PT 6-07

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

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Living at Home Waiver Program Transmittal No. 12
Waiver for Older Adults Transmittal No. 17

September 8, 2006

To: Living at Home Waiver Providers of Attendant Care Services
Living at Home Waiver Providers of Nursing Supervision Services
Living at Home Waiver Case Managers

Waiver for Older Adults Providers of Personal Care Services
Waiver for Older Adults Providers of Nurse Monitoring Services
Waiver for Older Adults Case Managers

From: Mark A. Leeds, Director
Long Term Care and Community Support Services

Note: Please share the information in this transmittal with appropriate staff within your organization.

Re: Distribution of provider service forms for the Waiver for Older Adults and the Living at Home Waiver programs

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The Department of Health and Mental Hygiene and the Maryland Department of Aging (MDoA) have jointly developed standardized forms for providers of attendant care and nursing supervision in the Living at Home Waiver and personal care and nurse monitoring in the Waiver for Older Adults. DHMH and MDoA developed the forms to:

1. Enable providers to adequately document attendant care/personal care services; and
2. Create a uniform tool that would function for both waiver programs.

Effective **November 1, 2006**, providers who render services to people living at home must attach the new standardized forms to all timesheets in order to receive payment for their services. The waiver programs will return all incomplete or incorrect forms to the provider for revision. DHMH and MDoA will place the forms on their respective websites www.dhmh.state.md.us and www.mdoa.state.md.us. Paper versions of the forms will be available at all Area Agencies on Aging after October 15, 2006.

DHMH and MDoA will offer training for providers to learn how to complete the forms.

The training dates and locations are as follows:

Friday, September 29, 2006 10:00 a.m. – 1:00 p.m.	Executive Office Building Auditorium 101 Monroe Street Rockville, MD 20850
Tuesday, October 10, 2006 10:00 a.m. – 1:00 p.m.	The State Center Auditorium 300 West Preston Street Baltimore, Maryland 21201

If you would like to register for a provider training, please complete the attached registration form and return it to the mailing address or fax number listed on the form. You may also register by calling the telephone number listed on the registration form.

Please carefully review the attached forms, instructions and process. If you have any questions regarding the requirements or training registration, please contact:

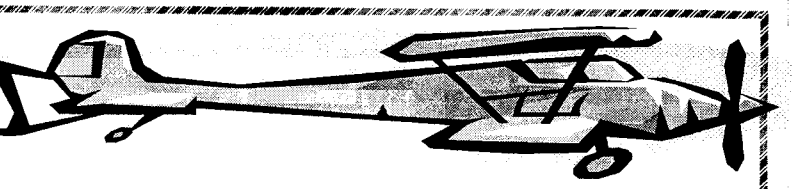
The Living at Home Waiver
Department of Health and Mental Hygiene
Dolle Brown, Provider Specialist
(410) 767-5285, or

The Waiver for Older Adults
Department of Health and Mental Hygiene
Kristin Jones, Waiver Coordinator
(410) 767-5220

Enclosures

cc: Maryland Department of Aging

IMPORTANT TRAINING ANNOUNCEMENT



The Department of Health and Mental Hygiene, Living at Home Waiver and The Maryland Department on Aging, Waiver for Older Adults will sponsor training for Nurse Monitoring, Personal Care and Attendant Care providers.

The training is scheduled from 10:00 a.m. until 1:00 p.m. on the following dates:

✓ **Friday, September 29, 2006** — Executive Office Building Auditorium
101 Monroe Street
Rockville, MD 20850

✓ **Tuesday, October 10, 2006** — The State Center Auditorium
300 West Preston Street
Baltimore, Maryland 21201

The training offers guidance on waiver program requirements that affect providers and participants including:

- How to Complete the Provider Service Reports
- Reportable Events Updates
- Interpreting Criminal Background Reports for Agency Providers
- Questions and Answers

✓ We highly recommend that you attend this essential training.

✓ Registration is limited and is offered on a first come, first serve basis.

*** Please register for this training no later than September 25, 2006**

For your convenience, we have attached a training registration form. If you have any questions, please call Della Brown at 410-767-5220

Thank you in advance for attending this very important training.

2006 PROVIDER TRAINING SCHEDULE

Each Session begins at 10:00 a.m. and will end by 1:00 p.m.

Session Name	Location	Date
Montgomery County	Executive Office Building Auditorium 101 Monroe Street Rockville, MD 20850	Friday, September 29, 2006
Baltimore Area	State Center Auditorium 300 West Preston Street Baltimore, MD 21201	Tuesday, October 10, 2006

You may register by phone, fax or mail.

