMAR 10.07.09.12C(1) explicitly require nursing facilities to provide residents a written bedhold policy at the time of admission — usually done via provisions contained in the standard admission contract issued by the Office of Health Care Quality (OHCQ).[2] Because the end of paid bed reservation marks a change in the terms of Medicaid policy regarding payment for hospital leave, facilities must notify all residents of this change, regardless of payer status.

As stated above, the discontinuation of hospital bedhold as a Medicaid-covered service does not relieve nursing facilities of their responsibility to readmit hospitalized residents upon discharge to the first available bed in a semi-private room if the resident is Medicaid eligible[3] and still requires the services provided by the facility. Hospital discharge planners will expect a recipient to return to the same facility, and even a resident who has received a notice of involuntary discharge before being hospitalized will likely return, to await the end of the 30-day notice period or the resolution of an appeals hearing.

Smaller or highly-occupied nursing facilities may not be able to admit a recipient to the same bed and room, but are still obligated to re-admit the person to the next available gender-appropriate bed. This may mean at least temporarily admitting to a bed in an area usually reserved for Medicare skilled short-stay patients, but since nursing facility beds in Maryland are overwhelmingly dually-certified for both Medicaid and Medicare, this should not present a problem. Representing to discharging hospitals that a nursing facility "does not have an available Medicaid bed," or that the facility is near or at 100% occupancy, will require documentation to both OHCQ and the Program if a facility refuses a re-admission on these grounds.

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[2] The standard admission contract references paid hospital leave, so the contract will be revised and re-posted; however, the contract already states, at section 4.E.(2), that the Medicaid Program may "increase or decrease" paid bedhold days, and concludes with the statement that changes resulting from federal or State law do not invalidate the rest of the contract.

[3] For purposes of eligibility for re-admission, a resident whose Medicaid eligibility is pending and expected to be approved is considered to be Medicaid eligible. See COMAR 10.07.09.12E(2).

Claim Submission: Actual Discharge to Hospital versus Discharge from Medicaid Payment

When a recipient is hospitalized in a given month, the period before hospitalization and following readmission must be submitted on separate claims. For example, if a recipient is admitted to the hospital on the 14th of the month and readmitted to the facility on the 18th, two claims must be submitted for that month, one for the first through the 13th and the second for the 18th through the end of the month. This is the only exception to the rule of submitting one claim per month for Medicaid reimbursement.

During the period of time the resident is out of the facility, he or she is not included in the midnight census, and has therefore been physically discharged; however, please do not submit a discharge DHMH 257 unless the recipient is transferred to another facility after the hospital stay. Submitting a discharge form 257 and/or a bill type 214 (Skilled Nursing Facility Inpatient Last Claim) will end the authorized Medicaid payment to your facility for the recipient's care, and require you to repeat the entire Medicaid medical and financial eligibility process in order to re-establish payment of claims.

Reimbursement for Leave of Absence (revenue code 0183) (also known as therapeutic leave) is unaffected by this change, and will continue to be covered. Please note, however, that coverage of Leave of Absence is limited to visits with friends or relatives, or participation in State-approved therapeutic or rehabilitative programs. Facilities may not use this benefit for absence due to acute hospitalization; using code 0183 during a recipient's hospitalization may result in conflicting claims (hospital and nursing facility) being presented and in the nursing facility claim being denied.

Resident Resource Allocation

Medicaid claims processing has been programmed to access a resident's resource first, applying that amount to the days of care provided by the facility. Since facilities will no longer bill for the days a recipient spends in the hospital, the nursing home will submit a separate claim for each period of consecutive days that the recipient is in the nursing facility, and the resource would be deducted from claims submitted for that month until the resource is exhausted. If the resident is in the hospital at the beginning of the month, there may be a single claim for that month.

Medical Eligibility Determinations

Although the Medicaid Program will no longer pay nursing facilities to hold a resident's bed during an acute hospitalization, the provisions of the Program's Nursing Home Transmittal No. 208 still apply. This transmittal provides that, for readmissions from hospital stays of 15 days or less, it is not necessary to contact the Program's Utilization Control Agent for a medical eligibility determination, unless the recipient has been readmitted under Medicare SNF benefits, and a return to Medicaid NF is desired. In that case, the Utilization Control Agent will need to confirm a recipient's continued need for nursing facility level of care before the facility again bills for long term care Medicaid benefits.

The Medicaid Program is confident that nursing facility providers will work cooperatively with residents' families and other legal representatives to minimize disruption resulting from hospitalizations. Any questions regarding this transmittal may be directed to the Nursing Home Program at (410) 767-1736. For further information about billing, please call the Problem Resolution Hotline at (410) 767-5457. Questions regarding resident's rights in the context of notification, transfer, and readmission should be directed to the Office of Health Care Quality at (410) 402-8201.

cc: Nursing Home Liaison Committee
Acute General and Specialty Hospitals
Utilization Control Agent
Maryland Long Term Care Ombudsman Program
Office of Health Care Quality

Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**FIA ACTION TRANSMITTAL**
Control Number: # 10-17 **Obsoletes AT # 09-34**	**Effective Date: Upon Receipt** **Issuance Date: January 5, 2010**

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS AND ELIGIBILITY STAFF

FROM: KEVIN M. MCGUIRE, EXECUTIVE DIRECTOR, FIA
DEBBIE RUPPERT, EXECUTIVE DIRECTOR, DHMH/OES

RE: LONG-TERM CARE FACILITY STAY FOR LESS THAN 30-DAYS OR MEDICARE CO-PAY DAYS

PROGRAM AFFECTED: MEDICAL ASSISTANCE

ORIGINATING OFFICES: OFFICE OF PROGRAMS AND DHMH'S OFFICE OF ELIGIBILITY SERVICES (OES)

SUMMARY: In April 2009, action transmittal 09-34 informed local department staff of the new procedures for processing Long-Term Care Patient Activity Reports (DHMH 257) and submission of the DES 501 for recipients of Community Medical Assistance who were admitted to a Long Term Care Facility (LTCF) for less than 30 days or for Medicare Co-Pay days in a LTCF for recipients of Community Medical Assistance who are not receiving Waiver Services. This process would remain in effect until the opening of the Bureau of Long Term Care Eligibility (BLTCE). **Effective October 16, 2009, this process is now conducted at the BLTCE**. This transmittal obsoletes action transmittal 09-34 and updates procedures for processing DHMH 257 forms for customers **on Medicare Co-Pay** days. **There are no procedural changes for local department staff.**

ACTION REQUIRED:

I. Local Department Procedures

A. Local departments were instructed to process all DHMH 257 forms received in the local departments on or before **April 14, 2009** for recipients of Community Medical Assistance who are not receiving Waiver Services.

B. Any DHMH 257 form received from the Utilization Control Agent (UCA) with a date of April 15, 2009 or later in the **date** field in section "**Action Requested**", must be forwarded to:

LTC Processor
P.O. Box 13066
Baltimore, Maryland 21203

C. The Division of Eligibility Waiver Services (DEWS) staff will continue to process 257 forms for customers receiving Waiver Services.

II. LTC Provider Procedures for a LTCF Stay Less Than 30 Days

A. LTC providers must submit DHMH 257 forms to the LTC Processor for recipients of Community Medical Assistance not receiving Waiver Services who are admitted to a LTCF for less than 30 days.

B. The LTC provider must:

- Complete the DHMH 257 form clearly indicating "Community MA"
- **Not** enter the local department of social services address on the DHMH 257 form in the local department address field but must enter the following address:

  LTC Processor
  P.O. Box 13066
  Baltimore, Maryland 21203

- Submit the DHMH 257 form to the UCA for Level of Care.

  Note: For a Utilization Control Agent (UCA) stay of less than 30 days, providers cannot submit the DHMH 257 form **without** a discharge date.

III. LTC Provider Procedures for Medicare Co-Pay Days

A. The LTC Provider:

1. Completes the DHMH 257 form clearly indicating "Community MA";
2. Specifies **Medicare Coinsurance** in the Action Requested section in the **Begin Payment/Other** field;
3. Indicates the **actual Medicare co-pay end date** in the Action Requested section, in the **Cancel Payment/Other** field; and
4. Submits the DHMH 257 form directly to the LTC Processor and not to the UCA, since Medicare has already determined Level of Care.

   Note: Providers can no longer enter an anticipated date of discharge; they must wait until a community medical assistance recipient with Medicare is discharged from the LTCF before they submit the DHMH 257 form.

B. Providers can submit the DHMH 257 form by mail or e-mail

1. When mailing the DHMH 257 form, send to:

   LTC Processor
   P.O. Box 13066
   Baltimore, Maryland 21203

2. Providers e-mailing the DHMH 257 form must do the following:

   - Establish a LTC Provider Password by completing and returning the attached LTC Provider Password Identification form (Attachment A) to the following address:

     LTC Processor
     P.O. Box 13066
     Baltimore, Maryland 21203

   - Submit the DHMH 257 form to the following e-mail address:
     - LTC25750Process@dhr.state.md.us

INQUIRIES: Direct MA policy questions to DHMH's Division of Eligibility Policy at 410-767-1463, or 1-800-492-5231 (select option 2 and request extension 1463); operational questions to the Bureau of Long-Term Care Eligibility at (410) 455-7517.

cc: DHMH Management Staff
FIA Management Staff
Constituent Services
DHR Executive Staff
DHR Help Desk

Attachment A

LTC PROVIDER PASSWORD IDENTIFICATION FORM

DATE: _____

PROVIDER ID: _____

ADDRESS:

_____

_____

_____

_____

TELEPHONE NUMBER: _____

PASSWORD: _____

SIGNATURE: _____

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 234
Hospital Transmittal No. 213
Medical Day Care Transmittal No. 78
July 1, 2011

TO: Nursing Home Administrators
Chronic Hospital Administrators
Special Pediatric Hospital Administrators
Medical Adult Day Care Center Directors

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

SUBJECT: DHMH 257 – Revised Form and Process

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The Maryland Medical Assistance Program has revised the Long Term Care Patient Activity Report (DHMH 257-Rev. 4/2011). The form has been revised to more clearly reflect the various uses of the form (e.g., Medicare co-insurance, temporary stays, etc.). Please note that when initiating payment for Medicare coinsurance, reimbursement of bed reservation days under a Medicare stay, or a temporary stay, both begin and end dates must be entered.

Please note that, for nursing facility residents already community Medicaid-eligible, initially admitted to a nursing facility on Medicare co-pay days and now applying for full payment under Medicaid long term care benefits, the DHMH 257 form should be submitted once only: to indicate the beginning and end of the Medicare co-pay period, and the date on which full Medicaid long term care benefits are requested to begin.

The revised DHMH 257 form and instructions for completion are attached for your reference. Providers may begin using the revised form effective immediately. Through July 31, 2011, the Program will accept either the earlier version or the revised version. For transactions submitted on or after August 1, 2011, however, only the revised forms will be accepted.

Please address and submit completed DHMH 257 forms as follows:

Nursing facilities and chronic hospitals:

Enter one of the following addresses under "TO: Receiving Agency":

1. Local Department of Social Services or the Bureau of Long Term Care Eligibility, unless otherwise indicated in #2 or 3 below

2. Waiver participants with an anticipated stay of less than 30 days under Medicaid or up to 80 days Medicare coinsurance - Division of Eligibility Waiver Services, 6 St. Paul Street, Suite 400, Baltimore, MD 21202

3. Non-Waiver participants with an anticipated stay of fewer than 30 days under Medicaid or up to 80 days Medicare coinsurance - LTC Processor, P.O. Box 13066, Baltimore, MD 21203

For cases where Utilization Control Agent certification of medical eligibility is required, please submit all copies to Delmarva Foundation for Medical Care, 4920 Centreville Road, Easton, MD 21601. The Agent will certify the appropriate level of care, return the "Provider" copy to the provider, retain the "UCA" copy, and forward the "Agency" copy to the appropriate agency for confirming financial eligibility, as indicated above.

If Agent certification is not required, please submit the "Agency" and "UCA" copies directly to appropriate eligibility agency, and retain the "Provider" copy.

Medical day care centers

Enter the following address under "TO: Receiving Agency": DHMH, Division of Community Long Term Care, 201 W. Preston Street, Room 133, Baltimore, MD 21201. All copies of the DHMH 257 shall be submitted to this address. Following processing, the "Provider" copy will be returned to the provider.

Nursing facilities and chronic hospitals that have questions regarding completion of the DHMH 257 should contact the Division of Long Term Care Services at 410-767-1736. Medical adult day care centers that have questions should direct them to the Division of Community Long Term Care at 410-767-1444.

