Reference Guidelines for Resource Coordinators:

Community Pathways Waiver Application & Requirements

August 2014

Web site: http://dda.dhmh.maryland.gov

REFERENCE GUIDELINES: COMMUNITY PATHWAYS WAIVER APPLICATION AND REQUIREMENTS

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OVERVIEW:

Historically, the Developmental Disabilities Administration (DDA) has administered two Medicaid 1915 (c) home and community-based services waiver programs (known as Community Pathways (CP) and New Directions (ND)) on behalf of the Department of Health and Mental Hygiene's (DHMH) Medicaid Program (also known as Medical Assistance). Waiver programs provide a specific services and support package for targeted individuals to be supported in a community rather than an institutional setting. Medicaid waiver programs allow the State of Maryland to share the cost of services with the federal government through the Medicaid program for eligible participants. People who are enrolled in one of Maryland's waiver programs are eligible for Medicaid, a comprehensive health insurance plan. This plan may be used as a back-up plan if the person already has insurance and often covers things that typical health insurance does not.

The Community Pathways and New Directions programs are required to be renewed by the Federal government, through the Centers for Medicare and Medicaid Services (CMS), every five years. Maryland submitted a renewal application to merge the two programs that was approved March 26, 2014 with a retroactive effective start date of July 1, 2013. While the effective is July 2013, the transition of participants to the renewed merged waiver, and alignment of individual plans to include any new service options, will occur over the course of 18 months from the waiver approval date, which is March 26, 2014, during annual meetings or sooner as determined by the participant and their Individual Plan (IP) team.

The merger provides participants greater opportunity to self-direct certain services. The merger helps to streamline access to services, update and standardize service descriptions and provider qualifications, and enhance quality and oversight activities. There were no substantive changes from the existing service package and providers' rates were not reduced. In addition to the existing services, the renewal included two new services and the expansion of one service for self-directing participants.

Waiver participants may choose between traditional/provider managed services and self-directed services. Traditional/provider services are provided by licensed agencies. Under self-directed services, the individual with the assistance of a Support Broker and Fiscal Management Service provider directs the planning, budgeting, management, and payment of services. It is important to note that not all waiver services can be self-directed such as Community Residential Habilitation and Medical Day.

Maryland Code of Regulations, COMAR 10.22.12.11 (a) and (f), requires, that before the DDA can fund services, the individual must apply for Medicaid which includes waiver services under Community Pathways. Application to the CP waiver program is based on priority categories, established in regulations, and the availability of DDA funding allocated by the General Assembly.

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

Children and adults who have been notified through their resource coordinator that they are targeted for DDA funding in a particular fiscal year must then apply to the waiver.

To be eligible for waiver services, the person must meet specific technical, medical, and financial eligibility criteria. They must demonstrate, through a screening process, that they need the level of support that people receive in an institution, meet the waiver's financial eligibility requirements, and have an individual plan that supports their health and welfare. People do not have to go into an institution, or agree to apply to an institution, to apply to the waiver or receive services. They do need to be determined appropriate for a priority category and notified that they have been targeted for funding.

This guide outlines the waiver eligibility criteria, application process and associated forms, annual redetermination and recertification processes, strategies to assist in maintaining continuous eligibility for the DDA waiver, and waiver specific reporting forms.

WAIVER ELIGIBILITY

PROTOCOLS AND BUSINESS RULES

The following protocols and business rules are based on the premise that the DDA Regional Office had notify the resource coordinator of intent to fund services for the individual, giving authorization for moving forward with the waiver application process.

A. Federal requirements and eligibility requirements are specified in the approved Community Pathways Waiver application which is available on the CMS and DDA websites.

B. Waiver participants must:

1. Be a current resident of Maryland;
2. Meet the waiver Level of Care (LOC) criteria, which will be determined annually by the resource coordinator;
3. Not be enrolled in another waiver;
4. Choose between waiver services and institutional services;
5. Have a person centered plan that describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service; and (b) the other services (regardless of funding source, including State plan services) and informal or natural supports that complement waiver services in meeting the needs of the participant.

> **NOTE:** The IP documented in PCIS2 must list the name of waiver services in the "My Team Recommended Services" section of the IP module. The individual must demonstrate a need for at least one waiver service, as documented in the individual's service plan.

6. Demonstrate a need for waiver services at least monthly, or if the need for services is less than monthly, require monthly monitoring which must be documented in the IP; and

7. Meet the waiver's financial eligibility standards.

> **NOTE:** Financial criteria are specified in the approved waiver document. The criteria differ from community Medicaid requirements as individuals can have up to 300% of the Supplemental Security Income (SSI) standard. This means both people who meet the community Medicaid financial standards and people who qualify under the approved waiver up to 300% of SSI may meet the financial standards for the Community Pathways Waiver.

C. The DDA determines technical and medical eligibility for the waiver.

D. The DHMH's Eligibility Determination Divisions (EDD) determines financial eligibility for Medicaid under the waiver.

- ❖ The Eligibility Determination Division (EDD) was formerly named the Division of Eligibility Waiver Services (DEWS). EDD contacts are noted in Appendix A-1.
- ❖ EDD will review assets, income, and medical expenses and apply special financial eligibility rules under the waiver. Individuals must apply to the waiver regardless of their income and assets.

E. The Department of Human Resources' State Review Team conducts initial disability determinations for individuals who are not currently receiving Supplemental Security Income.

- ❖ If a person does not have any federal benefits (SSI, SSDI, Railroad, or Veterans Administration) they must also be determined disabled by the State Review Team (SRT) in order to be enrolled in the waiver. In these cases, if a person is determined "Not Disabled" by the SRT, they will not be eligible for the waiver. The person can appeal and ask for reconsideration.

F. Individuals who have been determined by the DDA to meet the "developmental disability" (DD) eligibility status must apply for the Community Pathways Waiver. Those individuals who are determined "supports only" (SO) are not eligible to apply for the waiver.

> Prior to beginning the waiver application, an individual must be determined "DD" eligible by the DDA **and** the DDA Regional Office must notify the resource coordinator of intent to fund services for the individual, giving authorization for moving forward with the waiver application process.

G. Individuals given authorization for moving forward with the waiver application process by the DDA, whether they currently have Medicaid or not, must still apply to the waiver.

H. A Medicaid application with "waiver" checked is required for all individuals as part of a "waiver application packet".

I. Resource coordinators conduct initial and annual Level of Care reviews.

J. As part of the initial DDA eligibility determination, a Critical Needs List Recommendation (CNLR) Form is completed and forwarded to the DDA Regional Office (RO). The DDA RO staff review the CNLR recommendation, along with the supporting documentation, and make a final determination on eligibility. The date of this determination is documented on the LOC Form (Appendix E).

K. LOC eligibility is reviewed annually for changes in status by the resource coordinator. Changes in an individual's status results in then need for the resource coordinator to submit a revised CNLR recommendation to the DDA Regional Office for review.

L. If an individual no longer meets level of care or other eligibility requirements, this should be indicated on the revised CNLR form. The Regional Office will notify the resource coordinator of their decision regarding the person's eligibility status. If the person is determined to no longer be eligible by the Regional Office, the resource coordinator completes the Waiver Discharge Reporting Form WC12-B (Appendix F-5) and the individual is dis-enrolled from the waiver.