- Call Della Brown at 410-767-5220
- Fax a completed registration form to Della Brown at 410-333-5213
- Mail a completed registration form to:

The Department of Health & Mental Hygiene
Office of Health Services
201 West Preston Street, Room 122 A
Baltimore, Maryland 21201 – 2399

2006 PROVIDER TRAINING REGISTRATION FORM

Please list each person attending the training

Name(s) _____

Address _____

_____

Email Address _____

Phone number _____

Please place a check in the box next to the session you wish to attend.

☐ Montgomery County, Executive Office Building, Friday, September 29, 2006

☐ Baltimore, State Center Auditorium, Tuesday, October 10, 2006

Please register for this training no later than September 25, 2006.

Medicaid Home and Community-Based Services
Waiver for Older Adults (WOA) and Living at Home Waiver (LAH)

Instructions and Process for Nurse Monitoring

Effective October 1, 2006

Part 1 – Instructions for Completing the Nurse Monitor Forms:

Participant Assessment - DHMH 4658 A (N – PA) – Completed by the nurse monitor during every visit to document the comprehensive evaluation of the participant's medical condition. The nurse monitor and participant sign this form. The nurse monitor must:

- Forward the original white copy of the DHMH 4658 A (N – PA) to the participant's case manager within 10 days of the assessment date.
- Keep the yellow copy of the DHMH 4658 A (N – PA)
- Give the pink copy of the DHMH 4658 A (N – PA) to the participant/representative

Caregiver Service Plan - DHMH 4658 B (N – CSP) – Completed by the nurse monitor during the initial visit with the caregiver and participant. Shows the services/tasks the caregiver is required to perform for the participant. The nurse monitor will revise the Caregiver Service Plan at least annually or as needed based on changes in the participant's condition. The nurse monitor signs this form. The nurse monitor must:

- Forward the original white copy of the DHMH 4658 B (N – CSP) to the participant's case manager.
- Keep the yellow copy of the DHMH 4658 B (N – CSP)
- Give the pink copy of the DHMH 4658 B (N – CSP) to the participant/representative.
- Give the goldenrod copy of the DHMH 4658 B (N – CSP) to the caregiver.

Caregiver Assessment DHMH 4658 C (N – CA) – Completed by the nurse monitor when observing and documenting the caregiver's ability to perform all tasks listed on the Caregiver Service Plan. The nurse monitor uses the Caregiver Assessment to evaluate the caregiver at each visit. If the participant uses multiple caregivers, the nurse must assess each caregiver according to program requirements. The nurse and caregiver sign this form. The nurse monitor must:

- Forward the original white copy of the DHMH 4658 C (N – CA) to the participant's case manager.
- Keep the yellow copy of the DHMH 4658 C (N – CA)
- Give the pink copy of the DHMH 4658 C (N – CA) to the participant/representative.
- Give the goldenrod copy of the DHMH 4658 C (N – CA) to the caregiver.

Nurse Monitor Timesheet DHMH 4658 D (N – TS) – Completed by the nurse monitor during each visit. Documents the date and time the nurse monitor rendered services. The nurse monitor and the participant or representative complete and sign the timesheet after every visit in the participant's residence. The nurse monitor must:

- Keep the yellow copy of the DHMH 4658 D (N – TS)
- Give the pink copy of the DHMH 4658 D (N – TS) to the participant/representative.
- **Carefully follow the payment instructions listed below:**

Medicaid Home and Community-Based Services
Waiver for Older Adults (WOA) and Living at Home Waiver (LAH)

Instructions and Process for Nurse Monitoring

Effective October 1, 2006

Waiver for Older Adults

- **Agency** nurse monitors submit the original white signed copy of the DHMH 4658 D (N – TS) time sheet and WOA – CMS 1500 billing form to your agency. Agencies forward the white copy of the DHMH 4658 D (N – TS) time sheet and the white copy of the WOA – CMS 1500 billing form to MDoA for payment. Agencies should copy the DHMH 4658 D time sheet and WOA – CMS 1500 billing form for their records.

Living at Home Waiver

- **Independent** nurse monitors submit the original white signed copy of the DHMH 4658 D (N – TS) time sheet and the original white signed copy of the LAH – DHMH 4660 billing form to DHMH for payment. Nurse monitors keep the yellow copy of the 4658 D (N – TS) time sheet and the yellow copy of the DHMH 4660 billing form.