Attachments

cc: Nursing Home Liaison Committee
Bureau of Long Term Care Eligibility
Local Departments of Social Services
Maryland Association of Adult Day Services

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

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

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

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

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

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

Nursing Facility (NF) or Chronic/Special Hospital (CSH) Activities		UCA
Initiate NF or CSH benefits, MA only	Line A1	X
Initiate NF or CSH benefits, start Medicare co-payment, convert to full MA	Lines A1 and A2 (both begin and end dates for Medicare co-insurance must be entered)	X
Initiate NF or CSH benefits, Medicare co-payment only (no full MA)	Line A2 (both begin and end dates for Medicare co-insurance must be entered)	
Initiate NF benefits, payment for bed reservations during initial full Medicare coverage	Line A3 (both begin and end dates for bed reservation payment must be entered)	X
Community MA recipient or Waiver participant for temporary NF or CSH placement less than 30 days Medicaid or up to 80 days coinsurance	Check "Community" or "Waiver" box at top right, Lines A1 and B1 (check "Community" as discharge destination).	X
Hospice recipient revoking Hospice care and returning to NF care	Line A4	X
Discharge from NF or CSH to another NF or CSH	Line B1, check "Another Provider" box, write name of receiving NF or CSH	
Discharge from NF or CSH to home, or to destination other than NF or CSH if not returning to facility	Line B1, check "Community"	
Died while in NF, CSH, or in acute hospital while on bedhold from NF	Line B2	

Medical Day Care (MDC) Center Activities	
Initiate MDC benefits	Line A1, enter Begin Pay date and check "Initial"
Continue MDC benefits	Line A1, check "Continued" and enter Begin Pay date
Discharge	Line B1, check "Discharge" box and enter date of discharge
Discharged-admitted to NF for long term care	Line B1, check "Another Provider" box, write name of nursing facility if known (otherwise enter "NF")
Died while a participant	Line B2, enter date of death

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

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

LONG TERM CARE ACTIVITY REPORT

□ Community MA □ Waiver

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

TO: Receiving Agency________________________

Address ________________________

____

FROM: Name of Provider ________________________

Address________________________

____

Medicaid Provider ID________________ CARES Vendor ID________________

Contact Name________________________ Telephone________________

PROVIDER TYPE □ Nursing Facility □ Chronic/Special Hospital □ Medical Day Care Center □ Other____________

RECIPIENT INFORMATION

Name ________________________ Sex □ M □ F Date of Birth ____________

Medicare Claim No. ________________ MD Medicaid No. ________________

Representative________________________ Phone________________

Address________________________

ACTION REQUESTED - COMPLETE EITHER BOX A OR B AS APPROPRIATE, AND PRINT AND SIGN NAME/DATE

* *

A. Begin Payment Admission Date____________ Private pay rate__________

Check all that apply - both beginning and ending pay dates must be completed when requested. NOTE: Actions marked with "*" require Utilization Control Agent/DHMH certification

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

* *

B. Cancel Payment

1. □ Discharged to □ Another Provider □ Community □ Hospice Date of Discharge ______________
   If discharged to another provider, name of provider ________________________
2. □ Death – Date of Death __________________

* *

Administrator/Designee Signature________________________ Date________________

Print Name of Administrator/Designee________________________ Title________________

Level of Care Certification (For UCA/DHMH Use Only)

The above named recipient is certified for the following level of care (check one):

□ Chronic/Special Hospital □ Nursing Facility Effective Dates ______________ through______________

________________________ ________________________ ________________

Utilization Control Agent/DHMH Authorized Signature M/D/YYYY

DHMH 257 (Revised 4/2011)

AGENCY/UCA/PROVIDER COPY

MARYLAND DEPARTMENT of HUMAN RESOURCES
MARYLAND DEPARTMENT of HEALTH and MENTAL HYGIENE
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE APPLICATION

Check List of Items Needed for Your Long-Term Care / Waiver Application

(Please keep this page for your records)

SEND PROOF If you do not already receive Long-Term Care Medical Assistance, we need the items listed below to process your application. Please send as many items as you can with this application. Please send copies, **do not send originals.** In some cases, we may need to request additional documents not listed below. If so, we will give you time to supply the additional documents.

DO NOT WAIT TO APPLY

If you do not have copies of all the documents listed, send in all the copies you do have when you apply. It is important to apply as soon as possible. We will give you more time to send additional documents needed.

If you or your spouse sold, traded, gifted, or disposed of any property, motor vehicles, stocks, bonds, cash or other assets in the past 5 years you will have to provide the following:

- ☐ Type of asset
- ☐ Value of asset
- ☐ Amount received for the asset
- ☐ Reason for transfer
- ☐ Who received the asset

If you want to find out if your spouse can keep some of your monthly income, please provide:

- ☐ Spouse's gross monthly income
- ☐ Condo fees
- ☐ Mortgage
- ☐ Lot Rent
- ☐ Property tax bill
- ☐ Rent
- ☐ Electric bill

The following items are needed from you and your spouse to determine if you are eligible for Long-Term Care Medical Assistance:

- ☐ Federal Tax Returns for the current year and the preceding four years (please include all forms and schedules). A Record of Account can be obtained from the IRS free of charge by calling 1-800-908-9946 if your Federal tax returns cannot be located.
- ☐ Bank and Financial statements on all accounts owned and co-owned:
  - ☐ Current Month (month of application)
  - ☐ Previous Month (month prior to application)
  - ☐ The last five years of the anniversary month of the application
- ☐ Current statement of retirement accounts
- ☐ Current statement of IRA or Keogh Accounts
- ☐ Current statements of:
  - ☐ Stocks
  - ☐ Bonds
  - ☐ Money Market Funds
  - ☐ Mutual Funds, Treasury, or Other Notes
  - ☐ Certificates
- ☐ Current gross monthly income from all sources including:
  - ☐ VA Pensions
  - ☐ Railroad Retirement
  - ☐ Pensions
  - ☐ Annuities
- ☐ Face and cash value of Life Insurance policies (current annual statement)
- ☐ Current statement for burial accounts
- ☐ Burial Plot Deeds
- ☐ Life Estate Deeds
- ☐ Promissory Notes
- ☐ Mortgage Notes and Mortgage Deeds
- ☐ Trusts (including appendices, schedules, annual accountings, and amendments for the past five years)
- ☐ Private Health Insurance Cards including Medicare (copy of both sides)
- ☐ Health Insurance premium amounts
- ☐ Power of Attorney or Legal Guardianship Documents (if any)

Please continue by completely answering every question on the attached application. If you need more space to complete the application, please attach additional sheets.

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MARYLAND DEPARTMENT of HUMAN RESOURCES MARYLAND DEPARTMENT of HEALTH and MENTAL HYGIENE LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE APPLICATION

Date Signed Application Received in Local Department MUST BE DATE STAMPED

FOR WORKER USE ONLY *This part is for our staff. Please continue to Section A.*	LDSS Office Worker's Name Application Date	Programs Applied For or Receiving	Assistance Unit IDs Client ID
	Program Medical Coverage Group _____ AU ID _____		

SECTION A – BENEFIT SELECTION: *Please tell us about which benefits you want and which benefits you already have.*

I am applying for:
- ☐ Long-Term Care
- ☐ Waiver

Do you need Medical Assistance for medical bills incurred in the past 3 months?
If yes, you will need to provide copies of the bills to your case manager.
☐ YES ☐ NO

Tell us if you are currently receiving other assistance. I currently receive:
- ☐ Medical Assistance ID # _____
  If you already receive Medical Assistance, please provide your ID number.
- ☐ Cash Assistance
- ☐ Food Stamps
- ☐ Other, list: _____
  If you receive any other benefits, please list all the benefits here.

SECTION B – APPLICANT INFORMATION: *Please tell us about yourself.*

Last Name	First Name	Middle Name	Suffix	Maiden Name or Other Name
			(Jr., Sr., etc.)	

Social Security Number:
If you have a Social Security Number, enter it here.

Additional Social Security Number:
If you have an additional Social Security Number, enter it here.

Date of Birth: (Month,Day,Year)

Gender: ☐ Male ☐ Female

SECTION B – APPLICANT INFORMATION (continued)

Ethnicity
Optional

☐ 1 – Hispanic or Latino

☐ 2 – Not Hispanic or Latino

Race
Optional – Please choose all race codes that apply to you.

☐ 1 – American Indian/Alaskan Native
☐ 2 – Asian
☐ 3 – Black/African American
☐ 4 – Native Hawaiian/Pacific Islander
☐ 5 – White

You do not have to give information about your race or ethnicity. If you do, it will help show how we obey the Federal Civil Rights Law. We will not use this information to decide if you are eligible. If you do not give us your race, it will not affect your application. The case manager will enter a race code for statistical purposes only. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

Are you a resident of Maryland? ☐ YES ☐ NO

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Are you receiving Medical Assistance (Medicaid) benefits from another state? ☐ YES ☐ NO

If yes, please list the state: _____

Are you a U.S. Citizen? ☐ YES ☐ NO

If you answered NO, please complete SECTION C – IMMIGRATION STATUS, below.

What is your primary language? _____

Do you need an interpreter? ☐ YES ☐ NO

If you are not registered to vote, would you like to receive a voter registration form? ☐ YES ☐ NO ☐ Already registered to vote

SECTION C – IMMIGRATION STATUS (FOR NON-CITIZENS ONLY)

SEND PROOF *Please send a photocopy of the front and back of your INS card.*

What is your current INS Status?	On what date did you receive your INS Status?	Are you a Sponsored Immigrant? ☐ YES ☐ NO	What is your Country of Origin?
_____	_____/_____/_____		_____

When did you enter the U.S.?	What is your INS Number?	If you are a refugee, please list your Refugee Resettlement Agency:
_____/_____/_____	_____	_____

SECTION D – CURRENT ADDRESS of HOME or INSTITUTION/LONG-TERM CARE FACILITY: *Please tell us about your Long-Term Care Facility, if you live in one.*

If you live in a facility, what is the name of the facility?

_____

On what date did you enter the facility?

_____/_____/_____

What is your home address or the address of your facility?

Street _____

City _____ State _____ ZIP _____

Telephone # _____ Cellular Telephone # _____

Is this your mailing address? ☐ YES ☐ NO If you checked NO, please provide your mailing address information in Section V.

Do you (applicant/recipient) intend to return home? ☐ YES ☐ NO

Do you (applicant/recipient) intend to return home within 6 months? ☐ YES ☐ NO

SECTION E – PREVIOUS ADDRESSES: *Please tell us where you have lived for the past five years.*

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

Street _____

City _____ State _____ ZIP _____

Did you or your spouse own this home? ☐ YES ☐ NO

SECTION F – AUTHORIZED REPRESENTATIVE: Do you authorize someone to represent you in this application? If so, please tell us about your authorized representative.

First Name	Middle Name	Last Name	Suffix
_____	_____	_____	_____ *(Jr., Sr., III, etc.)*

Address _____

City _____ State _____ ZIP _____

SECTION F – AUTHORIZED REPRESENTATIVE (continued)

☐ Home Telephone #_____

☐ Cellular Telephone #_____

☐ Work Telephone #_____

What is the authorized representative's relationship to you?

_____

If answer is spouse, please complete the next question:

Do you or your spouse own this home? ☐ YES ☐ NO

If Authorized Representative is your spouse,
please provide spouse's Social Security Number: _____

SECTION G – SPOUSAL INFORMATION: *Please tell us about your spouse. Leave this section blank if your spouse is listed as your Authorized Representative in Section F.*

Last Name	First Name	Middle Name	Suffix	Maiden Name or Other Name
			(Jr., Sr., etc.)	

Spouse's Social Security Number _____

Street _____

City _____ State _____ ZIP _____

Telephone # _____

Do you or your spouse own this home?
☐ YES ☐ NO

SECTION H – DISABILITY: *Please tell us about your disability, if you have one.*

Are you disabled? ☐ YES ☐ NO

If yes, when did the disability begin?

_____/_____/_____

What is your disability?

_____

_____

	Premium Amount
Do you receive Medicare Part A? ☐ YES ☐ NO	$ _____
Do you receive Medicare Part B? ☐ YES ☐ NO	$ _____
Do you receive Medicare Part C? ☐ YES ☐ NO	$ _____
Do you receive Medicare Part D? ☐ YES ☐ NO	$ _____

SEND PROOF *Please send verification of the premium amounts you pay*

If yes, please provide your Medicare Claim Number: _____

SECTION I – VETERAN INFORMATION: *If you are a veteran, a disabled widow(er), or a disabled child of a deceased veteran, fill in this section:*

SEND PROOF *Please send a photocopy of the front and back of your military service card.*

Veteran's Name	Relationship to Veteran	Veteran's Status	Military Service Number

SECTION J – MEDICAL INSURANCE: *If the applicant/recipient is insured, fill in this section: If you have more than one policy, place additional information in Section V.*

SEND PROOF *Please send a photocopy of the front and back of your insurance card(s) and verification of the premium amounts you pay.*

Policy Number	Group Number	Policy Holder Name

Relationship to Policy Holder	Policy Effective Dates
	From: _____ To: _____

Policy Holder Address

Street _____

City _____ State _____ ZIP _____ Telephone _____

Insurance Company

Insurance Company Name _____

Street _____

City _____ State _____ ZIP _____ Telephone _____

Union

Union Name _____ Union Local Number _____

Street _____

City _____ State _____ ZIP _____ Telephone _____

SECTION K – INCOME FROM WORKING: *Please tell us about any income you or your spouse are currently receiving from working, including any sick leave payments.*

SEND PROOF *Please send copies of any proof of pay, such as a paystub. If you need additional space to complete this section, please use Section V or attach additional sheets.*

Employer Name _____	Type of Job _____
Employer Address _____ City_____ State_____ ZIP Telephone # _____	

Date Job Began_____	Date Job Ended_____	Gross Wages per Pay Period, including tips and commissions. $_____ per _____
Hours per Pay Period _____	How often do you get paid? ☐ Weekly ☐ Biweekly ☐ Monthly	If the job has ended, what is your last expected pay date? _____

SECTION L – YOUR BENEFITS AND OTHER INCOME: *Please tell us about any income or benefits that you are receiving, have applied for, or have been denied.*

SEND PROOF *Please send current copies of statements that verify the gross amount of income you receive.*