M. Although resource coordination providers are responsible for facilitating, assisting, and reminding the individual to provide required documentation, it is ultimately the responsibility of the individual or family to submit the required application and documents to EDD.

N. Resource coordinators must document their efforts within PCIS2, on reporting forms, and checklists regarding their activities associated with supporting the individual in applying for and maintaining waiver eligibility.

O. Applicants who do not complete the waiver application process, which includes providing required documentation to EDD, will receive letters from DDA indicating that their enrollment in services will be in jeopardy if they do not comply within 30 days.

P. Applicants that fail to submit required documentation will receive letters noting that they will be dis-enrolled from services.

DDA Waiver Application Packet

A. The following documents compose the DDA "Waiver Application Packet":

1. Community Pathways Waiver Enrollment Checklist (Appendix B-1)
2. Medicaid Application (Appendix G)
3. Level of Care – Initial Certificate of Need (Appendix E-1)
4. Freedom of Choice Form (Appendix D)
5. Individual Plan (IP) - The most recent individual plan (Initial or Annual)
6. Waiver meeting minutes and the sign-in sheet.

CLARIFICATION: WAIVER CONVERSIONS

Waiver applications are completed for individuals receiving DDA State funded services with a "DD" eligibility category, to convert their funding source from 100% State dollars to the waiver for the federal match. These are referred to as "conversions." For waiver conversions, the meeting minutes and sign-in sheet is also required when the IP is not developed during the meeting when the waiver application was completed. These individuals may have been previously enrolled or found ineligible for the waiver. It is also important to review the scope of services and appropriately align them with services under the merged waiver.

B. The resource coordinator shall ensure all forms to be included in the waiver packet are completed accurately, signed, and dated. Forms are located in the Appendix.

C. All waiver packets are submitted to the appropriate DDA Regional Office for which the person was referred from.

   ❖ Signed completed waiver packets must go to the appropriate Regional Office in a timely manner. Packets should not be held while trying to gather necessary financial information.

D. Effective January 15, 2014, Regional Office staff log in all waiver packets received.

E. Regional Offices review the waiver packet for completeness and compliance with waiver requirements. The waiver packet is then forwarded to the DDA Headquarters' office for final review.

F. The DDA HQ submits all waiver applications and required forms to EDD with the DDA's recommendation for enrollment, denial, or an advisory opinion.

G. EDD may close a case for failure to submit all required documentation.

Community Pathways Waiver Enrollment Checklist

A. This checklist is the cover sheet for the waiver packet and is used to ensure all required documents are submitted (Appendix B-1).

B. Complete all information that applies to the individual.

C. Indicate the appropriate category group associated with the applicant as follows:

   1. Placement from a State Residential Center (SRC), Secure Evaluation Therapeutic and Treatment program (SETT), Nursing Facility (NF) or State Hospital: if the applicant is transitioning from one of these facilities into the community, check this box and enter the name of the facility and include the actual discharge date.
      - Applicants transitioning from a facility may be eligible under for additional services under the Money Follows the Person (MFP) program.
   2. Transitioning Youth (TY) – Fiscal Year (FY): check this box and enter the year of eligibility for the applicant.
      - For example, youth transitioning out of the public school system at age 21 when the school year ends in June 2014 are considered TY FY 2015.
   3. Currently receiving State only funding (Conversion): check this box for applicants that are currently receiving ongoing funding from the DDA under the State funded program.
   4. Money Follow the Person (MFP): check this box for applicants also associated with MFP.
   5. Waiting List Equity Fund (WLEF): check this box for applicants associated with the WLEF.
      - The DDA Regional Office will inform the resource coordinator of the funding source when authorizing the start of the waiver application process.
   6. Crisis Resolution: check this box for applicants associated with the approval for funding due to crisis or emergency.
      - The DDA Regional Office will inform the resource coordinator of the funding source when authorizing the start of the waiver application process.

D. Indicate the person's current address at time of enrollment.
   - ❖ If the applicant is residing in a facility, indicate the address for which the person is moving to and not the address of the facility they are transitioning from.

E. Check all waiver services that the person is seeking, even if a provider has not been identified.

F. Place a check for each waiver packet form included and indicate the date of each document.
   - ❖ The Medicaid Application must be dated within six (6) months of the date the waiver is to be effective.

G. Include the contact information for the resource coordinator i.e. a fax number and email address.

Medicaid (MA) Application

A. The majority of individuals supported by the DDA have Medicaid.
   1. To verify whether a person is currently eligible or receives any Medicaid services, a resource coordinator can access e-Medicaid (Appendix G-2).
   2. e-Medicaid is a secure online portal established for Medicaid providers to verify Medicaid recipient eligibility including waiver eligibility. Resource coordination providers can establish an account based on their Medicaid provider number. The system allows for one administrator that can authorize access to individual users. Accessing this system to check on the status of a person's Medicaid eligibility is often referred to as the "EVS check".
   3. The following link can be used by resource coordination providers to verify recipient eligibility: https://encrypt.emdhealthchoice.org/emedicaid. The site will also advise if the person is in a waiver program. For example: "DRW" is the code for the Developmental Disabilities Waiver.

B. Before completing an MA application, you must first determine which type of MA application should be submitted (the "Long" form, "Short" form, or the OES 014) which can expedite the MA application process for some waiver applicants.

C. To determine which format is required, the subsequent instructions should be followed for each individual applying for the waiver.

D. Resource coordinators shall submit a request to the Division of Recipient Eligibility Programs (DREP) to check the Medicaid Management Information System (MMIS) for Medicaid community eligibility under the waiver.

E. Resource coordinators must complete the "Medicaid System Check" Form (Appendix C) then fax to DREP to make the request. This form was previously referred to as the "DREP Form."

F. If the applicant is found to be enrolled in a Medicaid community coverage group included under the waiver, or has completed an application for Long Term Care Medicaid services within the last six (6) months, a significantly shortened application may be completed by the applicant and reviewed by the resource coordinator.

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

Process for Completing the "Medicaid System Check" Form:

Simplified instructions for completion of the Medicaid application are noted on the Medicaid System Check Form and also noted below.

STEP 1: Complete the Medicaid System Check Form
STEP 2: Fax to 410-333-5087 attention the DHMH/DREP.
STEP 3: Upon response from DREP, the applicant must file the "Long", "Short", or OES 014 application as specified on the Medicaid System Check/ Response Form.

G. The Long-Term Care Medical Assistance Applications can be found on the following link: https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Long%20Term%20Care%20Forms.aspx

CLARIFICATION

Instructions for completing the application on the link noted above are related to application for community MA and not the Waiver. Therefore follow the instruction on the Medicaid System Check/Response Combination" (DREP) Form as listed below.

MA APPLICATION: "LONG" FORM

A. Depending on the age of the applicant, there are two versions of the MA application.

1. For any person under 21 years of age, the DHR/FIA CARES 9708 (Revised 10/2006) Form must be submitted (Appendix G-3).
    - This is known as the "Maryland Department of Human Resources (DHR) Family Investment Administration (FIA) Eligibility Determination Document for a Child in Long Term Care, Waiver, Kinship Care or any Person under 21 not in a Family".
2. For adults age 21 and older, the DHR/FIA 9709 (Revised 7-1-2011) must be submitted (Appendix G-4).
    - This is known as the Maryland Department of Human Resources Maryland Department of Health and Mental Hygiene Long –Term Care/Waiver Medical Assistance Application.