- **Agency** nurse monitors submit the original white signed copy of the DHMH 4658 D (N – TS) time sheet and the original white signed copy of the LAH – DHMH 4660 billing form to their agency. The agency forwards the white copy of the DHMH 4658 D (N – TS) time sheet and the white copy of the LAH – DHMH 4660 billing form to DHMH for payment. Agencies should copy the DHMH 4659 (C-TS) time sheet and LAH – DHMH 4660 billing form for their records.

Part 2 - Nurse Monitoring Process:

1. Nurse monitors shall provide services in the participant's residence with the caregiver present in order to assess the caregiver's work and the participant's health status.

2. Nurse monitors must abide by the number of visits identified in the participant's Waiver Plan of Care/Service. If, in the nurse's professional judgment, the participant needs additional monitoring, the nurse monitor must contact the participant's case manager for approval before providing extra visits.

3. If a service change is for a Living a Home waiver participant, the case manager must get DHMH LAH staff approval prior to service delivery.

4. **Failure to obtain prior approval may result in denied payments.**

Medicaid Home and Community-Based Services Waiver Program
Participant Assessment (use only for people at home)

Participant Name: _____

GENERAL HEALTH
Temperature: _____ *Pulse:* _____ *Respiration:* _____ *Blood Pressure:* _____
Current Weight: _____ ☐gain ☐ loss *Target weight:* _____
Diet/Nutrition: ☐Regular ☐Low Salt ☐Puree/Chopped ☐Diabetic/No Concentrated Sweets ☐Other_____
Fluid: ☐Unlimited ☐ Restricted ☐ Amount: _____
Identify any changes over past month:
☐Diagnosis ☐Medications ☐Health Status ☐Hospitalization ☐Falls ☐ Incidents ☐ Other
Describe change:_____
_____

RESPIRATORY
☐ Within Normal Limits
☐ Cough ☐Wheezing ☐ Other: _____
When is the person noticeably short of breath?
☐Never short of breath
☐When walking > than 20 ft. or climbing stairs
☐With moderate exertion (e.g. dressing, using commode, walking <20ft.)
☐With minimal exertion (eating, talking)
☐At rest (during day/ night)
Respiratory treatments utilized at home:
☐ Oxygen (intermittent or continuous)
☐ Aerosol or nebulizer treatments
☐ Ventilator (intermittent or continuous)
☐ CPAP or BIPAP
☐ None

PAIN/DISCOMFORT
Pain frequency:
☐No pain or pain does not interfere with movement
☐Less often than daily
☐Daily, but not constant
☐All the time
Site(s): _____
Intensity ☐High ☐ Medium ☐Low
☐ Person is experiencing pain that is not easily relieved, occurs at least daily, and effects the ability to sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity
Cause (if known):_____
*Treatment:*_____

GENITOURINARY STATUS
☐Catheter ☐ Content _____
☐ Urine Frequency _____
☐Pain/Burning ☐ Discharge
☐ Distention/Retention
☐Hesitancy ☐ Hematuria
☐ Other: _____
☐Person has been treated for a Urinary Tract Infection over the past month
☐ Normal

CARDIOVASCULAR
☐ BP and Pulse within normal limits
Rhythm ☐ Regular ☐ Irregular
Edema:
RUE: ☐ Non-pitting ☐ Pitting
LUE: ☐ Non-pitting ☐ Pitting
RLE: ☐ Non-pitting ☐ Pitting
LLE: ☐ Non-pitting ☐ Pitting
*Other:*_____

GASTROINTESTINAL STATUS
Bowels: frequency _____
☐Diarrhea ☐Constipation ☐Nausea ☐ Vomiting
☐ Swallowing issues: _____
☐ Pain:_____ ☐abdominal ☐ epigastric
☐ Anorexia
☐ Other: _____
Bowel incontinence frequency:
☐ Very rarely or never incontinent of bowel
☐ Less than once per week
☐ One to three times per week
☐ Four to six times per week
☐ On a daily basis
☐ More than once daily
☐ Person has ostomy for bowel elimination

NEUROLOGICAL
Cognitive functioning
☐ Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently
☐ Requires prompting (cueing, repetition, reminders)only under stressful or unfamiliar situations
☐ Requires assistance, direction in specific situation, requires low stimulus environment due to distractibility
☐ Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall more than half the time.
☐ Totally dependent due to coma or delirium
Speech: ☐ Clear and understandable ☐ Slurred ☐ Garbled ☐Aphasic ☐ Unable to speak
Pupils: ☐ Equal ☐ Unequal
Movements: ☐Coordinated ☐ Uncoordinated
Extremities:
Right upper ☐ Strong ☐ Weak ☐Tremors ☐No movement
Left upper ☐ Strong ☐ Weak ☐Tremors ☐No movement
Right lower ☐ Strong ☐ Weak ☐Tremors ☐No movement
Left lower ☐ Strong ☐ Weak ☐Tremors ☐No movement

