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

TO: DHS/LDSS/LHD Case Manager
District Office: _____
Address: _____
_____

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

Part I. Recipient Identification

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

Part II. Facility Identification

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

Part III. Recipient Under 21 Years Old

To be completed after ***one full calendar month*** in the facility.

This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on _____ / ___ / _____ if enrolled in an MCO. If not enrolled in an MCO date of admission _____/____/_____.

Part IV. Recipient Aged 21 Through 64

To be completed after ***the 30th consecutive day*** in the institution **or** after the ***60th cumulative day during a calendar year*** in an institution.

This certifies that this individual has been institutionalized in the above facility

[ ] For 30 consecutive days, effective _____
[ ] For 60 days during the calendar year, effective _____

Part V. Recipient 65 Years Old or Older

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

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

To be completed ***upon discharge from the facility***.
This certifies that this individual was ***discharged from the above facility*** on _____ to

[ ] Home _____
[ ] LTCF _____
[ ] Other _____

Facility Certification: Signature _____ Date _____ Phone _____

Administrative Services Organization Authorization:

Signature_____Date _____ Phone _____

OES 1000
White–Customer/Authorized Representative Copy Yellow-Long Term Care Facility Copy Pink-Case Record Copy

INSTRUCTIONS

Facility:

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

Administrative Services Organization:

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

Case Manager:

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

HealthChoice Enrollment Section:

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

Discharge Notification - To Be Completed By the Facility:

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

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

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