B. The resource coordinator must conduct a face-to-face interview to review the application, collect required documentation, and obtain original signatures.

C. Be sure to check that the applicant is applying for a "Waiver".

D. Seek permission to be listed as an **authorized representative for notices only**, in order to receive copies of correspondence sent to the individual. This will enable the resource coordinator to provide assistance with requests for additional information and future redeterminations.

❖ Make a copy of the application page which reflects the authorized representatives contact information.

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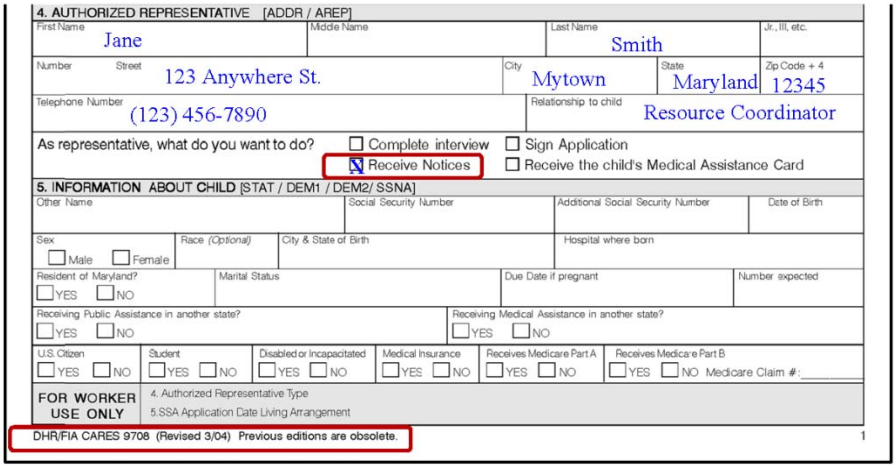
- For DHR/FIA CARES 9708: Make a copy of page 1, complete #4, provide your contact information, and mark "Receive Notices" or write on the copy **"For Notice Only."**



4. AUTHORIZED REPRESENTATIVE [ADDR / AREP]

First Name: Jane | Middle Name | Last Name: Smith | Jr., III, etc.

Number Street: 123 Anywhere St. | City: Mytown | State: Maryland | Zip Code + 4: 12345

Telephone Number: (123) 456-7890 | Relationship to child: Resource Coordinator

As representative, what do you want to do? ☐ Complete interview ☐ Sign Application ☒ Receive Notices ☐ Receive the child's Medical Assistance Card

5. INFORMATION ABOUT CHILD [STAT / DEM1 / DEM2/ SSNA]

Other Name | Social Security Number | Additional Social Security Number | Date of Birth

Sex ☐ Male ☐ Female | Race (Optional) | City & State of Birth | Hospital where born

Resident of Maryland? ☐ YES ☐ NO | Marital Status | Due Date if pregnant | Number expected

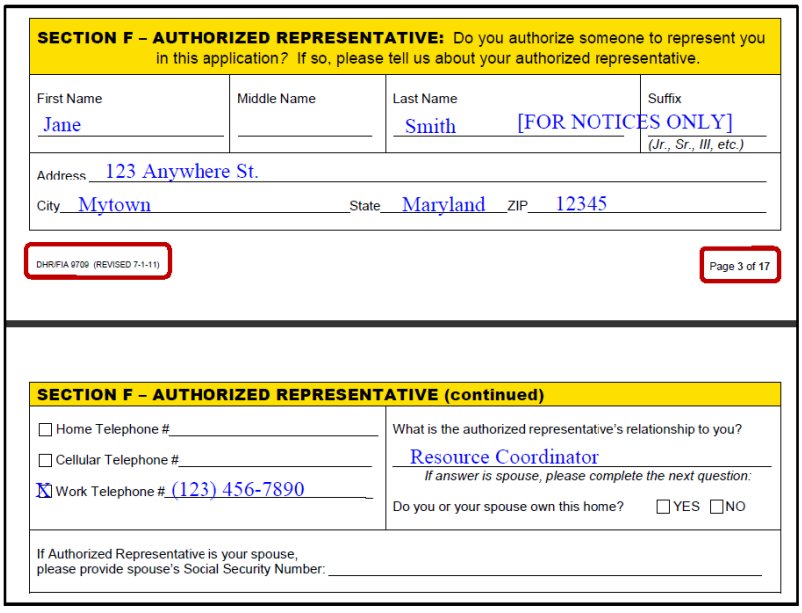
Receiving Public Assistance in another state? ☐ YES ☐ NO | Receiving Medical Assistance in another state? ☐ YES ☐ NO

U.S. Citizen ☐ YES ☐ NO | Student ☐ YES ☐ NO | Disabled or Incapacitated ☐ YES ☐ NO | Medical Insurance ☐ YES ☐ NO | Receives Medicare Part A ☐ YES ☐ NO | Receives Medicare Part B ☐ YES ☐ NO Medicare Claim #:

FOR WORKER USE ONLY: 4. Authorized Representative Type; 5.SSA Application Date Living Arrangement

DHR/FIA CARES 9708 (Revised 3/04) Previous editions are obsolete. 1

- For DHR/FIA 9709 (Revised 7-1-2011): Make a copy of page 3, complete Section F, provide your contact information, write on the copy **"For Notice Only,"** and sign a copy of the signature page.



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: Jane | Middle Name | Last Name: Smith [FOR NOTICES ONLY] | Suffix (Jr., Sr., III, etc.)

Address: 123 Anywhere St.

City: Mytown State: Maryland ZIP: 12345

DHR/FIA 9709 (REVISED 7-1-11) Page 3 of 17

SECTION F – AUTHORIZED REPRESENTATIVE (continued)

☐ Home Telephone #

☐ Cellular Telephone #

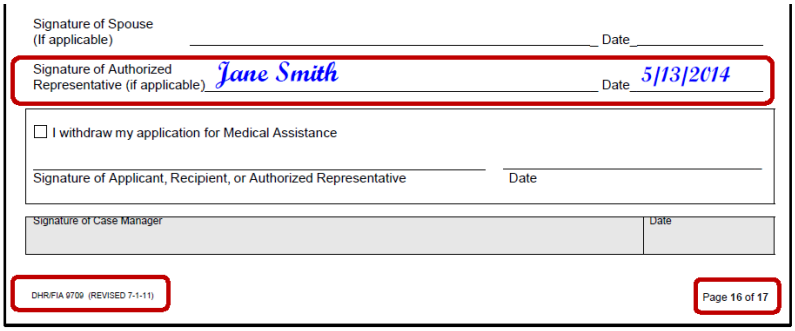
☒ Work Telephone #: (123) 456-7890

What is the authorized representative's relationship to you? Resource Coordinator

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:



Signature of Spouse (If applicable) Date

Signature of Authorized Representative (if applicable): Jane Smith Date: 5/13/2014

☐ I withdraw my application for Medical Assistance

Signature of Applicant, Recipient, or Authorized Representative | Date

Signature of Case Manager | Date

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E. Complete all sections of the MA Application.