Medicaid Home and Community-Based Services Waiver Program
Participant Assessment (use only for people at home)

SENSORY

Vision with corrective lenses if applicable

☐ Normal vision in most situations; can see medication labels, newsprint
☐ Partially impaired; can't see medication labels, but can see objects in path; can count fingers at arms length
☐ Severely impaired; cannot locate objects without hearing or touching or person non-responsive

Hearing with corrective device if applicable

☐ Normal hearing in most situations, can hear normal conversational tone
☐ Partially impaired; can't hear normal conversational tone
☐ Severely impaired; cannot hear even with an elevated tone

PSYCHOSOCIAL

Behaviors reported or observed

☐ Indecisiveness
☐ Diminished interest in most activities
☐ Sleep disturbances
☐ Recent change in appetite or weight
☐ Agitation
☐ A suicide attempt
☐ None of the above behaviors observed or reported

Is this person receiving psychological counseling?

☐ Yes
☐ No

MUSCULOSKELETAL

☐ Within Normal limits
☐ Unsteady Gait
☐ Poor endurance
☐ Altered Balance
☐ Weakness
☐ Other _____
☐ Deformity
☐ Contracture
☐ Impaired ROM
☐ Poor coordination

MENTAL HEALTH

☐ Angry ☐ Depressed ☐ Uncooperative ☐ Hostile
☐ Panic ☐ Flat affect ☐ Anxious ☐ Phobia
☐ Agitated ☐ Paranoid ☐ Obsessive/Compulsive
☐ Tics Spasms ☐ Mood swings
☐ Depressive feeling reported or observed
☐ None of above

SKIN

Color ☐ Normal ☐ Pale ☐ Red ☐ Irritation ☐ Rash
Skin Intact ☐ Yes ☐ No (if no, complete next section)

Pressure Ulcer Stages	Number of Pressure Ulcers				
Stage 1: Redness of intact skin; warmth, edema, hardness, or discolored skin may be indicators	0	1	2	3	4 or more
Stage 2: Partial thickness skin loss of epidermis and/or dermis. The ulcer is superficial and appears as an abrasion, blister, or shallow crater.					
Stage 3: Full thickness skin loss; damage or necrosis of subcutaneous tissue; deep crater					
Stage 4: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures					
Location of ulcers:					

Surgical or other types of wounds (describe location, size and nature of wound) _____

Medicaid Home and Community-Based Services Waiver Program
Participant Assessment (use only for people at home)

Mobility and Transfers:
☐ Dependent ☐ Independent ☐ Assist ☐ Stand-by
☐ One person ☐ Two person assist with transfer
Uses _____ to aid in ambulating.
Uses _____ to aid in transfer.

Bathing:
☐ Dependent ☐ Independent ☐ Assist ☐ Cue
☐ Uses transfer bench or shower chair

Personal Hygiene: hair, nails, skin, oral care
☐ Dependent ☐ Independent ☐ Assist ☐ Cue

Toileting: bladder, bowel routine, ability to access toilet
☐ Dependent ☐ Independent ☐ Assist ☐ Cue
☐ Incontinent bowel
☐ Incontinent bladder

Dressing:
☐ Dependent ☐ Independent ☐ Assist ☐ Cue

Eating and Drinking:
☐ Dependent ☐ Independent ☐ Assist ☐ Cue

HEALTH MAINTENANCE NEEDS
☐ Reinforce diet education
☐ Supervision of blood sugar monitoring
☐ Routine care of prosthetic/orthotic device
☐ Education on medical equipment use or maintenance
☐ Referral to physician
☐ Other health education needed
☐ Other_____
Notes:_____
_____
_____

GENERAL PHYSICAL CONDITION
☐ improving ☐ stable ☐ deteriorating
☐ Other: _____

MEDICATION MANAGEMENT
Current Medications (attach additional pages if necessary)

Medication	Dose	Freq.	Physician	Purpose

☐ Able to independently take the correct medications at the correct times
☐ Able to take medications at the correct time if:
-individual doses are prepared in advance by another person
-given daily reminders
☐ Unable to take medication unless administered by someone else
☐ No medications prescribed
☐ Other_____

NOTES:
_____
_____
_____
_____
_____
_____
_____

Nurse Monitor visit: ☐ **initial** ☐ **monthly** ☐ **45 day** ☐ **3 month** ☐ **4 month** ☐ **annual assessment**

Activities of Visit: ☐ Developed Caregiver Support Plan ☐ Provided Information and Training to Caregiver
☐ Reviewed Caregiver Support Plan ☐ Assessed/Monitored Caregiver
☐ Assessed/Monitored Participant

Caregiver Names (Please list all caregivers in this section)

By signing below, both the participant and nurse certify that services were delivered.