TYPE OF BENEFIT OR INCOME	RECEIVING INCOME OR BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Social Security Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Black Lung Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
SSI (Supplemental Security Income) Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Veteran's Pension/Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Pension or Retirement	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Civil Service Annuity	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Railroad Retirement Benefits Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Alimony	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	

SECTION L – YOUR BENEFITS AND OTHER INCOME (continued)

TYPE OF BENEFIT OR INCOME	RECEIVING INCOME OR BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Worker's Compensation	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Disability/Sick Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Union Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Unemployment Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Lump Sum Cash Amounts	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Interest/Dividends from Stocks, Bonds, Savings, or other investments	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Business Income	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other (e.g., ☐ Rental Income, or ☐ Compensation from a Legal Settlement)	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	

SECTION M – ASSETS: *Please tell us about your assets as of the first day of this month. Check YES or NO for each ASSET TYPE. If you check YES, fill in the other boxes. List all assets owned by you or your spouse individually, jointly, or with other persons. If you have more than one asset of the same type, use the "Other" boxes at the bottom of the list.*

SEND PROOF *Please send copies of current statements that verify the value of the assets.*

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Cash on Hand	☐ YES ☐ NO		$		
Checking Account	☐ YES ☐ NO		$		
Savings Account	☐ YES ☐ NO		$		
Credit Union Account	☐ YES ☐ NO		$		
Trust Fund	☐ YES ☐ NO		$		
IRA or Keogh Account	☐ YES ☐ NO		$		
Other Retirement Accounts	☐ YES ☐ NO		$		
Stocks and Bonds	☐ YES ☐ NO		$		

SECTION M – ASSETS (continued)

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Treasury or Other Notes	☐ YES ☐ NO		$		
Annuity	☐ YES ☐ NO		$		
Ownership in a Company	☐ YES ☐ NO		$		
Patient Fund Account	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		

SECTION N – OTHER ASSETS: *Please tell us about any other assets you own and assets jointly owned with other individuals. This could include livestock, recreational vehicles, or any other property of value such as collections of antiques, coins, jewelry, or stamps.*

SEND PROOF *Please send copies of current statements or documents that establish the fair market value of the asset(s) as well as the amount owed.*

ASSET TYPE	CURRENT FAIR MARKET VALUE	CURRENT AMOUNT OWED	OWNER(S)
	$	$	
	$	$	

SECTION O – POTENTIAL ASSET OR INCOME: *Please tell us about any accident settlement, trust fund, inheritance, or any other money, property, real property, or assistance you expect to receive.*

SEND PROOF *Please send copies of current statements or documents that describe the nature, amount, and payment schedule of the asset.*

Asset Type	Lawyer Name
_____	_____

SECTION O – POTENTIAL ASSET OR INCOME (continued)

Explanation	Lawyer Telephone #
_____	_____
Anticipated Date of Receipt _____	

SECTION P – REAL PROPERTY: *Please tell us about any real property that you own in or out of the state of Maryland.*

SEND PROOF *Please send a copy of the deed to each property. Please also send copies of current documents that verify the equity value of each property.*

Do you and/or your spouse own or have a legal interest in any other real property? ☐ YES ☐ NO
If yes, please answer the following questions:

ADDRESS OF PROPERTY	TYPE OF OWNERSHIP (CHECK ONE)	CURRENT FAIR MARKET VALUE	CURRENT AMOUNT OWED
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights Burial Plot	$	$
	☐ Rental Property ☐ Vacation Property ☐ Time Share ☐ Vacant Land ☐ Other Property Rights ☐ Burial Plot	$	$

SECTION Q – LIFE INSURANCE AND FUNERAL PLANS: *Please tell us about any life insurance or pre-paid burial plans or funds that you own. Please list all policies and funds, no matter who pays for them.*

SEND PROOF *Please send a copy of the declaration page of each policy. Please also send copies of current statements to verify the cash value of each policy, if applicable.*

ORIGINAL FACE VALUE OR VALUE OF PLAN	CASH VALUE	TYPE OF PLAN	POLICY NUMBER OR ACCOUNT NUMBER	POLICY OWNER	COMPANY, FUNERAL HOME, OR BANK NAME
$	$	☐ Life Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ Burial Plan			
$	$	☐ Life Insurance ☐ Burial Plan			

SECTION R – TRANSFER OF ASSETS: *Please tell us about any assets that you sold, traded, gifted, or disposed of in the past five years. This could include personal and real property, motor vehicles, stocks, bonds, cash, or other assets.*

SEND PROOF *Please send copies of current statements or documents that verify the date the asset was transferred, the value of the asset at the time of the transfer, and the amount you received for the transferred asset. If you need additional space to complete this section, please use Section V or attach additional sheets.*

TRANSFER DATE	TYPE OF ASSET	VALUE OF THE ASSET AT THE TIME OF THE TRANSFER	WHO RECEIVED THE ASSET AND THE REASON FOR THE TRANSFER	AMOUNT RECEIVED
				$
				$
				$

SECTION S – SPOUSAL BENEFITS AND OTHER INCOME: *Please tell us about any income or benefits that your spouse is receiving, has applied for, or has been denied.*

SEND PROOF *Please send current copies of statements that verify the gross amount of income your spouse receives.*

TYPE OF BENEFIT	RECEIVING BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Social Security Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Black Lung Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
SSI (Supplemental Security Income Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	

SECTION S – SPOUSAL BENEFITS AND OTHER INCOME (continued)

TYPE OF BENEFIT	RECEIVING BENEFITS?	AMOUNT	APPLICATION STATUS	APPLICATION DATE OR DENIAL DATE
Veteran's Pension/Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Pension or Retirement	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Civil Service Annuity	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Railroad Retirement Benefits Please write your claim number:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Alimony	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Worker's Compensation	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Disability/Sick Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Union Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Unemployment Benefits	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Lump Sum Cash Amounts	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Interest/Dividends from Stocks, Bonds, Savings, or other investments	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	
Other Please describe:	☐ YES ☐ NO	$	☐ Applied for ☐ Denied	

SECTION T – SPOUSAL NEEDS (SPOUSAL IMPOVERISHMENT): *If you have a living spouse, fill in this section. List all assets owned in the month the applicant was admitted to a long-term care facility. Include all assets owned individually or jointly by the applicant, or owned individually or jointly by your spouse.*

SEND PROOF *Please send copies of statements that verify the value of the assets.*

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Cash on Hand	☐ YES ☐ NO		$		
Checking Account	☐ YES ☐ NO		$		
Savings Account	☐ YES ☐ NO		$		

SECTION T – SPOUSAL IMPOVERISHMENT (continued)

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT NUMBER	INSTITUTION NAME
Credit Union Account	☐ YES ☐ NO		$		
Trust Fund	☐ YES ☐ NO		$		
IRA or Keogh Account	☐ YES ☐ NO		$		
Other Retirement Accounts	☐ YES ☐ NO		$		
Stocks and Bonds	☐ YES ☐ NO		$		
Certificates and Money Market Funds	☐ YES ☐ NO		$		
Treasury or Other Notes	☐ YES ☐ NO		$		
Annuity	☐ YES ☐ NO		$		
Ownership in a Company	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		
Other _____	☐ YES ☐ NO		$		

SECTION U – RESIDENTIAL, SPOUSAL, OR DEPENDENT ALLOWANCE

Have you or your spouse been in an institution/Long-Term Care Facility in the past? ☐ YES ☐ NO

If yes, please provide the following:

Date Entered Institution/
Long-Term Care Facility _____ Name of the Facility _____

Is there a spouse, child under 21, or any other dependent relatives at home? ☐ YES ☐ NO

If YES, fill in the section below. If you need additional space for assets for dependent children and relatives at home, please use Section V or attach additional sheets.

NAME	RELATIONSHIP	AGE	GROSS MONTHLY INCOME SEND PROOF	TYPE OF INCOME	VALUE OF ASSET SEND PROOF	ASSET TYPE
			$		$	

SECTION U – RESIDENTIAL, SPOUSAL, OR DEPENDENT ALLOWANCE (continued)

NAME	RELATIONSHIP	AGE	GROSS MONTHLY INCOME SEND PROOF	TYPE OF INCOME	VALUE OF ASSET SEND PROOF	ASSET TYPE
			$		$	
			$		$	

If applicant/recipient intends to return home within six months and if there is no spouse, child under 21, or other dependent relatives, fill in the section below:

SEND PROOF *Please provide your most recent statements to verify the expenses you listed below:*

Rent/Mortgage $_____	Utilities $_____	Heat (if separate from utilities) $_____	Property Taxes $_____
Home Owner's Insurance $_____	Condo Fees $_____	Other Shelter Costs (Specify) $_____	Other Shelter Costs (Specify) $_____

SECTION V – ADDITIONAL INFORMATION: *Please use this area for any information that would not fit in the spaces provided on this application.*

SECTION W – TAX RETURNS: *Please tell us about any tax returns filed by you and/or your spouse in the last five years.*

Did you or your spouse file Federal income tax returns in the last five years? ☐ YES ☐ NO

SEND PROOF *Please send copies of Federal tax returns for the current year and the preceding four years, including all forms and schedules.*

SECTION X – PRE-ELIGIBILITY MEDICAL EXPENSES (NON-COVERED SERVICES): *Please tell us about any unpaid medical bills that you incurred in the last three months. You may be eligible for deductions from your income.*

Do you have any unpaid medical bills that you incurred in the last three months? ☐ YES ☐ NO

SEND PROOF *If you answered yes, provide a newly dated, itemized, unpaid medical bill(s) that you incurred up to three months prior to this application. The bill must contain a service date, charge, and a detailed description of the service(s) provided. Attach copies of the bill(s) to the form and submit them with your Long-Term Care Medical Assistance application. If you do not have the bills at the time you submit the application, the bills may be submitted at a later date during this application process.*

Please check one of the YES or NO choices below and sign where you have indicated your choice:

☐ YES, I HAVE unpaid medical bills from the last three months.

☐ I am sending copies of my bills with this application.

☐ I will send copies of my bills at a later date during this application process.

Signature: _____(Applicant)

Date: _____

Signature: _____ (Authorized Representative)

Date: _____

☐ NO, I DO NOT HAVE unpaid medical bills at this time.

Signature: _____(Applicant)

Date: _____

Signature: _____(Authorized Representative)

Date: _____

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND I HAVE THE FOLLOWING RIGHTS:

- **The Department cannot discriminate against me.** Federal and State law prohibit the Department from discriminating against me because of race, color, national origin, sex, age, or disability. If I think the Department has discriminated against me, I may contact the U.S. Department of Health and Human Services at: HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 202-619-0403 (voice) or 202-619-3257 (TDD).
- **I have the right to privacy of my personal information.** I am providing personal information (that includes, but is not limited to: name, address, date of birth, Social Security number, income history, employment history, medical history) in this application for Medical Assistance. The purpose of requesting this personal information is to determine my eligibility for Medical Assistance. If I do not provide this information, the Department may deny my application for benefits. I have a right to inspect, amend, or correct this personal information. The Department will not permit inspection of my personal information, or make it available to others, except as permitted by Federal and State law. I understand, however, that the Department may deny my application for Medical Assistance if I do not provide this information.
- **If my case is approved, the Department will provide me with a written notice explaining my benefits.** The Department must give me written notice when it changes my benefits or, determines that I am ineligible for Medical Assistance. I have 90 days from the date of the notice to request a hearing. If I am already receiving benefits and request a hearing within 10 days from the date of the notice, I may continue to receive benefits while I wait for the hearing. Any erroneous benefits I receive from the Department must be repaid to the Department.
- **I have the right to appeal certain actions taken by the Department.** I can request a hearing if: my application for Medical Assistance eligibility is denied; I assert the Department's decision about Medical Assistance services was erroneous; or, there was a delay in the Department's action(s) related to my application. I may call the Department at 1-800-332-6347 for help requesting a hearing. I am responsible for providing the reason for requesting a hearing. At the hearing, I may speak for myself or I may be accompanied by a lawyer, friend, or relative to speak on my behalf.

IF I ACCEPT MEDICAL ASSISTANCE, I UNDERSTAND BY SIGNING THIS APPLICATION:

- **Payment Authorization** - I authorize payment under Medicare Part B to be made directly to health care providers and medical suppliers.
- **Assignment of Health Insurance/Third Party Payments** - I assign all rights, title, and interest of health insurance payments I may have to the Department and give the Department the right to seek payment from private or public health insurance and any liable third party for the costs the Department incurs for the benefits I receive under Medical Assistance. The Department may seek payment without legal action, providing it does not keep more than the amount Medical Assistance paid. I agree to promptly forward, to the Department, any health insurance payments I receive, including payments received as a settlement from an accident.
- **Access to Records** - I give the Department the right to inspect, review, and copy all relevant portions of my medical records for purposes of determining my eligibility for, and for determining the appropriateness of the services received through, the Medical Assistance program.
- **Quality Review Cooperation** - I understand that the Department may select my case for a random check or audit for quality control purposes. I agree to allow any representative from the Department to visit me where I reside. I will fully assist the Department in retrieving all proof needed from any source.
- **Estate Recovery** - I understand that the Department may recover, from the estate of a deceased Medical Assistance recipient, Medical Assistance payments made on his or her behalf on or after the person attained age 55. The Department may recover only if there is no surviving spouse, unmarried child younger than 21, or blind or disabled child (married or unmarried) of any age.
- **Accurate and Confidential Application Information** - I acknowledge that I must provide true, correct, and complete information and provide proof of this information.