F. Provide assistance with gathering and submitting all required documents and verifications.

1. The DHR/FIA 9709 (Revised 7-1-2011) application includes a check list of items needed in order for EDD to make a determination;
2. If the applicant does not have copies of all the documents listed on the checklist, send in copies of all the documents they do have with the waiver packet;
3. EDD will send a follow-up letter to the individual, to request any missing information. The letter will provide a date the information must be received by EDD. The follow-up letter(s) are referred to as Request for Information (RFIs).
    - EDD may request quarterly bank statements for any of the five (5) years where a tax return was not filed.
4. If the applicant does not comply with the RFIs within designated timeframes, they will have to start the waiver application process all over again.

G. The application must be signed and dated by the applicant or legally authorized representative if a child.

H. **The resource coordinator must sign and/or initial and put the date of the waiver meeting on the application in the right hand top corner.** This is used to establish the waiver effective date.

I. An eligibility caseworker at EDD may conduct a telephone interview if additional information is needed.

MA APPLICATION: "SHORT" FORM

A. The DHR/FIA 9709S (Revised 4/1/2013) is used (Appendix E).

- ❖ This is known as the Maryland Department of Human Resources and Maryland Department of Health and Mental Hygiene SSI Recipient/Community Eligible Long Term Care/Waiver Medical Assistance Application.

B. The resource coordinator must conduct a face-to-face interview to review the application, collect required documentation and obtain original signatures.

C. Be sure to check the applicant is applying for a "Home and Community-Based Services Waiver".

D. Seek permission to be listed as an authorized representative on the application in order to provide assistance with request for additional information and future redeterminations.

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

For the DHR/FIA 9709S (Revised 4/1/2013), make a copy of page 3, complete Section D, provide your contact information, and write on the copy **"For Notice Only."**

E. Complete all sections of the MA Application.

F. Provide assistance with gathering and submitting all required documents and verifications.

1. The DHR/FIA 9709S (Revised 4/1/2013) Application includes a check list of items needed in order for EDD to make a determination;
2. If the applicant does not have copies of all the documents listed on the checklist, send in copies of all the documents they do have with the waiver packet;
3. People with SSI are considered categorically eligible and generally do not have to submit supporting documentation unless otherwise advised by EDD; and
4. EDD will send a follow-up letter to the individual, to request any missing information. The letter will provide a date the information must be received by EDD. The follow-up letter(s) are referred to as Request for Information (RFIs).

G. The application must be signed and dated by the applicant or legally authorized representative if a child.

H. **The resource coordinator must sign and/or initial and put the date of the waiver meeting on the application in the right hand top corner.** (This is used to establish the waiver effective date.)

I. An eligibility caseworker at EDD may conduct a telephone interview if additional information is needed.

NOTE: The eligibility determination by EDD could take 4 to 6 weeks, as long as all necessary information has been provided. The individual and resource coordinator, if listed as an authorized representative for notices only, will be notified if additional information/ documentation is needed in order to process the application. Please comply with any request for information immediately.

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

LOC - Initial Certificate Of Need

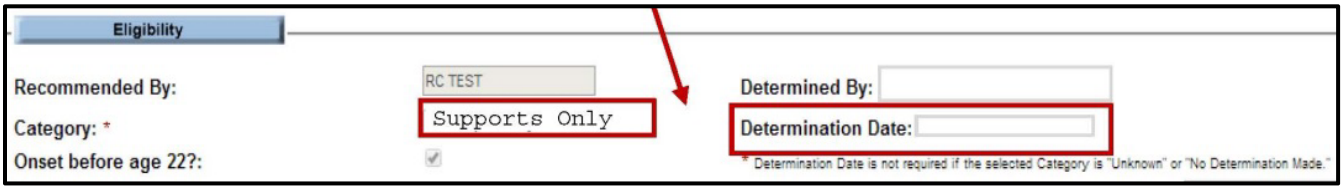
A. Prior to entering the Waiver program, a person must be certified as being in need of waiver services and must meet the Level of Care criteria. This form is used for this certification.

B. Under Maryland's system, individuals who meet the Annotated Code of Maryland, Health-General Article, Section 7-101 (e) "developmental disability" criteria or DD eligible, and have the need for active treatment, are deemed to meet the Community Pathway's Level of Care (LOC) requirement.

C. Resource coordinators shall complete the LOC Initial Certificate of Need form based on the person's current circumstances and eligibility status as noted within PCIS2.

D. The resource coordinator reviews all information and supporting documentation, including the individual plan and DDA eligibility.

E. Individuals "Supports Only" eligible as noted below do not meet the LOC.



F. The resource coordinator completes the LOC Initial Certificate of Need Form (Appendix F) and includes in the waiver application packet.

INSTRUCTIONS: INITIAL CERTIFICATE OF NEED FORM

A. Insert applicant's name (First, Middle, Last).

B. Insert applicant's MA number as applicable. If MA has not been determined at the time of application, write "pending" in place the number.

C. The effective date of the Level of Care (LOC) is the date of the meeting when the application was reviewed and completed.

D. Insert the determination date for the verification of a "developmental disability" per the DDA PCIS2 Eligibility Category. This is the date the person was determined eligible based on the comprehensive assessment and Critical Needs List Recommendation form. The date is listed in PCIS2 under the "eligibility tab" as shown below.

E. Indicate the service delivery model the person has chosen either traditional/provider managed or self-directed services.

F. The resource coordinator needs to sign, date, and print their name.

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

Freedom of Choice Form

A. Each person, or a minor child's parent or legal representative, who may qualify to participate in a home and community-based services waiver program, is given an explanation of the program's requirements and benefits, as well as information about alternative services that are available and about any options available within a specific waiver program. For example, when someone is eligible for both home and community-based waiver service and institutional services, information and assistance are provided to help the person make an informed choice between the two types of service and care settings. Also, within a waiver program there may be options about the specific services that can be received, who will provide the services, and other matters. Waiver eligible individuals confirm through signing consent from that they understand their options and choose to receive home and community-based waiver services.

B. Resource coordinators shall share the purpose of the Freedom of Choice Form as stated above. It is used to document that the person was advised of their service options if found eligible for the waiver. The options include:

   1. Receiving services in the community under the waiver, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or licensed nursing/rehabilitation facility.
   2. Service delivery model (traditional/provider managed or self-directed).
   3. Choice of waiver services and providers.

INSTRUCTIONS: FREEDOM OF CHOICE FORM

A. Write the name (first, middle, last) of the applicant.

B. Review all the options with the applicant.

C. By signing the form, the individual, authorized representative or guardian/parent are acknowledging that they have been advised of choices and agree with the choices noted on the form.

D. The resource coordinator needs to sign and date.

State Review Team

A. If a person does not have any federal benefits (SSI, SSDI, Railroad, Veterans Administration (VA)) they must also be determined disabled by the State Review Team (SRT) in order to be enrolled in the waiver.

B. The following documents are required to be submitted to with the waiver packet:

   1. Customer Declaration of Disability Form DHR/FIA 700 (Appendix H-1)
   2. Disability Report Form DHR/FIA 3368 (Appendix H-2)
   3. Substantial Gainful Activity Worksheet OES 06 (Appendix H-3)
   4. Authorization and Consent Form DHR/FIA 827 (Appendix H-4)

C. The applicant or their legally authorized representative must sign the consent form.

D. In these cases, if a person is determined "Not Disabled" by the SRT, they will not be eligible for the waiver.

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

Waiver Packet Exception

A. Medical Assistance applications for people residing in an institution (i.e. nursing facility, SRC, SETT, etc.) can be submitted to DDA without submitting a complete waiver packet.