RN Name (Print):

RN Signature: Date:

Please send the white copy of the signed form to the case manager within 10 days of completing the participant's assessment.

Participant Signature: Date

Immediately report suspected abuse, neglect, and exploitation to Adult Protective Services at 1-800-917-7383.
Immediately contact the case manager to report health and safety concerns.

Medicaid Home and Community-Based Services Waiver Programs
Caregiver Service Plan (use only for people at home)

Participant:	Date of Plan:
Nurse Monitor:	**Signature:**

The Nurse Monitor - Develop a Caregiver Service Plan (CSP) that documents services or tasks the caregivers are required to perform for the participant. The nurse monitor must: ask the case manager for a copy of the Plan of Care/Plan of Service (POC/POS), use the POC/POS with appropriate input from the participant and caregivers to help develop the CSP, ensure that caregivers understand all CSP tasks and expectations, complete a new CSP when adding services or tasks, add additional pages as needed and give a CSP copy to both case manager and caregivers. Immediately contact the case manager and other appropriate professionals to report suspected health and safety concerns. (Adult Protective Services at 1-800-917-7383, emergency Personnel, Police, etc.)

Task	Frequency	Tasks: Please note all special instructions and precautions	Note and Comments
Personal Hygiene (i.e. bathing, hair, oral, nail, and skin care)			
Toileting (i.e. bladder, bowel, and bed pan routines; movement to/from bathroom)			

Medicaid Home and Community-Based Services Waiver Programs
Caregiver Service Plan (use only for people at home)

Participant Name:			Date of Plan:
Task	**Frequency**	**Tasks: Please note all special instructions and precautions**	**Note and Comments**
Dressing & Changing Clothes			
Mobility & Transfers			
Eating & Drinking			
Medications		(Place a check next to each required item) Medication reminder___ Assist to self-medicate___ CMA ____MAR____ (Medication Admin. Record)	
Light Housekeeping			
Errands			
Other			

Medicaid Home and Community-Based Services Waiver Programs
Caregiver Assessment

Participant Name:_____ **Service Date:** _____

Nurse Monitor - Use the Caregiver Assessment (CA) to observe and evaluate the caregiver's ability to correctly perform Caregiver Service Plan (CSP) tasks. Complete a CA during each visit. If multiple caregivers are used, assess each caregiver according to program requirements. Write "yes" or "no" in the box next to each task observed during the visit. Give detailed information on concerns, findings, or training in the comment section. Attach additional pages as needed. Immediately contact the case manager to report health and safety concerns or recommend Caregiver Service Plan or Plan of Care/Service changes. Immediately report abuse, neglect or exploitation to Adult Protective Services 1-800-917-7383.

	Task	Observed (Yes/No)	Comment
Activities of Daily Living	Bathing		
	Personal Hygiene (i.e. hair, oral, nail, and skin care)		
	Toileting (i.e. bladder, bowel, bed pan routines, etc.)		
	Dressing & Changing Clothes		
	Mobility & Transfers		
	Eating & Drinking		
	Medications (Review MAR - Medication Admin. Report)		
	Task	**Observed (Yes/No)**	**Comment**
Instrumental Activities	Meal Preparation		
	Light Housekeeping		
	Grocery Shopping		
	Transportation/Traveling in the Community		
	Laundry		
	Handling Money		
	Using the Telephone		
	Reading of Specific Items		
	Wash Equipment		
	Other		

Nurse Name:	Signature:	Date:
Caregiver Name:	Signature:	Date:

DHMH 4658 C (N - CA) Approved 7/01/06

White Copy - Case Manager Yellow Copy - Nurse Monitor Pink Copy - Participant/Representative Goldenrod - Caregiver

Medicaid Home and Community-Based Services Waiver Programs
Nurse Monitor Time Sheet (use only for people at home)

Waiver Program: ☐ Waiver for Older Adults (WOA) ☐ Living at Home Waiver (LAH)

Waiver Participant's Name (Print) _____

Nurse Monitor's Name (Print) _____

Please check all applicable boxes below:

Provider Type: ☐ Agency _____(Name) ☐ Independent

Type of visit:

Waiver for Older Adults

☐ Initial Visit
☐ Monthly Visit
☐ Other _____ (note frequency)

Living at Home Waiver

☐ Initial Visit
☐ 45 Day Visit
☐ 3 Month Visit
☐ 4 Month Visit
☐ Other _____ (note frequency)

Date of Service	Start Time	Stop Time	Start Time	Stop Time	Total Hours

Participant and Provider Certification – Please carefully read, date and sign this section.