- **Social Security Number(s)** - I must provide my (and my spouse's) Social Security number as an applicant for Medical Assistance. The Department will use the Social Security number(s) and other information I provide to verify the information I provide for program reviews. The Department will do this to make sure I am eligible. The Department may also verify my information by contacting my employer, bank, or other parties; and/or, the Department may contact local, State, or Federal agencies to make sure the information I provide is correct. If I do not have a Social Security number, I must apply for one and the Department can provide assistance in applying for a number.
- **Accurate Financial Reporting** - I understand that I am responsible for reporting true, correct, and complete financial information. This includes, but is not limited to information about: all my assets; potential assets; transfer of assets within the last 5 years of my initial application; transfer of assets within the last 12 months of the date of the annual redetermination of my eligibility; income; insurance; real property; annuities; and all other benefits I may be receiving. I understand that Federal law requires that, as a condition of receiving long-term care services, the Department must be named, in my annuity, as the primary remainder beneficiary.
- **Report Changes** - I am responsible for reporting changes in my situation. I must report changes within 10 days. The best way for me to report changes is in writing. Examples of changes in my situation are changes in my income, assets, address, health insurance premiums, or persons living in my home. My representative (person acting on my behalf who may file my application) is responsible for reporting such changes. Changes must be reported to the appropriate Local Department of Social Services or the Bureau of Long-Term Care Eligibility.
- **Medical Assistance Card Misuse** - If I become eligible for Medical Assistance, I must use my Medical Assistance card properly. It is against the law to allow another person to use my card.
- **Medical Assistance Fraud** - If I do not report true, correct, and complete information, or report changes, the Department may deny, stop, or reduce my benefits. A judge may fine me and/or imprison me if I intentionally do not give correct information or report changes.

SIGNATURES:

I swear or affirm that I have read or had read to me this entire application. I also swear or affirm, under penalty or perjury, that all the information I have given is true, correct, and complete to the best of my ability, knowledge and belief. I have received a copy of my rights and responsibilities. I authorize any person, partnership, corporation, association, or governmental agency which knows the facts relevant to determining my eligibility to release that information to the Department. I also authorize the Department to contact any person, partnership, corporation, association, or governmental agency that has provided information relevant to my eligibility for benefits. I certify, under penalty of perjury, by signing my name below, that the person for whom I am applying is a U.S. citizen or lawfully admitted immigrant.

Signature of Applicant/Recipient _____ Date_____

Signature of Witness (If you Signed an X) _____ Date_____

Signature of Spouse (If applicable) _____ Date_____

Signature of Authorized Representative (if applicable)_____ Date_____

☐ I withdraw my application for Medical Assistance

_____ _____

Signature of Applicant, Recipient, or Authorized Representative | Date

Signature of Case Manager	Date

DECLARATION

I swear or affirm, under penalty of perjury, that all information, including financial information, I have provided on this application is true, correct, and complete to the best of my knowledge. The requirement to report true, correct, and complete information includes the requirement to report financial changes that may affect my eligibility for benefits. Federal and State law requires that I disclose all transfers or gifting of assets within the 60 month (5 year) period prior to the month of application.

I understand that if I knowingly do not tell the truth, hide information, pretend to be someone else, or withhold information about myself (and my spouse, if any) or about the person for whom I am applying (and that person's spouse, if any), I may be breaking the law. Information provided on the application may be verified or investigated by Federal, State, and local officials including Federal and State Quality Control staff.

The consequences of not complying with the law are: my benefits may be denied; I may be required to pay back the State for benefits received; my case may be investigated for suspected fraud; and I may be prosecuted for perjury, larceny, and/or Federal health care fraud [not limited to Statute 42 U.S.C. sec. 1320a-7b(a)(ii)], which may involve a fine up to $10,000 per offense and/or federal imprisonment.

_____ _____
Signature of Applicant/Recipient Date

_____ _____
Signature of Witness (If signed with X) Date

_____ _____
Signature of Spouse (If applicable) Date

_____ _____
Signature of Authorized Representative (If applicable) Date

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I ID SCREEN FOR
MENTAL ILLNESS AND MENTAL RETARDATION OR RELATED CONDITIONS

NOTE: This form must be completed for all applicants to nursing facilities (NF) which participate in the Maryland Medical Assistance Program regardless of applicant's payment source.

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____
SSN: _____ Sex: M ___ F ___ Actual/Requested Nursing Facility Adm. Date: _____
Current Location of Individual: _____
Address: _____
City/State: _____ Zip: _____
Contact Person: _____ Title/Relationship _____ Tel. # _____

A. EXEMPTED HOSPITAL DISCHARGE

1. Is the individual admitted to a NF directly from a hospital after receiving acute inpatient care? Yes ☐ No ☐
2. Does the individual require NF services for the condition for which he received care in the hospital? Yes ☐ No ☐
3. Has the attending physician certified before admission to the NF that the resident is likely to require less than 30 days NF services? Yes ☐ No ☐

IF ALL THREE QUESTIONS ARE ANSWERED YES, FURTHER SCREENING IS <u>NOT</u> REQUIRED (PLEASE SIGN AND DATE BELOW). IF ANY QUESTION IS ANSWERED NO, THE REMAINDER OF THE FORM MUST BE COMPLETED AS DIRECTED.

IF THE STAY EXTENDS FOR 30 DAYS OR MORE, A NEW SCREEN AND RESIDENT REVIEW MUST BE PERFORMED WITHIN 40 DAYS OF ADMISSION.

Signature _____ Title _____ Date _____

B. MENTAL RETARDATION (MR) AND RELATED CONDITIONS (see definitions)

1. Does the individual have a diagnosis of MR or related condition?
   If yes, specify diagnosis_____ Yes ☐ No ☐
2. Is there any history of MR or related condition in the individual's past, prior to age 22? Yes ☐ No ☐
3. Is there any presenting evidence (cognitive or behavior functions) that may indicate that the individual has MR or related conditions? Yes ☐ No ☐
4. Is the individual being referred by, and deemed eligible for services by an agency which serves persons with MR or related conditions? Yes ☐ No ☐

Is the individual considered to have MR or a Related Condition? If the answer is <u>Yes</u> to one or more of the above, check "Yes." If the answers are <u>No</u> to all of the above check "No." Yes ☐ No ☐

Name_____

C. SERIOUS MENTAL ILLNESS (MI) (see definitions)

1. Diagnosis. Does the individual have a major mental disorder? Yes ☐ No ☐
   If yes, list diagnosis and DSM IV Code_____

2. Level of Impairment. Has the disorder resulted in serious functional limitations in major life activities within the past 3-6 months (e.g., interpersonal functioning; concentration, persistence and pace; or adaptation to change)? Yes ☐ No ☐

3. Recent treatment. In the past 2 years, has individual had psychiatric treatment more intensive than outpatient care more than once (e.g., partial hospitalization) or inpatient hospitalization; or experienced an episode of significant disruption to the normal living situation for which supportive services were required to maintain functioning at home or in a residential treatment environment or which resulted in intervention by housing or law enforcement officials? Yes ☐ No ☐

Is the individual considered to have a SERIOUS MENTAL ILLNESS? If the answer is Yes to all 3 of the above, check "Yes." If the response is No to one or more of the above check "No." Yes ☐ No ☐

If the individual is considered to have MI or MR or a related condition, complete Part D of this form. Otherwise, skip Part D and sign below.

D. CATEGORICAL ADVANCE GROUP DETERMINATIONS

1. Is the individual being admitted for convalescent care not to exceed 120 days due to an acute physical illness which required hospitalization and does not meet all criteria for an exempt hospital discharge (Described in Part A)? Yes ☐ No ☐

2. Does the individual have a terminal illness (life expectancy of less than six months) as certified by a physician? Yes ☐ No ☐

3. Does the individual have a severe physical illness, such as coma, ventilation dependence, functioning at a brain stem level or other diagnoses which results in a level of impairment so severe that the individual could not be expected to benefit from Specialized Services? Yes ☐ No ☐

4. Is the individual being provisionally admitted pending further assessment due to an emergency situation requiring protective services? The stay will not exceed 7 days. Yes ☐ No ☐

5. Is the individual being admitted for a stay not to exceed 14 days to provide respite? Yes ☐ No ☐

If any answer to Part D is Yes, complete the Categorical Advance Group Determination Evaluation Report and attach. Additionally, if questions 1, 2 or 3 are checked "Yes," or if all answers in Part D are No, the individual must be referred to GES for a Level II evaluation.

I certify that the above information is correct to the best of my knowledge. If the initial ID screen is positive and a GES level II evaluation is required, a copy of the ID screen has been provided to the applicant/resident and legal representative.

Name & Title _____ Date _____

FOR POSITIVE ID SCREENS NOT COVERED UNDER CATEGORICAL DETERMINATIONS, check below.

_____ This applicant has been cleared by the Department for nursing facility admission.
_____ This resident has been assessed for a resident review.

Local GES Office _____ Contact _____ Date _____

HOSPICE REVOCATIONS

DHMH 257 – Hospice Questions and Answers

1. Is it necessary to submit for a level of care when a Medical Assistance recipient is switching from full MA to hospice MA?

- No. It is not necessary to submit for a level of care in this situation.

2. What documentation needs to be submitted with the 257 if a Medical Assistance recipient is switching from Hospice MA to Full MA?

- Providers are required to submit the following documentation to Delmarva:
  - Level of Care
  - Copy of 3871B that is signed by a physician
  - Approved level of care certification period dates

3. Where do nursing facilities send a completed 257 after hospice benefit revocation?

- When a patient residing in the nursing facility elects the hospice benefit, the facility does **not** need to submit a DHMH 257/Cancel Payment. The LTC spans for that nursing facility will be end-dated in the MMIS-II system via an internal procedure that takes place during the Hospice election/enrollment process at DHMH.

- If at any point after hospice election, the patient decides to discontinue hospice care and benefits and return to nursing facility care, the facility must submit a DHMH 257/Begin Payment and another 3871B, for assignment of reimbursement level.

- Because Medicaid operations canceled the recipient's previous LTC span on MMIS-II via an internal process only, the recipients LTC spans are still open and continuous on the CARES system. Please complete the new DHMH 257/Begin Payment, submit it to Delmarva for processing, noting on the form that Delmarva should forward this DHMH 257 to the following address:

  Christina Allen, Supervisor
  Medical Assistance Problem Resolution Division
  201 W. Preston Street, Rm SS-5
  Baltimore, MD 21201
  Attn: Hospice Revocation DHMH 257(s)

STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 208
November 30, 2007

TO: Nursing Home Administrators
Chronic Hospitals

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

RE: Use of DHMH 257 and 259 Forms –
Supplemental Information to DHR-DHMH Action Transmittal 06-30;
Special Instructions for Nursing Facility Residents Receiving Hospice Benefits

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This transmittal describes the appropriate use of two DHMH forms related to medical and financial eligibility for Medical Assistance reimbursement in nursing homes: DHMH 257 Long Term Care Patient Activity Report and DHMH 259 Medical Care Transaction Form. All parties to Medical Assistance nursing home payment – the facilities, the Program's Utilization Control Agent (UCA), and local departments of social services (LDSS) – should adhere to these procedures. The information is to be read and followed in conjunction with Action Transmittal #06-30, issued jointly by the Family Investment Administration of the Department of Human Resources and Medicaid's Office of Systems, Operations, Eligibility, and Pharmacy dated March 3, 2006. A copy of this action transmittal is attached.

In summary, please use the DHMH 257 and 259 forms as follows:

- Use the DHMH 257 upon admission to the nursing home to open a LTC payment span and upon discharge from the nursing home to close the LTC payment span.[1]
- Use the DHMH 259 as described below to move a recipient from Medicare co-pay to "Begin Full MA." In addition, submit the DHMH 3871B to the UCA so that it can determine whether the patient meets the NF level of care.

[1] The AT #06-30 expands upon this directive more fully, explaining how and when to use the DHMH 257 when a person enters a facility directly from the community for an expected stay of 30 or fewer days, with or without existing Community MA, MCO or non-MCO, and/or with Medicaid or QMB (Qualified Medicare Beneficiary) co-pay if applicable.

- For facilities with both chronic and nursing facility levels of care (so-called "dual" facilities) – please continue to use the DHMH 259 to move between these levels, clearly marking the form with "DUAL CHRONIC-NF," until a separate form is established for this process.

INSTRUCTIONS FOR USING THE DHMH 257 AND 259 FORMS

Processing Level of Care Changes Using the DHMH 257 & 259 Forms

To Begin Payment

Initial DHMH 257/Begin Payment must be submitted according to instructions stated in Action Transmittal #06-30.

Medicare Coinsurance DHMH 257/Begin Payment – submit directly to the LDSS office. The UCA does not assign level of care because Medicare payment, by definition, indicates the patient's need for skilled nursing and/or other skilled services, such as rehabilitation.

Straight Medicaid DHMH 257/Begin Payment – submit directly to the UCA with form DHMH 3871B, for medical eligibility determination and assignment of Medicaid payment level (i.e., light, moderate, heavy, or heavy special). The UCA will forward to LDSS after the need for nursing home level of care has been determined.

To Change Reimbursement Levels from Medicare Co-pay to Begin Full MA

Fill out the DHMH 259 Level of Care Transaction Form to indicate Medicare co-pay days are ending and forward to UCA. Also submit the DHMH 3871B form to the UCA for medical eligibility determination and assignment of Medicaid payment level (i.e., light, moderate, heavy, and heavy special). The UCA will forward to the Department after the need for nursing home level of care has been determined.