B. This is done in order to request an advisory opinion from EDD regarding the person's financial eligibility for the waiver, prevents delays with financial documentation and the SRT process.

C. The application can be submitted up to six (6) months prior to discharge from the facility.

D. If the person is found financially eligible, EDD will determine the latest date community residence can be made.

E. Resource coordinators will need to submit the waiver packet to the Regional Office once the specific community residence and transition date is identified.

F. If the date that EDD determined to be the latest date for establishment of community residence expires, a new MA application will need to be submitted.

G. The Medical Assistance, if found eligible, will not be activated until the person is residing in the community and all other waiver paperwork has been received and approved by DDA.

Waiver Determination

A. EDD will process waiver applications to determine financial eligibility for all applications recommended by the DDA for approval or an advisory opinion.

B. EDD will issue an official notice to the applicant and their authorized representative for any addition information required in order to make the financial eligibility determination.

C. EDD will issue an official enrollment, denial, or advisory opinion to the person along with appeal rights.

D. For eligible applicants, EDD processes the information for enrollment into MMIS.

ANNUAL REQUIREMENTS - MAINTAINING WAIVER ELIGIBILITY

PROTOCOLS AND BUSINESS RULES

The following protocols and business rules are based on the premise that the person is currently enrolled in the Community Pathways Waiver.

A. Annually, the waiver program requires an annual individual plan and a Level of Care recertification of need to maintain eligibility in the waiver.

B. The waiver also requires participants to continuously meet financial criteria:

   1. All waiver participants are to report any change in income and assets throughout the year.

2. For participants with SSI, there is no redetermination process unless otherwise requested by EDD.
3. For waiver participants without SSI, those under an optional waiver eligibility category, an annual redetermination is required.
4. EDD may also conduct an unscheduled redetermination at any time during the year in addition to the annual requirements.

C. Resource coordinators are responsible for monitoring and following-up activities related to an individual's eligibility for waiver services. The intent of these activities is to assist individuals in providing required documentation for maintaining continuous eligibility for the Community Pathways Waiver.

D. In accordance with COMAR 10.09.48.06D, Monitoring and Follow-Up Activities include assessment of the individual's needs and supports to maintain eligibility for Medicaid, waivers, DDA services, and any other relevant benefits or services and application/re-application for necessary programs or services to prevent or remedy a gap in eligibility.

E. The resource coordinator is responsible for addressing the issue related to maintaining waiver enrollment for people they serve.

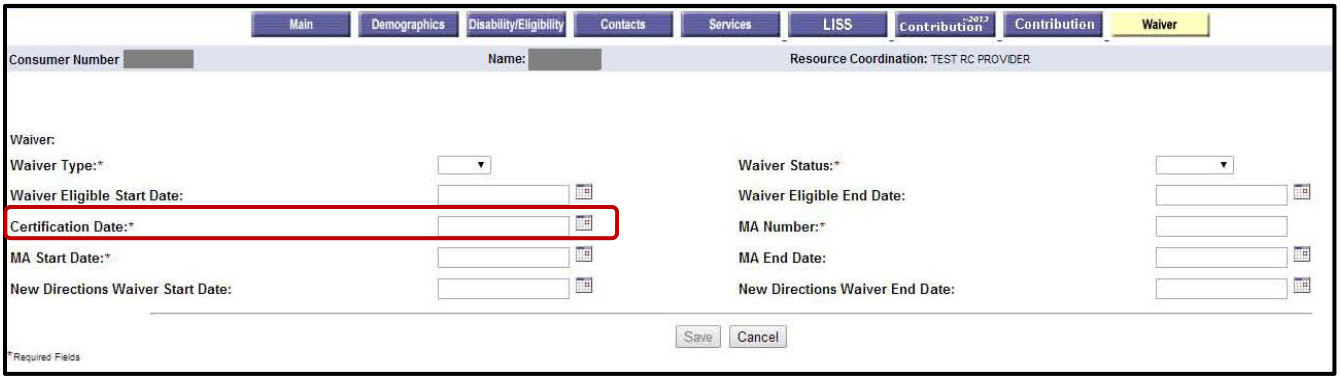
F. For individuals self-directing services, the IP and self-directed budget must also be completed and submitted to the DDA Regional Office for review.

G. The DDA has developed a Maintaining Waiver Eligibility Checklist that shall be used quarterly for monitoring and follow-up activities to be documented in PCIS2's resource coordination module. See Appendix G.

LOC: Annual Recertification Certificate Of Need

A. Resource coordinators are responsible for annually completing the "Level of Care Recertification of Need" Form. The LOC recertification date shall align with the previous year's date, unless the person was discharged from the waiver. This process is often referred to as "Recon."

B. The current certification (LOC) date is listed within PCIS2 under the person's waiver screen.



C. Resource coordinators should review information related to recertification during quarterly monitoring to prevent possible loss of waiver eligibility.

D. The resource coordinator reviews all supporting documentation, including the individual plan, and completes a "Level of Care Recertification of Need" Form to confirm the LOC is current.

E. The LOC "Recertification of Need" Forms must be received by the DDA Headquarters' Waiver Unit within 30 calendar days of completion.

F. During the recertification process, the individual is also informed of their choice of service delivery options and providers licensed by the DDA that may meet their needs and preferences.

G. If an individual no longer meets level of care or other eligibility requirements, the resource coordinator will also need to complete the Waiver Discharge Reporting Form (WC-12B) noted later in this guide and the individual is then dis-enrolled from the waiver.

H. In an effort to ensure timely recertification of the waiver LOC, the DDA HQ provides a quarterly LOC report to RC providers that reflects the LOC due date.

CLARIFICATION

1. Reports are currently distributed to the RC provider's primary waiver contact. These reports will also be shared with the RC provider's director.
2. RC providers are responsible for monitoring LOC recertification of need as part of the monitoring process and agency's quality performance measures.
3. DDA shall send a formal letter quarterly to the RC provider related to late LOCs. The letter will include the requirement for the RC provider to submit documentation of activities associated with the noncompliance findings for this performance measure.
4. DDA will review all documented evidence presented and record findings in a follow-up letter to the provider. A formal plan of correction (POC) will be required to address noncompliance findings.
5. All formal correspondence shall be documented in the RC provider's file.

Medicaid Financial Redeterminations

A. Medicaid financial redeterminations are not required for all waiver participants.
   1. Individuals who receive SSI do not have to complete this process unless notified by EDD.
   2. Individuals, who do not receive SSI, have to have their financial eligibility for MA under the waiver assessed every year. The date of the redetermination is determined by effective date of the MA. This process is referred to as "redets".

B. Resource coordinators shall facilitate the annual redetermination or "redet" process within two (2) months prior to the due date or sooner.
   - ❖ Required documents should be submitted minimally one month before the due date to prevent interruption of MA/Waiver status and allow time for processing and responding to additional documentation if requested.

C. Individuals receiving a Medicaid benefit other than SSI need to submit the MA Application DHR/FIA 9709R (Revised 7-1-2011) and all relevant supporting documents for the past year.