By signing this statement, the Nurse Monitor certifies that the delegated nursing functions, participant assessment and caregivers' performance is in accordance with the authorized Plan of Service/Care. The nurse monitor and participant also certify that the nurse monitor provided the service hours on the dates listed on this form.

_____ _____
Participant's/ Representative's Signature Date

_____ _____
Nurse Monitor's Signature Date

LAH – Independent nurse monitor – Attach the white copy of this signed timesheet to the appropriate program billing form (LAH – DHMH 4660.) Send both forms to the billing department for payment.
LAH and WOA – Agency nurse monitor – Submit the white copy of this signed time sheet to your agency. They will attach the white copy of this timesheet to the appropriate billing document for payment.

Immediately report any serious issues or participant needs to the Living at Home Waiver 1-877-463-3464 or the Waiver for Older Adults 1-800-243-3425.

Immediately report suspected abuse, neglect or exploitation to Adult Protective Services at 1-800-917-7383. Report any serious health or safety concerns to the case manager.

Instructions and Process for Caregivers
Effective October 1, 2006

Part 1 – Instructions for Completing Caregiver Forms:

Caregiver Time Sheets – DHMH 4659 (C – TS) Completed by the caregiver during each visit. Documents the date and time the caregiver rendered services. This form should be reviewed and signed by the caregiver and by the participant/representative at the end of the week that the caregiver provides services. The caregiver (agency or independent provider) must:

- Send the yellow copy of the DHMH 4659 (C – TS) to the nurse monitor.
- Give the pink copy of the DHMH 4659 (C – TS) to the participant/ representative.
- Caregiver keeps the goldenrod copy of the DHMH 4659 (C – TS).
- **Follow the payment instructions listed below:**

Waiver for Older Adults

- **Independent** caregivers send the original signed white copy of the DHMH 4659 (C – TS) timesheet and original signed white copy of the billing form WOA – CMS 1500 to MDoA for payment. Caregivers keep the goldenrod copy of the DHMH 4659 and a copy of the WOA - CMS 1500 billing form.
- **Agency** caregivers submit the original signed white copy of the DHMH 4659 (C – TS) timesheet and original signed white copy of the WOA - CMS 1500 billing form to their agency. The agency forwards the white copy of the DHMH 4659 (C – TS) timesheet and white copy of the WOA – CMS 1500 billing form to MDoA for payment. Agencies should copy the DHMH 4659 (C – TS) and WOA – CMS 1500 billing form for their records.

Living at Home Waiver

- **Independent** caregivers send the original signed white copy of the DHMH 4659 (C – TS) timesheet with original signed white copy of LAH – DHMH 4660 billing form to the fiscal intermediary Public Partnership (PPL). Caregivers keep the goldenrod copy of the DHMH 4659 (C – TS) timesheet. Caregivers keep the yellow copy of the LAH – DHMH 4660 billing form.
- **Agency** caregivers submit the original signed white copy of the DHMH 4659 (C – TS) timesheet and original signed white copy of the LAH - DHMH 4660 billing form to their agency. Agencies forward the white copy of the DHMH 4659 (C – TS) timesheet and white copy of the LAH – DHMH 4660 billing form to DHMH for payment. Agencies should copy the DHMH 4659 (C – TS) timesheet and LAH – DHMH 4660 billing form for their records.

Part 2 - Caregiver Process:

1. Caregivers must render services as specified in the Caregiver Service Plan.
2. The caregiver and nurse monitor must follow the instructions and deliver the services identified in the participant's Waiver Plan of Care/Service. The nurse monitor must contact the participant's case manager for approval before increasing, decreasing or making other service changes.
3. If a service change is for a Living at Home waiver participant, the case manager must get DHMH LAH staff approval prior to service delivery.
4. **Failure to obtain prior approval may result in denied payments.**

Medicaid Home and Community-Based Services Waiver Programs
Caregiver Time Sheet/Caregiver Service Record Form

Waiver Program: ☐ Waiver for Older Adults (WOA) ☐ Living at Home Waiver (LAH)

Waiver Participant Name (Print) _____ Caregiver (Attendant/Personal Care) Name (Print) _____

Check applicable box: Provider Type: ☐ Independent ☐ Agency _____ (Name)

Day	Date of Service	Start Time	Stop Time	Start Time	Stop Time	Total Hours	Participant Initials
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							

Participant's/ Representative's Signature _____ Date _____

Provider's Signature _____ Date _____

By signing above, the caregiver certifies the services rendered are in accordance with the authorized Plan of Service/Plan of Care on the above dates of service as specified in the Caregiver Service Plan and that the caregiver delivered to the participant all service hours listed on this form.

