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

Medical Day Care Transmittal No. 70

August 11, 2009

To: Medical Day Care Centers

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: Documentation for Continued Stay Reviews

Effective immediately, Medical Day Care providers are no longer required to submit to the Division of Community Long Term Care a copy of the participant's updated Service Plan and Plan of Care when submitting the Long Term Care Patient Activity Report (DHMH 257 form) for annual recertification as previously required by Medical Day Care Transmittal No. 62, dated June 30, 2008. Instead, providers are to submit to the Department the DHMH 257 form along with a new form called the Continued Stay Review Certification Form. The intent of this action is to lessen the administrative burden and cost experienced by providers.

The Continued Stay Review Certification Form must be completed, signed and dated by the Medical Day Care center's nurse as verification that the Service Plan and Plan of Care have been updated timely. To further assist providers, the Medical Day Care Services Waiver Documentation Chart has been updated to reflect the documentation needed for initial enrollments, continued stay reviews, transfers, and discharges. Attached for your reference is a copy of the Continued Stay Review Certification Form and the Medical Day Care Services Waiver Documentation Chart.

Any questions concerning this transmittal may be discussed with the Medical Day Care Services Waiver staff by calling 410 767-1444.

Attachments (2)

Continued Stay Review Certification Form

Participant's Name: ______________________________

MA #: ______________________________

RN Name: ______________________________
(Print)

RN Signature: ______________________________ Date __________

I, the registered nurse for ______________________________
(Center)
certify that the checked documents below have been reviewed and updated for the above named participant's annual reassessment. Enclosed along with this document is the DHMH 257 requesting authorization of payment for Medical Day Care Services rendered effective ________________.
(Anniversary Month)

☐ Plan of Care/ Date Updated __________

☐ Service Plan/ Date Updated __________

Medical Day Care Services Waiver Documentation Chart

Category	Freedom of Choice	DHMH 257	ADCAPS Service Plan	Plan of Care	STEPS	Physician Orders	KePRO Certification	CSR Cert. Form	VCT Form	Discharge Summary
Initial Enrollments	√	√	√	√	√	*	*			
Continued Stay Reviews		√	*	*		*	*	√		
Transfers									√	
Discharges		√								√

KEY

√ - Required document, submit to the Division of Community Long Term Care, maintain copy in the center file

* – Required document, do not submit to the Division of Community Long Term Care, maintain in the center file