D. Redetermination packets are submitted directly to EDD. They do not go through the Regional Office

E. If a person is receiving community residential habilitation services and the licensed DDA residential provider is the representative payee, the provider is responsible to submit the redet to EDD as they have all relevant financial information needed. Resource coordinators must follow-up with residential providers and document contacts related to facilitation and reminders for the redet process.

Self-Directed Services: IP and Self-Directed Budget

A. Individuals self-directing services (previously under New Directions) are required to submit an annual plan update in the spring of each year.

B. The IP and self-directed budget must be submitted to the Regional Office.

RESOURCE COORDINATION MONITORING ACTIVITIES: PREVENTING LOSS OF MEDICAID AND WAIVER ELIGIBILITY

PROTOCOLS AND BUSINESS RULES

Resource coordinators can view information related to both recertification and financial redetermination to prevent or address issues related to possible loss of waiver eligibility. There are several resources and communication to monitor Medicaid and Waiver eligibility as noted below.

A. As per the Reference Guidelines for Monitoring and Follow-Up, resource coordinators are to quarterly monitor eligibility. Information related to monitoring activities is documented in the **RC Monitoring Form** within the PCIS2 Resource Coordination Module.

B. Section #6 of the RC Monitoring Form is specific to eligibility and includes the following questions:

1. Medicaid eligible? *If no, include date determined not eligible*.
2. Eligible for DD waiver? *If no, include date determined not eligible.*
3. Is the Level of Care, the initial certification or the recertification of need, current?
4. Have the financial documents to support initial or ongoing waiver eligibility been submitted?
5. Is recertification and/or reapplication of other benefits needed?

C. Resource coordinators are to review these areas and indicate responses to these questions by checking "Yes", "No", or "N/A". Comments to "Yes" or "No" responses are required as noted below:

Section	Question	Requirement(s)
6: Eligibility	*Medicaid eligible?*	• Comment required if the answer is "No" (include date of determination). "NA" is not acceptable. *NOTE: An application for community Medicaid should be completed for all individuals supported, regardless of DDA eligibility, as it provides access to health services, prescriptions, and specialty services for children based on medical necessity.*
6: Eligibility	*Eligible for the DD Waiver?*	• Comment required if the answer is "No" (include date of determination). • Check "N/A" if the person has not been authorized funding from DDA for waiver services or they are not currently transitioning from a facility. *NOTE: An application for the DDA waiver is required for all individuals, allocated funding for ongoing services, with a developmental disabled or "DD" eligibility status as per regulations. This is important as the federal government covers half of the cost of waiver services which allows DDA to support more people with services.*

Section	Question	Requirement(s)
6: Eligibility	*Is the Level of Care (LOC), the initial certification or the recertification of need, current?*	• Comment required if the answer is "No" (include reason why the LOC was not completed). • Check "N/A" if the person has not been authorized funding from DDA for waiver services or they are not currently transitioning from a facility. *NOTE: The LOC or certificate of need is required initially for all waiver application and annually for continued waiver eligibility. Resource coordinators are responsible for completing these forms as outlined in the Waiver Guide.*
6: Eligibility	*Have the financial documents to support initial or ongoing waiver eligibility been submitted?*	• Comment required if the answer is "No" " (include reason why financial documents have not been submitted and action taken by the resource coordinator to support submission.) • Check "N/A" if the person has not been authorized funding from DDA for waiver services or they are not currently transitioning from a facility.
6: Eligibility	*Is recertification and/or reapplication of other benefits needed?*	• Comment required if the answer is "Yes."

D. Resource coordination providers are required to provide to DDA HQ and the Regional Office(s) a quarterly Quality Assurance Report that includes standardize measures that help gauge whether or not resource coordinators are performing all required duties.

E. The quarterly report includes a performance measures associated with maintaining wavier eligibly including financial and level of care eligibility.

Eligibility Information and Communications

Resource coordinators should utilized these tools and access these system to check on the status of a person's Medicaid and Waiver eligibility minimally quarterly as part of the comprehensive monitoring and follow-up activities.

A. e-Medicaid: The secure online portal established for Medicaid providers to verify Medicaid recipient eligibility including waiver eligibility.

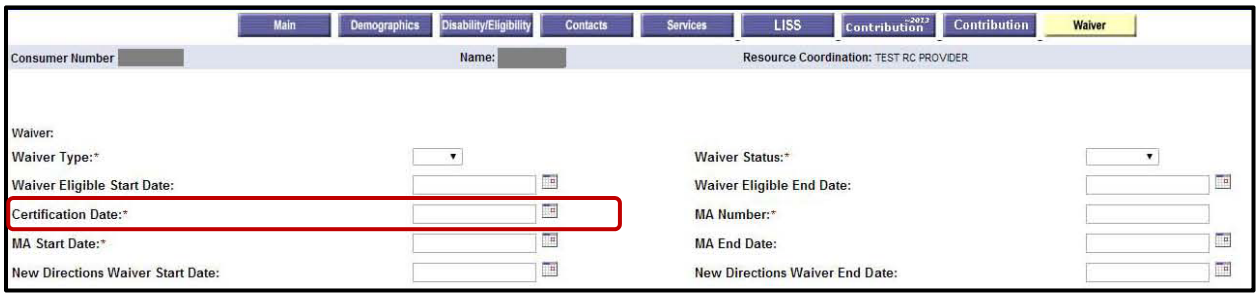
B. MMIS Daily Reports: In an effort to achieve real time notification of enrolment and loss of eligibility, DDA HQ and ROs receives a daily report from the MMIS that reflects information related to waiver eligibility. This daily report is titled HMMR2140 and also referred to as the "A02 Report". It includes names of individuals, MMIS eligibility codes associated with people who have or will lose their waiver eligibility, newly enrolled participants, and effective dates.

   1. Some individuals are listed on this report due to failure to provide required financial documentation.
   2. "A02" is the code associated with risk of or loss of eligibility due to financial requirements.

3. Individuals that submit the required information prior to the projected waiver eligibility end date and meet the eligibility criteria will remain enrolled in the waiver.
4. Individuals dis-enrolled from the waiver due to failure to submit the required information can be reenrolled (reinstated) if they provide the information within four months of required redetermination date and meet the eligibility criteria.

C. PCIS2 Waiver Screen: The DDA Provider Consumer Information System (PCIS2) includes a tab associated with the waiver including waiver eligibility start and end dates, certification date, status, services covered under the waiver, and disenrollment date.

1. The current certification (LOC) date is listed within PCIS2 under the person's waiver screen and is updated by the DDA HQ.



2. MMIS data related to waiver eligibility is uploaded into PCIS2 the first week of every month and is reflected under the heading "*Waiver data from Medicaid*" as shown below.

Waiver Data from Medicaid			
Begin Date	End Date	Plan ID	DIS-RSN
12/05/2010	1/31/2014	DRW	A02

NOTE: DRW – is the MMIS code for Community Pathways

D. EDD Eligibility Letters: EDD sends out official waiver letters related to financial redeterminations, enrollments, and disenrollment to the individual and their authorized representatives.

1. Resource coordinators designated as "authorized representative" receive these notifications.
2. Residential providers are often listed as an authorized representative and should submit financial documents requested. Resource coordinators shall coordinate with residential providers to prevent gaps or loss of eligibility.
3. DDA also receives a copy of EDD letters and forwards a copy to the RC provider.
4. Resource coordinators are to follow up with individuals and their authorized representatives to complete the financial redetermination process.