To Cancel Payment

Submit DHMH 257 Cancel Payment Transaction directly to LDSS in the event of:

Death;
Discharged home, or to another nursing facility; or
Termination of Bed Hold payment to nursing facility after maximum 15-day benefit for Hospital Leave/Bed Hold is exhausted*

***NOTE**: If the patient returns to the facility after a cancel pay due to expiration of the 15-day maximum Hospital Leave/Bed Hold, this process must start again, with the submission of a new initial DHMH 257/Begin Payment.

Dual Facilities: Move Between Chronic and Nursing Facility Levels of Care

- For facilities with both chronic and nursing facility levels of care – please continue to use the DHMH 259 to move between these levels, clearly marking the form with "DUAL CHRONIC-NF," until a separate form is established for this process.
- Facility provider numbers change as levels change between chronic hospital and nursing facility level of care, and LTC payment spans must change as well. Forward your "DUAL CHRONIC-NF" DHMH 259 documents to the following address for processing:

Christina Allen, Supervisor
Medical Assistance Problem Resolution
201 West Preston Street, Rm. SS-5
Baltimore, MD 21201
Attn: Dual Chronic-NF DHMH 259(s)

The Following Transactions Should Not Be Submitted Via DHMH 259:

1. Hospital Leave/Bed Hold days. There is no change in level of care status during this time period.

2. Expiration of Hospital Leave/Bed Hold. This transaction must be handled via a DHMH 257/Cancel Payment, as noted above.

3. Medicare coinsurance. Neither the UCA nor the LDSS have to confirm the need for nursing home level of care or assign a reimbursement level at this point, since the Medicare nursing benefit has been approved for skilled nursing and/or other skilled services. The nursing facility will have a Medicare EOMB in chart for assessment purposes.

SPECIAL INSTRUCTIONS FOR HOSPICE ELECTIONS

When a patient residing in the nursing facility elects the hospice benefit, the facility does not need to submit a DHMH 257/Cancel Payment. The LTC spans for that nursing facility will be end-dated in the MMIS-II system via an internal procedure that takes place during the Hospice election/enrollment process at DHMH.

If at any point after hospice election, the patient decides to discontinue hospice care and benefits and return to nursing facility care, the facility must submit a DHMH 257/Begin Payment and another 3871B, for assignment of reimbursement level.

Because Medicaid operations canceled the recipient's previous LTC span on MMIS-II via an internal process only, the recipient's LTC spans are still open and continuous on the CARES system. Please complete the new DHMH 257/Begin Payment, submit it to KePRO for processing, noting on the form that KePRO should forward this DHMH 257 to the following address:

Christina Allen, Supervisor
Medical Assistance Problem Resolution Division
201 W. Preston Street, Rm. SS-5
Baltimore, MD 21201
Attn: Hospice Revocation DHMH 257(s)

Any questions regarding this transmittal may be directed to the Division of Long Term Care Services at (410) 767-1736.

Attachment
cc: Nursing Home Liaison Committee
Local Departments of Social Services
Utilization Control Agent
Stacy A. Hromanik, MA Problem Resolution Division

Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**FIA ACTION TRANSMITTAL**
Control Number: #06-30	**Effective Date:** UPON RECEIPT **Issuance Date:** March 3, 2006

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS AND ELIGIBILITY STAFF

FROM: KEVIN M. MCGUIRE, EXECUTIVE DIRECTOR, FIA
CHARLES E. LEHMAN, EXECUTIVE DIRECTOR, DHMH, OOEP

RE: STANDARDIZATION OF MEDICAL ASSISTANCE LONG-TERM CARE PROCEDURES FOR JURISDICTION, LESS THAN 30 DAY STAY, AND MEDICARE DAYS

PROGRAMS AFFECTED: MEDICAL ASSISTANCE LONG TERM CARE (MA-LTC) FOR ADULTS

ORIGINATING OFFICE: OFFICES OF OPERATIONS AND PROGRAMS
DHMH OFFICE OF OPERATIONS, ELIGIBILITY AND PHARMACY

SUMMARY:

The Budget and Taxation and Appropriations Committees filed a joint report in November 2000, which required the Departments of Human Resources (DHR) and Health and Mental Hygiene (DHMH) to establish a workgroup with representatives of the Health Facilities Association of Maryland (HFAM) and Mid-Atlantic LifeSpan. The workgroup's main goal was to focus on ways to resolve communications issues between the agencies that provide customer service and develop procedures to expedite Medicaid eligibility determinations for Nursing Home residents.

A subcommittee of that workgroup recommended procedures for the Local Departments of Social Services (LDSSs) and Long-Term Care (LTC) providers that will reduce customer confusion and assist case managers, providers and customers with compliance requirements. While progress has been made, some topics continue to remain unresolved and require standardization on the part of LDSSs and LTC Providers.

To ensure that the recommended procedures will succeed, the subcommittee will take into consideration the impact not only on the nursing home community but also on the State's resources. It is essential that new procedures be adhered to consistently in order to ensure statewide compliance. The Executive Directors of both DHR and DHMH agree with the recommendations and support the actions of the subcommittee.

ACTION REQUIRED:

LDSS and LTC Facilities/Providers must observe the following procedures when processing LTC applications or redeterminations for adults.

STANDARDIZATION OF JURISDICTION OF RECORD FOR MA-LTC APPLICANTS:

Maryland Medicaid regulations address state residency only. An applicant for Maryland Medicaid must reside in a LTC facility in Maryland, and is considered to be a Maryland resident as of the date of admission to the LTC facility, with no waiting period. There are no local residency requirements. To ensure timely processing of Medicaid applications, use the following policies to determine where a customer's application will be processed. Please note, however, that the application must be taken and pended at the LDSS where the customer applies, in order to establish the date of application. An LDSS may not refuse to accept an application if the customer applies in an "incorrect" jurisdiction based on the following policies.

A LTC application is to be processed by the LDSS in the jurisdiction where the applicant resides. A LTC applicant is considered to reside in the Maryland jurisdiction where the customer lived before admission to the LTC facility, not in the jurisdiction where the LTC facility is located. If the LTC applicant did not reside in Maryland before admission to the LTC facility (e.g., the customer lived in a different state or country), the customer is considered to reside in the jurisdiction where the LTC facility is located.

Local Department Case Responsibility

A. Customer is admitted to a LTC facility directly from a community residence, that may be in a different jurisdiction than the LTC facility:

   - ❖ File, process and maintain application in the jurisdiction where the customer resided before admission to the LTC facility.

B. Customer is admitted to a LTC facility from a state institution:

   - ❖ File, process and maintain the application in the jurisdiction where the LTC facility is located.

C. Customer resided with their spouse then entered a LTC facility in another jurisdiction:

   - ❖ File, process and maintain the application in the jurisdiction where the customer resided before admission.

D. Applicant and spouse were separated before admission and lived in different jurisdictions and the excluded home is not in the jurisdiction where the applicant lived:

- ❖ File, process and maintain the application in the jurisdiction where the customer lived prior to admission.

E. Applicant did not live at home before admission (e.g., lived in an assisted living facility or with family) and the countable home is in a different jurisdiction than where the applicant lived:

- ❖ File, process and maintain the application in the jurisdiction where the customer lived prior to admission.

F. Customer is admitted to a LTC facility, and a previous community address either cannot be determined or was in a different state or country:

- ❖ File, process and maintain the application in the jurisdiction where the LTC facility is located.

Note: Under extenuating circumstances, a customer or his representative may request in writing to process the application in a local department other than where the case is currently maintained. Maintain the original copy of the written request in the case record.

MEDICAID COMMUNITY COVERAGE FOR LESS THAN 30 DAYS STAY IN LTC FACILITY

Refer to pages 900-23 – 900-24 in the Medicaid Eligibility Manual, issued in MR-108.

A Long Term Care Facility (LTCF) may admit a person for an anticipated stay of less than 30 days. When such a person is admitted to a LTCF from a community setting (including an acute hospital that admitted the person from the community), has a plan of care for a LTCF stay less than 30 days, and is discharged from the LTCF back to the community within 30 days, determine eligibility for community Medical Assistance under COMAR 10.09.24.09. For persons enrolled in HealthChoice, the Managed Care Organization (MCO) is responsible for the LTCF's charges during the first 30 days in a nursing home, chronic care hospital, or rehabilitation hospital; therefore, the facility must bill the MCO (see Medicaid billing instructions dated July 2005). Since either Medicaid or the MCO pays the provider, the client contribution to the cost of care (patient resource amount) is not assessed.

The LTCF will notify the LDSS LTC Eligibility Caseworker of admission and discharge from the LTCF via the DHMH 257 (Long Term Care Patient Activity Report). The DHMH 257 should be clearly marked "Community MA". The "Begin" and "Cancel" transactions should be included on the same form, so the stay of less than 30 days will be apparent.

A. Medical Assistance Applicant
(Non MA and Non Medicare at admission)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating " Community MA".
- Submits the DHMH 257 to DHMH's utilization control agent (UCA) for Level of Care.
- Refers the applicant to LDSS for an application and Community MA eligibility determination.

The LDSS LTC Eligibility Caseworker:
- Completes a Community MA eligibility determination.
- Completes a DES 501 if applicant is eligible.
- Sends a copy of the 501 to the LTCF.

B. Medical Assistance Applicant – MA Community Spenddown
(Non MA and Non Medicare at admission)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Submits the DHMH 257 to UCA for Level of Care.
- Refers the applicant to LDSS for an application and Community MA eligibility determination.
- Provides an itemized bill showing the cost of care, ancillaries, and other medical expenses on a day-by-day basis, if applicant is ineligible for Community MA due to excess income.

NOTE: A person certified for Medical Assistance under spenddown based on expenses incurred while in LTCF must pay the LTCF the excess income used to meet spenddown.

LDSS LTC Eligibility Caseworker:
- Completes a Community MA spenddown determination.
- Completes a DES 501 entering the applicant's spenddown amount as of the date of eligibility if applicant is eligible through spenddown.
- Sends a copy of the 501 to the LTCF.

C. Community Medical Assistance Recipient Not in MCO
(Non Medicare at admission i.e., SSDI recipients not on Medicare, spenddown)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Submits the DHMH 257 to UCA for Level of Care.

The LDSS LTC Eligibility Caseworker:
- Upon receipt of DHMH 257, updates case record in CARES to indicate recipient was in LTCF for less than 30 days, a DHMH 257 was submitted, and DES 501 was

completed.
- Completes the DES 501 and sends a copy to the LTCF.

D. Community Medical Assistance Recipient in MCO (Non Medicare at admission)

The Long Term Care Facility:
- Must notify MCO as soon as possible that the recipient is in LTCF.
- Must send DHMH 3871B to UCA
- Informs recipient/representative they should contact LDSS within 10 days to report recipient is in LTCF for less than 30 days.
- May contact LDSS regarding Community MA status of recipient.

The LDSS LTC Eligibility Caseworker:
- Upon notification, updates CARES narrative to reflect recipient is in LTCF for less than 30 days.

NOTE: Neither the DHMH 257 nor DES 501 is completed. LDSS LTC Eligibility Caseworker is only required to update the CARES narrative, if informed.

E. Community Medical Assistance Recipient Not in MCO (Medicare at admission – Stay Less Than Skilled so days not covered by Medicare)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Submits the DHMH 257 to UCA for Level of Care.

The LDSS LTC Eligibility Caseworker:
- Upon receipt of DHMH 257, updates case record in CARES to indicate recipient was in LTCF for less than 30 days, a DHMH 257 was submitted, and DES 501 was completed.
- Completes the DES 501 and sends a copy to the LTCF.

MEDICAID OR QMB COVERAGE OF CO-PAYMENTS FOR MEDICARE COVERED LTC STAY

Refer to page 900-24 in the Medicaid Eligibility Manual issued in MR-108, and pages 1000-53 – 1000-54 issued in MR-96.

Medicare covers a Medicare recipient in full for the first 20 days in the LTCF at a skilled or chronic level of care. For the 21st – 100th days in a LTCF at a skilled or chronic level of care, the Medicare recipient is assessed a co-payment. If the individual is a Medicaid or QMB recipient, Medicaid pays the Medicare Part A co-payment under the Medicare Buy-In Program. Medicare and Medicaid pay the provider since the client contribution to the cost of care (patient resource amount) is not assessed. If the individual is

expected to remain in the LTCF for 30 days or longer, it is recommended that the individual apply for LTC Medicaid, so that Medicaid will cover the LTC stay when the Medicare coverage ends.

The LTCF will notify the LDSS LTC Eligibility Caseworker of admission and discharge from the LTCF via the DHMH 257 (Long Term Care Patient Activity Report). The DHMH 257 should be clearly marked "Community MA". The "Begin" and "Cancel" pay dates should be included on the same form The "Begin" payment should be marked "Other: Medicare Coinsurance".

A. Medical Assistance or QMB Applicant
(Medicare covered stay - Skilled/Chronic Level)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Under Action Requested/Begin Payment/Other: specify "Medicare Coinsurance".
- Submits the DHMH 257 directly to LDSS and not to the UCA, since Medicare has already determined Level of Care
- Refers the applicant to LDSS for application and Community MA eligibility determination.

The LDSS LTC Eligibility Caseworker:
- Completes a Community MA eligibility determination.
- Completes a DES 501 to begin Medicare co-pay if applicant is Medicaid or QMB eligible.
- Sends a copy of the 501 to the LTCF.