Write "YES" or "NO" in the boxes next to the task to show what you did on each day

Task	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Comment
Personal Hygiene (i.e. bathing, hair, oral, nail, and skin care)								
Toileting (i.e. bladder, bowel, and bed pan routines; movement to/from bathroom)								
Dressing & Changing Clothes								
Mobility & Transfers								
Eating & Drinking								
Medications								
Light Housekeeping (e.g. Laundry)								
Errands								
Other (please specify):								

Independent caregiver – Attach the white copy of this signed timesheet to the appropriate program billing form. (LAH - DHMH 4660 or WOA - CMS 1500) Submit the forms for payment.
Agency caregiver – Submit the white copy of this signed time sheet to your agency. They will attach the white copy of the time sheet to the appropriate billing form and forward the documents to the billing department for payment.

Immediately report any serious issues or participant needs that you have identified to the nurse monitor and case manager (medical concerns, environmental problems in the home, or possible abuse or neglect).
Immediately report any suspected abuse, neglect or exploitation to Adult Protective Services at 1-800-917-7383.

Medicaid Home and Community-Based Services Waiver Programs
Living at Home Waiver Billing Form

Waiver Participant Information	Provider Information
Waiver Participant's Last Name / First Name	Provider Number
Participant's Medical Assistance Number	Provider Name [redacted]
	Address [redacted]
	City, State Zip [redacted]

#	Date of Service Month	Day	Year	Procedure Code	Units of Service	Description of Service	Charges
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
						Total	

LAH Use Only
Invoice Process
LAH Staff Initials
Date Processed

LAH WILL NOT PAY FOR SERVICES RENDERED UNLESS YOU SUBMIT THIS INVOICE WITHIN NINE (9) MONTHS OF DATE YOU PROVIDED THE SERVICE.

I do solemnly declare and affirm under the penalties of perjury that the contents of the foregoing document are true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws. I certify that the services shown on this report were rendered and that no charge has been or will be made for payment from the participant, the participant's family or other source, except as authorized by the Program. I certify further that all reasonable measures to identify and recover third party liabilities to the participant have been taken and all such collections therefrom have been or will be reported to the State. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to Title XIX recipients and to furnish information regarding any payments claimed for providing such services as the State may request for six years from the service date. Payment is hereby requested.

Date:	Provider's Signature:

Provider Service Record Pick-up Locations

Nurse Monitoring, Personal Care and Attendant Care providers may pick up Living at Home Waiver and Waiver for Older Adults Provider Service Record forms after **October 15, 2006** at the Maryland Area Agencies on Aging listed:

Allegany Co. Area Agency on Aging Human Resources Development Commission, Inc.	19 Frederick Street Cumberland, MD 21502	301-777-5970 ext.107
Anne Arundel County AAA	2666 Riva Road - Suite 400 Annapolis, MD 21401	410-222-4464
Baltimore City Commission on Aging and Retirement Education, Area Agency on Aging	10 North Calvert Street, Suite 300 Baltimore, MD 21202	410-396-4932
Baltimore County Dept. of Aging, Area Agency on Aging	611 Central Avenue Towson, MD 21204	410-887-2108
Calvert County Office on Aging Area Agency on Aging	450 West Dares Beach Road Prince Frederick, MD 20678	410-535-4606 301-855-1170 DC Line
Upper Shore Aging, Inc, Caroline, Kent & Talbot Area Agency on Aging	100 Schauber Road Chestertown, MD 21620	410-758-6500
Carroll County Bureau of Aging	125 Stoner Avenue Westminster, MD 21157	410-386-3800
Cecil County Dept. of Aging Area Agency on Aging	214 North Street Elkton, MD 21921	410-996-5295
Charles Co. Dept. of Community Services, Area Agency on Aging	8190 Port Tobacco Road Port Tobacco, MD 20677	301-934-0109
MAC, Inc. Dorchester, Somerset, Wicomico & Worcester Counties, Area Agency on Aging	1504 Riverside Drive Salisbury, MD 21801	410-742-0505
Frederick Co. Department of Aging Area Agency on Aging	1440 Taney Avenue Frederick, MD 21702	301-694-1605
Garrett County, Area Agency on Aging	104 E. Center Street Oakland, MD 21550-1328	301-334-9431 ext. 138
Harford Co. Office on Aging Area Agency on Aging	145 N. Hickory Avenue Bel Air, MD 21014	410-638-3025
Howard Co. Office on Aging Area Agency on Aging	6751 Columbia Gateway Drive 2nd Floor Columbia, MD 21046	410-313-6410
Montgomery Co. Area Agency on Aging Division of Aging and Disability Services	401 Hungerford Drive, 4th Floor Rockville, Maryland 20850	240-777-1131
Prince George's County Department of Family Services Aging Services Division	6420 Allentown Road Camp Springs, MD 20748	301-265-8450
Queen Anne's County Department on Aging, Area Agency on Aging	104 Powell Street Centreville, MD 21617	410-758-0848
St. Mary's Co. Department of Aging Area Agency on Aging	41780 Baldridge Street P.O. Box 653 Leonardtown, MD 20650	301-737-5670 301-475-4200 x1050
Washington County Commission on Aging Area Agency on Aging	140 W. Franklin Street. 4th Floor Hagerstown, MD 21740	301-790-0275