E. Level of Care (LOC) Recertification:

1. In an effort to ensure timely recertification of waiver LOC recertification, the DDA HQ provides a quarterly LOC report to RC providers that reflects the LOC due date.
2. Reports are currently distributed to the RC provider's primary waiver contact and the appropriate Regional Office. These reports will also be shared with the RC provider's Director.

WAIVER REPORTING FORMS

PROTOCOLS AND BUSINESS RULES

The following protocols and business rules are based on the premise that the person is enrolled in the Community Pathways Waiver.

A. Information related to specific changes associated with waiver participants must be reported upon knowledge to the DDA and EDD.

B. The following forms are used to report changes associated with:

1. Demographics
2. Placements
3. Transfers to new providers
4. Admissions to an institution
5. Discharges
6. Addition or reduction of a waiver service
7. Changes in income, insurance and/or resources

C. Some WC12 waiver reporting forms related to service changes require a service funding plan (SFP) be submitted in addition.

D. Any WC12 form that does not also require an SFP must be submitted by the resource coordinator directly to the DDA Regional Office. Examples of these circumstances include:

1. Admittances to nursing facility, chronic rehabilitation, or other facilities (WC12–A)
2. Site/Provider Changes (WC12–A)
3. Discharge from Services (WC12–B)
4. Discharge form the Waiver Program (WC12–B)
5. Reduction in Services (WC12–C)

E. WC12 forms that require an SFP must be submitted to providers in accordance with the **Service Funding Plan Policy**.

F. The resource coordinator should review the information on the form for accuracy, i.e. site address, correct service, correct effective date, etc.

G. The effective date needs to be completed on the form. Forms should not be submitted with a "TBD" date.

H. The Regional Office will mail or email (waiver.dda@maryland.gov) the WC12 forms and the corresponding Service Funding Plan to the DDA HQ Waiver Unit.

I. For new services, the Regional Office will send the WC12 forms to DDA HQ Waiver Unit when the actual start date of service has been entered into PCIS2.

J. The following waiver reporting forms shall be used:

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

1. WC12–A Reporting Form – Community Pathways/ Traditional Services Model: Report any changes regarding the consumer's address, change in placement, transfer of provider agencies, transfer of resource coordination agencies, and admission to a nursing or chronic rehabilitation facility (Appendix F-3).
    - If the person is transferring to CSLA/Personal Supports or F/ISS service, a copy of the Service Funding Plan must also be submitted.
    - If the person is transferring from one resource coordination provider to another, the "Notification of Provider of Site Change/RFSC Service-Neutral Activity" form is also required.
2. WC12–A Report Form – Community Pathways/ Self-Directed Services Model: Report any change in address, change in Fiscal Management Services (FMS), change in Support Broker (SB) also to include the SB's mailing address and email; transfer of resource coordination provider*, and admission to a nursing or chronic rehabilitation facility (Appendix F-4).
3. WC12–B Community Pathways Discharge Reporting Form: Report a discharge from the waiver program (Appendix F-5).
    - There may be situations when a person will be discharged from Community Pathways waiver but still receive DDA State funded services. Please be sure to check the correct box. The actual date of discharge (last day of service) needs to be reported.
4. WC12–C Community Pathways Change in Service: This form will be completed if the person is now receiving an additional service or has had a reduction in service (Appendix F-6).
    - If it is an additional service, the Service Funding Plan must also be submitted.
5. WC12–D Financial Reporting: Report any changes in the person's income, insurance and/or resources. *This form is to be sent to EDD only (Appendix F-7).

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

APPENDICES

Appendix A: Contact Information

- A-1: Eligibility Determination Division Contacts
- A-2: DDA Community Pathways Waiver Contacts

Appendix B: Checklists

- B-1: Community Pathways Waiver Enrollment Checklist
- B-2: Maintaining Waiver Eligibility Checklist

Appendix C: Medicaid System Check Form

Appendix D: Freedom of Choice Form

Appendix E: Level of Care Forms

- E-1: LOC − Initial Certificate of Need Form
- E-2: LOC – Annual Recertification of Need

Appendix F: Waiver Reporting Forms

- F-1: DDA2013006 Transmittal
- F-2: DDA2013008 Transmittal
- F-3: Community Pathways Reporting Form WC12–A Traditional Services
- F-4: Community Pathways Reporting Form WC12–A Self-Directed Services
- F-5: Discharge Reporting Form WC12–B
- F-6: Change in Service Reporting Form WC12–C
- F-7: Financial Reporting Form WC12–D

Appendix G: Medicaid Applications

- G-1: Memo Regarding Advisory MA Applications
- G-2: e-Medicaid – Recipient Eligibility Verification
- G-3: MA Application DHR/FIA 9708 – Child Under 21
- G-4: MA Application "Long" DHR/FIA CARES 9709
- G-5: MA Application "Short" DHR/FIA 9709S
- G-6: Intent to Apply for Waiver Services Form OES014
- G-7: DHR/FIA 9709-R Redetermination Application

Appendix H: State Review Team Documents

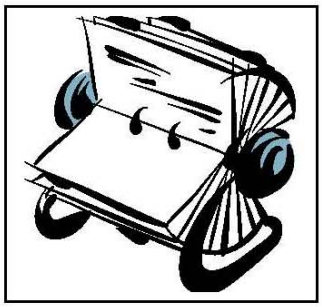
- H-1: Customer Declaration of Disability Form DHR/FIA 700
- H-2: Disability Report Form DHR/FIA 3368
- H-3: Substantial Gainful Activity Worksheet OES 06
- H-4: Authorization and Consent Form DHR/FIA 827

Appendix I: Waiver Covered Services

APPENDIX A: CONTACT INFORMATION

APPENDIX A-1: ELIGIBILITY DETERMINATION DIVISION CONTACTS

Eligibility Determination Division Information



Mailing Address: Schaefer Tower
6 St. Paul Street, Suite 400
Baltimore, MD 21202

Fax: 410-333-0109

Carolyn Cornish	Supervisor	carolyn.cornish@maryland.gov	410-767-6603
Audree Watkins	Deputy Director	audree.watkins@maryland.gov	410-767-8268

Caseload Breakdown by Client's Last Name

Effective 2/1/14

Last Name Breakdown	DEWS Worker	Email	Phone
A – E	Michael Edmonds	mike.edmonds@maryland.gov	410-767-6619
F - J	Susan Davis	susan.davis@maryland.gov	410-767-6622
K, L, O, Ra-Rh, Sa-Si	Gabrielle Kelly	gabrielle.kelly@maryland.gov	410-767-6563
M, N, P, Q, Ri-Rz	Ilka (Nita) James	ilka.james@maryland.gov	410-767-6627
Si-Sz, T - Z	Othille Henry	othille.henry@maryland.gov	410-767-6611