B. Medical Assistance Applicant – – MA Community Spenddown
(Medicare covered stay – Skilled/Chronic Level)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Under Action Requested/Begin Payment/Other: specify "Medicare Coinsurance".
- Submits the DHMH 257 directly to LDSS.
- Refers the applicant to LDSS for application and Community MA eligibility determination.
- Provides an itemized bill showing the cost of care, ancillaries, and other medical expenses on a day-by-day basis, if applicant is ineligible for Community MA due to excess income.

NOTE: A person certified for Medical Assistance under spenddown based on expenses incurred while in LTCF must pay the LTCF the excess income used to meet spenddown.

LDSS LTC Eligibility Caseworker:
- Completes a Community MA spenddown determination.

- Completes a DES 501 to begin Medicare Co-Pay, entering the applicant's spenddown amount as of the date of eligibility, if applicant is eligible through spenddown.
- Sends a copy of the 501 to the LTCF.

NOTES:
LDSS Eligibility Caseworkers cannot use any Medicare covered service in the spenddown determination, but may use the individual's incurred expenses for Medicare premiums, co-payments, and deductibles.

If applicant is ineligible for Community Medical Assistance through spenddown, the Community Eligibility Caseworker must determine eligibility for Qualified Medicare Beneficiary (QMB).

C. Community Medical Assistance or QMB Recipient (Medicare covered stay – Skilled/Chronic Level)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Under Action Requested/Begin Payment/Other: specify "Medicare Coinsurance".
- Submits the DHMH 257 directly to LDSS.

The LDSS LTC Eligibility Caseworker:
- Updates CARES narrative to reflect recipient is in LTCF.
- Completes a DES 501 to begin Medicare Co-Pay.
- Sends a copy of the 501 to the LTCF.

INQUIRIES:
Please direct questions pertaining to these procedures to Patricia Bailey, Bureau of Medical Assistance Operations at 410-767-8907 or at pbailey@dhr.state.md.us, Medical Assistance policy questions to the DHMH Division of Eligibility Services at 410-767-1463, and Medical Assistance CARES questions to Cathy Sturgill at 410-238-1247 or at csturgil@dhr.state.md.us.

cc: DHR Executive Staff
DHMH Executive Staff
FIA Management Staff
DHMH Management Staff
Constituent Services
RESI
DHR Help Desk

Maryland Medical Assistance
Medical Eligibility Review Form #3871B

Part A – Service Requested

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

4. Check Service Type Below:

- ☐ Nursing Facility
- ☐ Medical Day Care Waiver
- ☐ Waiver for Older Adults
- ☐ Living at Home Waiver
- ☐ PACE
- ☐ Model Waiver vent only dependent (all other MW use 3871)
- ☐ Chronic Hospital vent dependent only (all other CH use 3871)

5. Check Type of Request

- ☐ Initial
- ☐ Conversion to MA (NF)
- ☐ Medicare ended (NF)
- ☐ MCO disenrollment (NF)
- ☐ Readmission – bed reservation exp. (NF)
- ☐ Transfer new provider (NF)
- ☐ Update expired LOC
- ☐ Corrected Date
- ☐ Significant change from previously denied request
- ☐ Recertification (Waivers/PACE only)
- ☐ Advisory (please include payment)

Part B – Demographics

1. Client Name: Last _____First _____ MI _____ Sex: M ☐ F ☐

SS# _____- ____- _____ MA # _____ DOB _____

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

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

If placed in facility, name of facility _____

If in acute hospital, name of hospital_____

3. Next of Kin/ Representative

Last name _____ First Name _____ MI _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

4. Attending Physician

Last name _____ First Name _____ MI _____

Address 1 _____

Address 2 _____

City _____ State _____ ZIP _____ Phone _____

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

Review Item	Answer Y	Answer 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 – Diagnoses

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

Part E – Skilled Services:

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

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

Review Item (Please indicate the number of days per week each service is required)	# of days service is required/wk. (0-7)
1. Tracheotomy Care: All or part of the day	
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 O2 usage	
10. Parenteral Feeding or TPN: Necessary for providing main source of nutrition.	
11. Catheter Care: Not routine foley	
12. Ostomy Care: New	

13. Monitor Machine: For example, apnea or bradycardia	
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime or perform self care or treatment skills for recently diagnosed conditions (**must be ordered by a physician)**	

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

Review Item (Please indicate the number of days per week each service is required.	No. 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. Bowel and/or Bladder Retraining Program: Not including routine toileting schedule.	

Part F – 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. Brief Interview for Mental Status (BIMS): Was the examiner able to administer the complete interview? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent.) If yes, Score: _____ If No, check one of the following: ☐ Hearing Loss ☐ Applicant is rarely/never understood ☐ Language Barrier ☐ Refused ☐ Other (specify) _____	☐	☐

Behavior (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
7. Wanders (several times a day): Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
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 other's 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.	☐	☐

Applicant 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 feeding).	
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 G – Certification

1. Signature of Person Completing Form: _____ Date_____

   Printed Name_____

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

2. Signature of Health Care Professional: _____ Date_____

   Printed Name_____

STATE OF MARYLAND
DHMH

Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

A Guide to the 3871B

Instructions for Completing the Application to Determine Medical Eligibility for Medical Assistance Long Term Care Programs

Long Term Care and Community Support Services Administration
Office of Health Services
Maryland Medicaid Program

Revised 10/2011

If you have questions, or need further information, please call the
Delmarva Foundation Provider Service Line (866) 571-3629
or the Division of Long Term Care (410) 767-1736

Item # and Description	Explanation/Detailed Instructions
Part A	
1. Requested Eligibility Date	The date you want Medicaid to begin paying for the services. If you don't know, put today's date.
2. Admission Date	The date the individual is admitted to your facility. If the individual is not admitted yet, or you are not a facility, leave this blank.
3. Facility MA Provider #	Maryland MA Provider number or Name of Facility
4. Check Service Type	Check the program for which you are applying. Check ONE only. Please note that for Chronic Hospital and Model Waiver services, use of this form is limited to individuals who are ventilator dependent; all other requests for these services must use the DHMH 3871. For Chronic Hospital or Model Waiver Vent Dependent cases, please also submit the Additional Information, Vent Specific Question, and Patient Comorbidity Rating Scale forms.
5. Check Type of Request	This refers to the purpose for submitting a 3871B. To ensure prompt, appropriate processing, please check one box only. Please note that the following types of requests are used only for certain service types: >Conversion to MA, Medicare ended, and MCO disenrollment: nursing facility and chronic hospital vent dependent services > Readmission – bed reservation expired: nursing facility services only >Transfer to new provider - Nursing facility, Chronic Hospital vent dependent ,and Medical Day Care Waiver >Recertification - Waivers and PACE
	**The "Advisory" box should be checked when the individual does not intend to access MA benefits within the next 30 days, but wishes to know whether he/she may be medically eligible for benefits in the future. This type of request is usually sought when an individual with a community spouse plans to apply for Waiver services in the future and wants to establish a "start date" for purposes of calculating the spousal allowance. It may be used, however, any time an individual wishes to learn his/her current medical eligibility status for future long term care planning. NOTE: Requests for advisory determinations should be mailed to: KePRO, 11350 McCormick Road, Executive Plaza II, Suite 102, Hunt Valley, MD 21031, with a check of money order for $30.00 payable to KePRO.
Part B	
1. Client Information:	This refers to the individual for whom you are requesting a level of care
Last Name, First Name, MI	Individual's last name, first name, and middle initial. If he/she doesn't have a middle initial, or you don't know the middle initial, leave this blank.
Sex	M or F-Circle one. M=Male F=Female
SS#	Social Security number of the individual
MA#	Maryland Medical Assistance (MA) number for the individual. If none, leave blank. If the individual's family/representative has applied to Medical Assistance (by going to the Social Service Department in their county, for example), but they have not yet been assigned an MA number, enter "Pending" in this space. Pending only applies to those individuals who actually have an appointment scheduled or have already met with the Social Service Department
DOB	Individual's date of birth
2. Current Address	Individual's permanent address. Please check whether this is the individual's home address or the address of the nursing facility in which the individual is residing.
Address 1	Street address (e.g., 4 Rosamond Ave)
Address 2	Building number, apartment number, etc. (e.g., Apt 41). If none, leave blank
City, State, ZIP	City and state of residence (e.g., Baltimore, MD). The two-letter abbreviation for state may be used. For ZIP code, the 5-digit code may be used.
Phone	Individual's telephone number –Area code and 7-digit phone number (e.g., 410-555-5555)
If in a facility, name of facility	For individuals who are currently living in a facility.

Item # and Description	Explanation/Detailed Instructions
If in acute hospital, name of hospital	Complete only if the individual is currently in an acute hospital awaiting discharge.
3. Next of Kin/Representative	The individual's next of kin or legal representative/guardian. This person will get copies of all denial letters. If you cannot determine the next of kin, write "unknown." Refer to directions under #1 (Client Information) for completing address and phone information for the next of kin.
4. Attending Physician	The primary care physician of the individual (i.e., the physician who provides routine preventive and ongoing care to the individual). Refer to directions under #1 (Client Information) for completing address and phone information for the attending physician.

Part C	
1. Is there a diagnosis of Mental Retardation/related condition, or has the client received MR services within the past two years?	**Note:** "related condition" means a condition that manifests itself before age 22 and causes severe, chronic disability that is likely to continue indefinitely and is attributable to cerebral palsy, epilepsy, or a condition closely related to mental retardation (not including mental illness). Has the individual had a diagnosis of mental retardation or related condition identified by a physician? If so, check YES. Has the individual received any MR services during the past two years, whether or NOT they have a written diagnosis of MR? If so, check YES. Otherwise check NO.
2. Is there any presenting evidence of mental illness?	**Note**: dementia/Alzheimer's is NOT considered a mental illness. Has this individual been diagnosed by a physician with a serious mental illness diagnosable under DSM-III? If so, check YES. Otherwise check NO. If you check YES, check one or more types of mental illness diagnosed.
3. Has the client received inpatient services for mental illness within the past two years?	If the individual has actually been admitted to a psychiatric hospital or unit for inpatient care (not psychiatric day treatment or emergency room) within the past two years, check YES. Otherwise check NO.
4. Is the individual on any medication for treatment of a major mental illness or psychiatric diagnosis?	If the individual is on medication for treatment of serious mental illness (e.g., psychotropic medication, tranquilizers, antidepressants), check YES. Otherwise check NO. If you answered YES to this question, please answer question 4a.
4a. If YES, is the mental illness or psychiatric diagnosis controlled with medication?	If the medication has stabilized the unwanted symptoms for this individual, check YES. If not, or if the physician is still adjusting dosages, or if the answer to question 4 is NO, check NO.
5. Is the client a danger to self or others?	If the individual's behavior indicates that he/she might place himself/herself or someone else in danger, check YES. Otherwise check NO. This question focuses on behavior. The inability to prepare meals, eat an adequate diet, perform routine activities of daily living, or take medications as directed due to dementia or physical limitations does not constitute a behavior problem.

Part D	
1. Primary diagnosis related to the need for requested level of care	Please provide an International Classification of Diseases (ICD-most recent version) code and description of the individual's primary diagnosis that is related to the need for the level of care requested.
2. Other active diagnoses related to the need for requested level of care	Please provide descriptions of other diagnoses that are currently under treatment or otherwise directly affect the individual's need for the requested level of care

Item # and Description	Explanation/Detailed Instructions

Part E	
Table I-Skilled Services	**These complex services require a physician's order and the skill 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. They cannot be performed by an untrained caregiver.** **For each space, fill in the number of days per week the individual receives the service (0-7). There must be a number entered in the space. Items listed under Rehabilitation and Extensive Services may overlap.**
1. Tracheotomy care-all or part of the day	If the individual has a tracheotomy and any care is provided by the staff for that trach, at least once a day, it counts as ONE day. (e.g., if you provide trach care at least once a day on every day of the week, enter a 7.)
2. Suctioning-Not including routine oral-pharyngeal suctioning, at least once a day	This is deep endo-tracheal suctioning. It does not include suctioning saliva from the mouth or nasal passages (e.g., if you have to suction the trachea at least once a day on every day of the week, enter a 7. If you only have to suction 3 days a week, enter a 3).
3. IV Therapy: Peripheral or Central (not including self-administration)	Fill in the number of days per week the individual will be receiving IV therapy or IV medications (0-7). This number should be a zero (0) unless the individual will continue to receive the IV therapy in the nursing facility, medical day care, waiver, or PACE program. If the IV therapy is only given in the hospital and will be discontinued upon to discharge, or if the individual is able to administer the IV therapy himself/herself, enter a zero (0).
4. IM/SC Injections: At least once a day (not including self-administration)	If the individual receives an injection, ordered by the physician and given by the staff and is unable to administer the injection himself/herself, fill in the number of days per week at least one injection is given (0-7). If the individual will not be receiving the injection in the nursing facility, medical day care, waiver, or PACE program, or is able to administer the injection himself/herself, enter a zero (0).