DIRECTIONS TO EXECUTIVE OFFICE BUILDING
101 Monroe Street
Rockville, Maryland 20850

By Metro Rail (Red Line): Metro to Rockville Stop. Cross Route 355 at Metro Bridge to Monroe Street, at the south end of station. Follow concourse to Monroe Street. Turn left on Monroe and walk one block to 101 Monroe Street.

From Wheaton: Viers Mill Road to Rockville. When Viers Mill crosses Rt. 355 (Rockville Pike), it becomes Jefferson St. Monroe St. will follow first light on your right hand side.

South (Bethesda Area): North on I-270 to Falls Road exit (#5 to Rockville Town Center). Follow Maryland Ave. arrows. Go straight through the first traffic light. You will be on Maryland Avenue. Go to the corner of Maryland and Jefferson St. and make a right hand turn. At first light make a left hand turn to 101 Monroe Street.

Directions from Other Maryland Areas
Executive Office Building
101 Monroe Street
Rockville, Maryland 20850

From Hagerstown: Take I-70 E to Frederick. Merge onto I-270 S via Exit 53 to Washington.
Keep Right to take I-270 Local S via Exit 8 toward Shady Grove Rd/ Local Lanes.
Take the W Montgomery Ave/Md-28 exit 6B-A.
Take the MD-28 E exit 6A on the left toward Rockville Town Center.
Turn Left onto W. Montgomery Ave/ MD-28 E. Continue to follow MD 28 E.
Turn left on Monroe St. to the Executive Office Bldg. 101 Monroe Street.

Southern MD - Take 301 N to MD-5 N to **I-495 N Capital Beltway** - Baltimore/College Park.
Keep right to take **I-270 N** via Exit 35 toward Frederick.
Keep Right to take I-270 Local N toward Montrose Rd.
Take exit 5 MD-189 toward Falls Road.
Merge onto Great Falls Road/ MD-189 N toward Falls Rd North/Rockville/Town Center.
Turn Left onto Great Falls Rd/ MD-189.
Turn Right onto W Jefferson St/ MD-28.
Turn Left onto Monroe Street to the Executive 0ffice Building, 101 Monroe Street.

Eastern Shore – Take 50 W to I 495 N Capital Beltway.
Follow the above **I-495 N** directions to the Executive Office Building, 101 Monroe St.

Baltimore – Take I-95 S toward Washington.
Merge onto I-495 W/ Capital Beltway via exit 27 toward Silver Spring.
Follow the above **I-270 N** directions above to the Executive Office Building, 101 Monroe St.

DIRECTIONS TO STATE OFFICE BUILDING

DHMH Auditorium
301 West Preston Street
Baltimore, MD 21201

From I-95
Follow I-95 toward Baltimore
Take the exit for I-395/Marting Luther King Boulevard
Stay to the right, merging onto MLK Boulevard.
Stay to the right, merging onto MLK Blvd. And follow for several lights (at least 10) to Eutaw Street.

From I-83 (South)
From I-83 South, take the North Avenue exit. Get into the middle lane to continue straight onto Mt. Royal Avenue.
After going through several lights, you will come to a "V" in the road. The Lyric will be on the left. Stay to the right of the "V."
Pass the Myerhoff Symphony Hall.
Stay in the right lane and bear right onto Martin Luther King Boulevard.
Follow MLK and turn right onto Eutaw Street.
Turn right at the next light onto W. Preston Street
301 W. Preston is the building to your immediate right.

Public Transportation:

Light Rail

The Maryland State Center is near the Cultural Center light rail stop. Walk one block on Preston Street to the Maryland State Center

Metro

Exit the Metro at the State Center Station