

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

TO: DHS/LDSS/LHD Case Manager  
District Office: 299  
Address: 6 St. Paul Street, Ste 400  
Baltimore, MD 21202

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 _____	E&E 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 30<sup>th</sup> consecutive day* in the institution **or** after the *60<sup>th</sup> 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 *30<sup>th</sup> consecutive day* in the facility.  
This certifies that this individual was admitted to the above facility on \_\_\_\_\_ and is considered institutionalized on that date.

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

To be completed *upon discharge from the facility*.  
This certifies that this individual was *discharged from the above facility* on \_\_\_\_\_ to  
 Home \_\_\_\_\_  
 LTCF \_\_\_\_\_  
 Other \_\_\_\_\_

Facility Certification: Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Administrative Services Organization Authorization:

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

# INSTRUCTIONS

## Facility:

1. The LTC Application (DHS/FIA 9709) and the OES form must be submitted at the same time. Complete Part I and II of the OES 1000 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 MDH 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, the 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.