Item # and Description	Explanation/Detailed Instructions
5. Pressure Ulcer: Stage 3 or Stage 4 **AND** one or more skin treatments (including pressure relieving bed, nutrition or hydration intervention, application of dressing and/or medication)	**Note**: "Stage 1" means demarcated, reddened area of the skin characterized by unbroken skin surface which feels warm, blanches to the touch and does not fade within 30 minutes after pressure has been removed. "Stage 2" means reddened area with a skin break involving partial thickness ulceration of the epidermis and a portion of the dermis with superficial circulatory and tissue damage. There is removal of an area of skin. Drainage is usually serous fluid. "Stage 3" means full thickness loss of skin which may or may not include the subcutaneous tissue level, produces serosanguinous drainage and is surrounded by inflamed skin. "Stage 4" means full thickness loss of skin with invasion of deeper tissue such as fascia, muscle, tendon, or bone; this consists of a deep, broken area with necrosis and white or gray soft tissue. Drainage is usually purulent and foul-smelling secondary to infection. The surrounding area may be inflamed and warm to touch. This stage may also include "tunneling" in which the area forms deep, narrow tunnels into the surrounding tissue. If the individual has a Stage 3 or Stage 4 pressure ulcer (an ulcer caused by pressure, not trauma), regardless of how many other pressure ulcers they might have AND receives an aseptic treatment to the Stage 3 or Stage 4 pressure ulcer area, ordered by a physician, fill in the number of days the treatment is given per week (0-7). If the individual has a Stage 1 or Stage 2 pressure ulcer and no Stage 3 or Stage 4 ulcer, enter a zero (0). If the individual does not receive a treatment ordered by the physician for a pressure ulcer, enter a zero (0). If the individual has a Stage 3 or Stage 4 pressure ulcer and is on a pressure-relieving bed (e.g., Clinitron or other) enter a seven (7). This does not include routine eggcrate or air mattresses. "Nutrition or hydration intervention" means tube feedings, IVs or special feedings recommended by a dietician and ordered by a physician, several times a day. These special feedings must be administered or monitored by a nurse or physician. (This does NOT mean routine oral supplements, such as Ensure.) "Treatment" means application of an aseptic dressing and/or medication to the pressure ulcer. This treatment must be ordered by a physician.
6. Wound Care: Surgical wounds or open lesions with one or more skin treatments per day	"Wound care" means any other kind of open wound that isn't a pressure ulcer. This includes but is not limited to non-healing surgical wounds, stasis ulcers, severe open cellulites, etc. This does NOT include minor skin rashes for which a topical treatment is ordered. "Skin treatments" means application of an aseptic dressing and/or medication to a wound skin area. The treatment must be ordered by a physician. Fill in the number of days per week the individual will be receiving treatment (0-7). If the individual is not receiving treatment for the wound area, enter a zero (0).
7. Tube Feedings: 51% or more of total calories or 500cc or more of fluid intake via tube	Tube feedings are feedings ordered by a physician and administered by NG (nasogastric)/G (gastric) tube. The individual must receive at least 51% of his/her total daily caloric intake or 500 cc of fluid intake daily in order for it to count as a day. Fill in the number of days per week the individual receives tube feedings as defined above (0-7).

Item # and Description	Explanation/Detailed Instructions
8. Ventilator care: Individual would be on a ventilator all or part of the day.	Fill in the number of days per week the individual would be on a ventilator all or part of the day (0-7).
9 Complex Respiratory Services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	The individual is receiving respiratory services that require the supervision or direct care of a respiratory therapist, physical therapist or registered nurse. (e.g., an individual with frequent (more than once a week) bouts of respiratory failure or an individual on oxygen that is more than 2-3L/min maintenance, where monitoring, such as frequent blood gas measurements, by a health care professional is required). It includes, but is not limited to, an individual receiving IPPB or chest PT or nebulizer treatments requiring monitoring (not hand-held nebulizers). It includes but is not limited to individuals who require specialized instruction to be able to function within their own respiratory limitations (i.e., utilizing necessary equipment or receiving chest PT). Enter the number of days per week the individual will be receiving complex respiratory treatment (0-7).
10.Parenteral Feeding or TPN: Necessary for providing main source of nutrition	The individual receives nutrients into the blood stream intravenously. The individual has a central catheter, a PICC line or another type of peripheral line through which they are receiving necessary nutrition. Fill in the number of days the individual is receiving the feeding (0-7).
11. Catheter Care: Not routine Foley	Fill in the number of days per week the individual with a urinary catheter (Foley, suprapubic) requires more care than just routine emptying, cleansing or changing. The catheter would require, but is not limited to, frequent changes (once a week or more), irrigations at least two (2) times a week.
12. Ostomy Care: New	The individual has a new ostomy (less than 60 days old) and requires treatment to the stoma (non-healing or infected) with dressing and/or medication. The individual with a new ostomy needs assistance with changing the bag, cleansing and monitoring of the healing of the stoma; is not able to care for ostomy without assistance of another person. Fill in the number of days per week ostomy care is given (0-7). If the ostomy is not new (i.e., over 60 days old), it will be addressed under continence in Part E.
13. Monitor Machine: (for example, bradycardia or apnea)	The individual is on a monitor that will be used in the nursing facility, medical day care, waiver, or PACE setting, not in the acute hospital setting. This does not include blood pressure monitoring, blood glucose monitoring, or CPAP at night. If the monitor is used only in the hospital setting and will be discontinued upon discharge, enter a zero (0). Fill in the number of days the monitor is used per week (0-7).
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime, perform self care or treatment skills for recently diagnosed condition (**must be ordered by a physician**)	This is a program ordered by the physician to teach the individual or the family how to manage the treatment regime, perform self-care or treatment skills for a recently diagnosed condition (e.g., teaching self-injection and blood glucose monitoring for a newly diagnosed diabetic). Fill in the number of days per week during which there is formal teaching or training (0-7).

Item # and Description	Explanation/Detailed Instructions

Table II- Rehabilitation	PT, OT and Speech Therapy Services. Must be current, ongoing treatment and must be necessary to restore function. Services must be provided or overseen by a licensed physical, speech, or occupational therapist.
15. Extensive training for ADLs (restoration, not maintenance) including walking, transferring, swallowing, eating, dressing and grooming	This is restoration, not maintenance. The therapy is restoring one or more ADLs (walking, transferring, swallowing, eating, dressing or grooming) to previous improved level of independence. Fill in the number of days per week the individual receives therapy services (0-7).
16. Amputation/Prosthesis Training: For new amputee	The individual receives therapy for a new amputation or training by a therapist in the use of a new prosthesis. Fill in the number of days per week the individual receives this therapy (0-7).
17. Communication Training: For new diagnosis affecting the ability to communicate	This is an individual who has lost the ability to communicate due to a recent illness or injury (e.g., stroke, accident). The individual receives therapy by a speech therapist or occupational therapist to train/re-train him/her to speak again or communicate in some way. Fill in the number of days per week the individual receives the therapy (0-7).
18. Bowel and Bladder Retraining Program: not including routine toileting schedule	The individual WAS continent prior to an acute illness or injury and now is NOT continent. Training is ordered by the physician and is provided by and monitored closely by a professional therapist or nurse to restore continence as much as is possible. This does not include routine toileting schedules, reminders, or the need to take the individual to the restroom. Fill in the number of days per week this training occurs (0-7).

Part F	
Cognitive Status	
1. Orientation to Person: Individual is able to state his/her own name	If when asked his/her own name, the individual can state his/her name, check YES. If the individual cannot speak, but it is obvious by facial expression or body language that he/she knows his/her own name, check YES. Otherwise check NO.
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.	If the individual does or COULD administer his/her medications, whether or not it is allowed, check YES. Otherwise check NO.
3. Telephone Utilization: Able to acquire telephone numbers, place calls and receive calls without the assistance or supervision of another person	If the individual could make a phone call by himself/herself without the assistance of another person and could dial 911 in case of an emergency, check YES. Otherwise check NO. If the individual can make a phone call but cannot effectively communicate due to a language barrier, check YES.
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	If the individual COULD handle all of his/her own financial affairs without assistance, whether or not it is allowed, check YES. Otherwise check NO.
5. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, laundry and straightening up with the assistance or supervision of another person	If the individual COULD do their own laundry, wash dishes, dust and straighten up the house or apartment, whether or not it is allowed, check YES. If they need help maintaining their house or apartment, check NO.

Item # and Description	Explanation/Detailed Instructions
6. Brief Interview of Mental Status (BIMS). Was the examiner able to administer a complete BIMS?	The Brief Interview of Mental Status (BIMS) is an exam designed to determine an individual's attention, orientation, and ability to register and recall new information. The interview consists of three components, for a total of 15 points. You should cover all components. The interview must be conducted in a language in which the individual is fluent. Was the examiner able to administer the complete BIMS? Check YES or NO. Check YES only if the entire interview was complete. If YES, enter the score. If NO, check the closest reason why it was not given. Hearing loss-cannot hear the questions Applicant is rarely/never understood Language Barrier-no interpreter available Refused-the individual refused to take the exam Other-please briefly note the reason for non-completion If the complete interview could not be administered, yet you believe that the portion completed is relevant to the individual's need for services, you may submit a copy of the partially completed interview. Also, if an alternative test was administered as well, you may submit the results of that test for consideration, either in the iEXCHANGE notes or as an attachment to a faxed 3871B. **Please do not enter the results of other cognitive assessments in the area of the 3871B reserved for the BIMS results, as this may result in the application being erroneously denied.**
7. Wanders (several times a day) Moves with no rational purpose or orientation, seemingly oblivious to needs or safety	Behavior must be a consistent pattern, not just a one time issue. If the individual is confused and wanders with no purpose two or more times a day, check YES. Otherwise check NO.
8. Hallucinations or Delusions (at least weekly) Seeing or hearing non-existent objects or people, or a persistent false, psychotic belief regarding the self or other people or objects outside of self	Behavior must be a consistent pattern, not just a one time issue. If the individual has hallucinations or delusions (e.g., talks to people who are deceased, sees animals on the floor when there are none, or believes that they are someone they are not, such as the Queen of England) at least once a week, check YES. Otherwise check NO.
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	Behavior must be a consistent pattern, not just a one time issue. If the individual is aggressive or physically or verbally abusive toward other people two or more times a week, check YES. Otherwise check NO.

Item # and Description	Explanation/Detailed Instructions
10. Disruptive/Socially Inappropriate Behavior (several times a week): Interferes with the activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behaviors, disrobing in public, smearing or throwing feces, hoarding, rummaging through others' belongings, constantly demanding attention, urinating in inappropriate places	Behavior must be a consistent pattern, not just a one time issue. If the individual exhibits inappropriate behavior more than two (2) times a week, check YES. Otherwise check NO.
11.Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self; biting, scratching, picking behaviors, putting inappropriate objects into any body cavity (including ear, mouth or nose), head slapping or banging	Behavior must be a consistent pattern, not just a one time issue. If the individual exhibits any form of self-injurious behavior more than two (2) times a month, check YES. Otherwise check NO.
12. Hearing Impaired even with the use of a hearing aid: Difficulty hearing when not in a quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice, or totally deaf	If the individual cannot hear with just a moderately raised voice or radio/TV volume, check YES. Otherwise check NO. If the individual can hear with the assistance of a hearing aid, check NO.
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	If the individual cannot see to read or watch TV, even with glasses on, check YES. Otherwise, check NO. If the individual can see enough to read or watch TV with glasses on, check NO.
14. Self-expression: Unable to express information and make self understood using any means (with the exception of a language barrier)	If the individual cannot express his/her own needs in any way, check YES. Otherwise, check NO. If the individual cannot express their needs because you can't understand their language, and there is no interpreter, check NO.

Item # and Description	Explanation/Detailed Instructions

Functional Status	
15. Mobility: Purposeful mobility with or without assistive devices	If the individual needs no assistance in getting around the facility once he/she is up on his/her feet or in the wheelchair (e.g., once up, he/she is then able to move about by himself/herself), enter a zero (0). If the individual just needs some verbal encouragement or supervision/guarding for balance, to begin walking or wheeling wheelchair, enter a one (1). If the individual requires hands-on physical assistance (e.g., you need to help get the walker or wheelchair going and he/she needs some help to move about the facility, enter a two (2). If the individual can help a little bit, but requires a lot of assistance; really couldn't move about the facility without physical assistance of one or two people, enter a three (3). If the individual cannot propel himself/herself around the facility at all; someone needs to push him/her in a wheelchair or geri-chair, enter a four (4).
16. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also transferring to and from the toilet and/or shower	If the individual can transfer himself/herself to and from the bed, chair, toilet or shower independently without any assistance, enter a zero (0). If the individual can move himself/herself, but WON'T move unless you tell him/her to, or just needs someone to stand by to give moral support or supervision/guarding for balance, enter a one (1). If the individual needs limited physical assistance getting to and from the bed, chair, toilet or shower; you just have to hold on to him/her during transfer to make sure balance isn't lost, but the individual is doing most of the work, or can move from bed to chair but not from chair to bed, enter a one (2). If the individual needs physical extensive assistance to move to and from the bed, chair, toilet or shower (two-handed assistance or more than one person to assist) and couldn't accomplish the transfer without help, enter a three (3). If the individual cannot help with the transfer at all; needs lifting to get to and from bed, chair, toilet or shower, enter a four (4).
17. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair or face	If the individual can bathe himself/herself and take care of all cleansing needs, enter a zero (0). If the individual can wash and dry himself/herself but just needs encouragement or supervision to get started or to finish, enter a one (1). If the individual requires some hands on assistance with getting bathed properly, but can help quite a bit during the process, enter a two (2). If the individual requires extensive physical assistance with bathing; might be able to wash own face and hands, but nothing else. Individual would never be able to bathe properly without someone else doing most of the work, enter a three (3). If the individual cannot bathe themselves at all; requires total care, enter a four (4).
18. Dressing: The act of laying out clothes, putting on and removing clothes, fastening of clothing and footwear, including prosthesis, orthotics belts and pullovers	If the individual can prepare clothing for the day and dress himself/herself completely without the assistance of another person, enter a zero (0). If the individual can dress himself/herself but requires some verbal encouragement or supervision to be sure he/she dresses completely and appropriately or needs clothing to be laid out, enter a one (1).

Item # and Description	Explanation/Detailed Instructions
	If the individual requires a limited amount of physical assistance from another person, but can assist with the process (e.g., can dress self, but needs assistance with buttoning buttons or tying laces), enter a two (2). If the individual requires more extensive physical assistance, help with more than half of the dressing process of getting dressed or undressed (e.g., must be assisted to put on pants, shirt or dress), enter a three (3). If the individual cannot dress himself/herself at all and must be dressed or undressed by another person, enter a four (4).
19. Eating: The process of putting foods and fluids into the digestive system (including tube feedings)	If the individual can feed himself/herself without any assistance other than setting tray up or cutting up food, enter a zero (0). If the individual can feed himself/herself with just reminders to keep eating or some encouragement or supervision, enter a one (1). If the individual requires hands-on physical assistance (e.g., may start eating but needs help finishing the meal by actually feeding him/her the remainder of meal), enter a two (2). If the individual requires physical assistance from another person for most of the meal (e.g., might be able to drink from a cup, but requires feeding most of the meal), enter a three (3). If the individual requires feeding totally by another person; would not eat if another person did not feed him/her, OR the individual is tube fed, enter a four (4).
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 #16)**	If the individual can manage his/her own toileting hygiene, including wiping, flushing, adjusting clothes or management of an ostomy or catheter, enter a zero (0). If the individual can manage their toileting hygiene as above with only verbal cueing or encouragement or requires supervision to prevent injury, enter a one (1). If the individual requires some assistance with toileting hygiene (e.g., can wipe and flush but needs help with adjusting clothing), enter a two (2). If the individual requires quite a bit of physical assistance with toileting hygiene and can only assist a little bit (e.g., can wipe self, but cannot do anything else), enter a three (3). If the individual cannot manage own toileting hygiene or has an ostomy or catheter and cannot manage the care of it and someone else must do everything for him/her, enter a four (4). This does NOT include transferring to or from toilet. Transferring to and from toilet is addressed in "Transferring" under Functional Ability, Section E., above.
21. Bladder Continence: Ability to voluntarily control the release of urine from the bladder	If the individual is generally continent of urine or may have 1-2 accidents a week, has a catheter and can manage the care of it without assistance, or is able to ask to go to the bathroom prior to an accident, enter a zero (0). If the individual is totally incontinent of urine or has accidents 3 or more times a week, or has an ostomy that requires care by another person or has an indwelling catheter, suprapubic tube or Texas catheter or is only continent because they are maintained on a strict toileting schedule, enter a one (1).

Item # and Description	Explanation/Detailed Instructions
22. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel	If the individual is continent of stool, or has an occasional accident (once or twice a week), or has an ostomy he/she can care for without assistance from another person, enter a zero (0). If the individual is totally incontinent of stool, has accidents 3 or more times a week, cannot request to go to the bathroom or is only continent because of a strict toileting schedule, enter a one (1). If the individual has an ostomy or catheter that must be cared for by another person, enter a one (1).

Part G	
1. Signature of Person Completing Form	Signature of person completing the 3871B. This is usually a nurse or social worker.
Date	Date of form completion
Printed Name	Print name clearly and include professional degree (e.g., MD, RN)
2. Signature of Health Care Professional	In all cases, except the waiver programs and continued stay review for medical day care, a physician or nurse practitioner must sign this field. In the waiver programs and continued stay review for medical day care, a registered nurse may sign the form.
Date	Date health care professional signed the form
Printed Name	Print name clearly and include professional degree (e.g., MD, RN)

HEALTHCHOICE

MCO HEALTHCHOICE DISENROLLMENT FORM

(LONG TERM CARE)

INSTRUCTIONS FOR MCOS

1. The MCO representative should complete this form when the recipient has arrived at the 31st day of an MCO authorized and medically approved Nursing Facility stay.

2. All sections of the form must be completed by the MCO representative who will be the contact for DHMH. The nine-digit MCO provider number must be placed in the appropriate box.

3. If the recipient was admitted to the facility prior to being enrolled into an MCO, the Long Term Care Facility can send or fax the approved 3871 or 257 directly to the HealthChoice Long Term Care Disenrollment Unit.

4. Disenrollment from the MCO will be processed within 3-5 days of receipt of the form by the Department. After the disenrollment is entered into MMIS, the HealthChoice Disenrollment form showing the disenrollment date will be returned to the MCO.

Mail or fax forms to:

HealthChoice Long Term Care Disenrollment Unit
DHMH
201 W. Preston Street
Room L9
Baltimore, Maryland 21201
Phone: 410-767-5321
Fax: 410-333-7141

Note: All data is subject to confirmation by the Department through inspection of DHMH form 3871 or form 257 or other documentation. Please attach the Utilization Control Agent (Delmarva) certification of medical eligibility for LTCF services (from the 3871 or 257).

HEALTHCHOICE DISENROLLMENT FORM
(LONG TERM CARE)

Recipient M.A. ID:	Social Security Number:	DOB: Month/Day/Year
Last Name:	First Name:	M.I. Sex:
MCO Provider Name:	MCO Provider No:	

Long Term Care Facility Information:

Name: _____

Address: _____

Telephone Number: _____

Admission Date: _____

Anticipated Discharge Date, if any: _____

MCO Official Representative: _____ Date: _____

Title: _____ Phone: _____

Disenrollment Date: _____

(to be determined by Department)

Please attach the Utilization Control Agent (Delmarva Foundation) certification of medical eligibility for LTC services (from the DHMH 3871)

Send or fax to: HealthChoice Long Term Care
Disenrollment Unit
DHMH
201 W. Preston St., Rm L-9
Baltimore, MD 21201
Phone: 410-767-5321
Fax: 410-333-7141

DHMH INTERNAL USE ONLY

Completed by DHMH: _____

Initials: _____

Rev. 5/1/11

REFERENCES & RESOURCES

Maryland Medical Assistance Web Services/eMedicaid

For more information on how to:

- Enroll as a Medicaid provider
- Verify recipient eligibility
- Look-up a claim

https://encrypt.emdhealthchoice.org/emedicaid/

Utilization Control Agent (Delmarva)/Medical Assistance Long-Term Care Resources

For more information on the following resources:

- iExchange
  http://dhmh.dfmc.org/iEXCHANGE
- Level of Care forms (e.g. 3871B, BIMS)
- DHMH Forms (e.g. DHMH 257, DHMH 4345)
- and more!

http://dhmh.dfmc.org/longTermCare

MARYLAND MEDICAL ASSISTANCE CONTACT INFORMATION FOR PROVIDERS

For provider questions regarding Medical Assistance, please contact the appropriate staff listed:

Medical Assistance Problem Resolution Division	
LTC-UB04 claim/billing issues	**Medical Assistance Problem Resolution Division, Institutional Services (MAPR-Inst)** Gloria Williams, Supervisor (410) 767-5457
Long-term care span issues	**Medical Assistance Problem Resolution Division, Long Term Care (MAPR-LTC)** Christina Allen, Supervisor (410) 767-8699 Callen@dhmh.state.md.us
Management	**Stacy Hromanik** Medical Assistance Problem Resolution Division Chief (410) 767-5361 HromanikS@dhmh.state.md.us
HOSPICE PROGRAM	
Hospice-related questions	**DHMH Hospice Program** Jeneffer Haslam Hospice Program Analyst (410) 767-1444 Jhaslam@dhmh.state.md.us
HEALTHCHOICE ENROLLMENT UNIT	
Disenrollment from MCO questions	**Long Term Care** Angela Powell Medical Care Program Associate Lead (410) 767-5321 PowellA@dhmh.state.md.us
Management	**Shirley Maas** Manager HealthChoice Enrollment Unit MaasS@dhmh.state.md.us

MARYLAND MEDICAL ASSISTANCE CONTACT INFORMATION FOR PROVIDERS

OFFICE OF SYSTEMS, OPERATIONS AND PHARMACY	
Provider Enrollment questions	**Provider Enrollment** (410) 767-5503
Pharmacy questions	**Pharmacy** 1-800-492-5231 option #3 (410) 767-5800 option #3
DEPARTMENT OF HUMAN RESOURCES/LONG TERM CARE	
Eligibility-related LTC questions	**Long Term Care Customer Line** 1-855-458-2273 1-855-4LT-CARE

BUREAU OF LONG TERM CARE ELIGIBILITY
EMPLOYEE ROSTER
910 Frederick Road
Catonsville, Maryland 21228

MAIN NUMBER: 410-455-7510 FAX NUMBER: 410-744-2432 or 410-744-2437
Customer Service (1) 855-458-2273

NAME	TITLE	UNIT	LOC.	PHONE#
Mazie Johnson	**Director**	**90**	**102**	**(410) 455 - 7511**
Angela Tallie	**Administrative Aide**	**90**	**203**	**(410) 455 -7517**
Tamara Cannida-Gunter	**Asst. Director**	**90**	**103**	**(410) 455 - 7515**
CLERICAL UNIT Londa Rossette	**SUPERVISOR**	**73**	**101**	**(410) 455-7516**
Miesha Marvin	Office Service Clerk	73	235	(410) 455 -7595
Rosetta Randall	Office Service Clerk	73	210	(410) 455-7564
Tavonia Lancaster	Office Service Clerk	73	201	(410) 455-7513
Brenda Bailey	Office Service Clerk	73	202	(410) 455-7514

TRIANGE UNIT Brenda McIlwain	**SUPERVISOR**	**91**	**104**	**(410) 455-7512**
Lori Kosecki	Asst. Supervisor	71	206	(410) 455-7560
Lynette Scott	Case Manager	71	206	(410) 455-7566
Sandra Simmons	Case Manager	71	209	(410) 455-7568
VACANT	Case Manager	71		
VACANT	Case Manager	71		
VACANT	Case Manager	71		
VACANT	Case Manager	71		
PROCESSING UNIT LaShona Rahman	**SUPERVISOR**	**91**	**105**	**(410) 455-7598**
Oscar Snow	Assistant Supervisor	70	213	(410) 455-7582
Mary Floyd	Case Manager	70	219	(410) 455—7573
Natasha Boney	Case Manager	70	216	(410) 455-7570
Adine Oney	Case Manager	70	218	(410) 455- 7572
Angela Brown-Burgess	Case Manager	70	220	(410) 455-7574
VACANT	Case Manager	70		

VACANT	Case Manager	70		
VACANT	Case Manager	70		
CONTINUING UNIT Dorothy Bowers	**SUPERVISOR**	**91**	**122**	**410) 455-7596**
Jane Ferdinand	Assistant Supervisor	72	230	(410) 455-7587
Sharon Jones Cover, A – Finn, Z	Case Manager	72	232	(410) 455 - 7592
Jennifer Ellis Manis, A – Odonnell, Z,	Case Manager	72	225	(410) 455-7585
Barbara Williams Odorns, A – Rosebourgh, Z	Case Manager	72	2230	(410)455 -7590
Stephen Thomas Roseby, A – Stransnick, A	Case Manager	72	226	(410) 455-7586
Andrew Montillo Stratton, A – Wilgis, Z	Case Manager	72	231	(410) 455-7591
Shirley Bouges	Case Manager	72	211	(410) 455- 7565
CO PAY UNIT Torri Cheeks	**SUPERVISOR**	74	123	(410) 455-7597
Shelby Robertson	Assistant Supervisor	74	207	(410) 455-7561

Ingrid Gist	MA Co-Pay Case Manager, HCR Health Care Hyattsville	74		(301) 559-0300 Ext 159
Doris Underdue	MA Co-Pay Case Manager Manor Care, Ruxton	74		(410) 821-9600 Ext. 4173
Sheila Lawrence	MA Co-Pay Case – Manager, Manor Care, Ruxton	74		(410) 821-9600 Ext. 3026
Gabriel Mack	MA Co-Pay Case – Manager,St. Thomas Moore	74		(301) 864-2333 Ext. 1135
Patricia Eganey	MA Co-Pay Case– Manager, Future Care	74		(410) 766-7750
Aaron Johnson	MA Co-Pay Case– Manager, Fayette Health& Liberty Heights	74	208	(410) 455 - 7562 (410) 727-3947
Heather Lord	MA Co-Pay Case – Manager, Marley Neck	74		(410) 768-8200 ext.235 (410) 455-7593
Elisha Taylor	MA Co-Pay Case Manager, Forestville	74		(301) 736-0240 Ext. 122
Kimberly Zachary	MA Co-Pay Case– Manager, White Oak Senior Care	74		(301) 868-3600
VACANT		74		

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SPECIAL FUNCTIONS UNIT DeVonna Pea	**SUPERVISOR**	**73**		**(410) 767-7535**
Karen McKenzie	Office Service Clerk	73	259A	(410) 767-7748
Debra Bryant	Case Manager	73	259B	(410) 767-7739
Noreasa Mayfield	Case Manager	73	259C	(410) 767 - 7750
Terri Williams	Case Manager	73	259D	(410) 413-4113
VACANT		73		
Doretha Smith	Case Manager Genesis Cromwell CoPay	73		(410) 494-8567
VACANT	Case Manager Genesis Headquarters Co Pay	73		(410) 821-9600 Ext.3026
STATE TECH. ASST. UNIT VACANT	**SUPERVISOR**	**90**		
James Whitehead	Customer Service Specialist	90	205	(410) 455-7519

Albert James	Customer Service Specialist	90	204	(410) 455-7518
VACANT	Customer Service Specialist	90		

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