APPENDIX A-2: DDA COMUNITY PATHWAYS WAIVER CONTACTS

COMMUNITY PATHWAYS & SELF-DIRECTED WAIVER PROGRAM CONTACTS

State & Federal Relations	Rhonda Workman, Assistant Director (410) 767-8690
Community Pathways	Terri Hartman (410) 767-5421
	Micheale Keenan (410) 767-1161
Self-Directed Services	Grace Serio (410) 767-8692
Support Staff	Alma Ford (410) 767-8814
Support Staff	Marcie Barksdale (410) 767-6924
DDA Regional Office Waiver Liaisons	
Western Maryland Regional Office	Tina Swink (240) 313-3877
Central Maryland Regional Office	Natalie Jones (410) 234-8269
Self-Directed Services	(410) 234-8200
Southern Maryland Regional Office	Carol Bowman (301) 362-5110
Self-Directed Services	(301) 362-5100
Eastern Shore Regional Office	Edwina Harris (410) 572-5926
Self-Directed Services	Jonna Hitch (410) 572-5942

Updated: 8/12/2014

APPENDIX B: CHECKLISTS

APPENDIX B-1: COMMUNITY PATHWAYS WAIVER ENROLLMENT CHECKLIST

COMMUNITY PATHWAYS WAIVER ENROLLMENT CHECKLIST

INDIVIDUAL'S NAME: _____ (FIRST, MIDDLE, LAST)

Current address: _____ **County:** _____
_____ **Zip Code:** _____

DDA FUNDING CATEGORY GROUP *(CHECK ALL THAT APPLY)*

☐ Transitioning Youth – Fiscal Year _____
☐ Currently receiving State only funding (Conversion)
☐ Money Follows the Person (MFP)
☐ Crisis Resolution/Emergency
☐ Waiting List Equity Fund (WLEF)
☐ Placement from an SRC/SETT/Nursing or State Hospital Facility
Facility Name: _____ Discharge Date: _____

WAIVER SERVICE REQUESTED: (CHECK ALL THAT APPLY)

	Assistive Technology & Adaptive Equipment		Environmental Accessibility Adaptations		Support Brokerage
	Behavioral Supports		Environmental Assessments		Supported Employment
	Community Learning Service		Family and Individual Support Services		Transition Services
	Community Residential Habilitation		Live-In Caregiver Rent		Transportation
	Community Supported Living Arrangement/Personal Supports		Medical Day Care		Vehicle Modifications
	Day Habilitation		Respite		
	Employment Discovery & Customization		Shared Living (formerly Individual Family Care)		

DOCUMENTS:

√	Document Name	Date Completed
	Medicaid Application (Long or Short Form)	
	Level of Care – Initial Certificate of Need	
	Freedom of Choice Form (WC-3B)	
	Individual Plan (IP) – Traditional Model: The most recent IP (Initial or Annual)	
	Individual Plan (IP) – Self-Directed Model: IP and Self-Directed Budget	
	Waiver meeting minutes and sign in sheet.	

For Regional Office Use Only

√	Document Name	Date Completed
	Service Funding Plan (SFP) with Regional Office Sign-Off	

Resource Coordinator (printed name):_____

Resource Coordination Agency (printed name):_____

Office Address: _____

Email Address: _____

Phone: _____ Fax: _____

Resource Coordinator (signature): _____ Date: _____

DDA Regional Waiver Coordinator: _____ Date: _____

CP Waiver Enrollment Checklist
Revised August 2014

APPENDIX B-2: MAINTAINING WAIVER ELIGIBILITY CHECKLIST

RESOURCE COORDINATION
MAINTAINING WAIVER ELIGIBILITY CHECKLIST

Waiver Participant: _____

LOC – Recertification of Need ("RECON")

____ Check LOC Certification on PCIS2 "Waiver" Tab (Note Date Listed: _____)

____ Check DDA Quarterly LOC Report for Current Date (Indicate Date Due: _____)

____ Review Current Needs and Individual Plan

____ Complete LOC – Recertification of Need form (if criteria met)

____ Complete WC12-B Form (if criteria no longer met) and Submit to Regional Office

Financial Redetermination ("REDET")

____ EDD Redetermination Target Date (Indicate Date Due: _____)

____ Check EVS (e-Medicaid) for Eligibility:

- ____ DRW – Community Pathways
- ____ NRW – Community Pathways – Self Direction
- ____ Eligible for Date of Service (for Community Medicaid)
- ____ Not Eligible (for Community Medicaid)

____ Check PCIS2 Waiver Screen

____ Review EDD Notification Letter:

- _____ Inform participant and authorized representatives of upcoming redetermination requirement(s).
- _____ If the person is receiving residential habilitation services; contact the provider to inquire about the status of submitting required documents.
- _____ Ask if assistance is needed to submit required documents.
- _____ Complete the MA "Long" Form for participants receiving MA benefit other than SSI.

NOTE: Document all activities in PCIS2 as monitoring and follow-up activities and record on the Monitoring Form as either a comprehensive review or focused review.

Resource Coordinator:_____ Date:_____
Signature

Maintaining Waiver Eligibility Checklist
June 3, 2014

MEDICAID SYSTEM CHECK FORM

CONFIDENTIAL INFORMATION

Please ensure the security of this information.

This form is used for determining whether a waiver applicant shall complete the "***short***" or "***long***" Medicaid Application or the "***Intent to Apply for Waiver Services***" (OES 014) form. If a person is currently active in a specified coverage group that does not have an end date, they may complete the "short" version of the Medicaid Application form. If a person recently (within 6 months) applied for long term care services, they may complete the OES 014 Form.

To: Division of Recipient Eligibility Programs, DHMH Fax Number: (410) 333-5087 Date:_____

From: _____ Phone Number: _____

Email Address: _____ Fax Number:_____

Agency: _____

Name of Waiver	Applicant Name	Social Security Number	Date of Birth	Medicaid Number	For DREP Use Only			
					OES014 Form	Long Form	Short Form	Comments

****

DREP Determination: Based upon a search of the MMIS and CARES systems for coverage groups under the waiver program and recent long term care applications, the applicant must file the OES 014, the "Long" Form, or the "Short" Form as indicated above. These findings are unofficial and advisory only. When the Eligibility Determination Division (EDD) determines waiver eligibility, it may have different findings and require additional information and verifications. For the OES 014 Form, the date of the long term care application shall be entered in the comments box above.

DREP Representative Name:_____ Date:_____

Phone Number: _____ Email Address: _____

Intent to Apply for Waiver Services (OES 014) Form: This form is used for applicants who have already applied for LTC Medicaid and now intend to apply for waiver services within the six (6) month consideration period of the LTC application. Use the LTC application date noted in the comments box above.

"Short" Form: Complete the DHR/FIA 9709S (Revised 4/1/2013) for the waiver and submit all required documentation.

"Long" Form:

- For any person under 21 years of age, complete the DHR/FIA CARES 9708 for the waiver and submit all required documentation.
- For any person age 21 years or older, complete the DHR/FIA CARES 9709 (Revised 7/1/2011) for the waiver and submit all required documentation.

Medicaid System Check Form
Revised June 4, 2014

APPENDIX D: FREEDOM OF CHOICE FORM

Developmental Disabilities Administration
Community Pathways Waiver
Freedom of Choice

Individual's Name _____ (*FIRST, MIDDLE, LAST*)

I understand that there are alternative services for which I may be eligible, including services in the community under the waiver, in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID). and licensed nursing/rehabilitation facility. I understand and have considered my options which have been explained to me. I further understand that in order to receive, and continue to receive home and community-based waiver services, I must meet all the eligibility criteria of the Maryland Medical Assistance program and DDA Waiver program.

Please check your choice in services to be received:

☐ I choose to receive home and community-based services under the Maryland Medical Assistance Program/DDA Community Pathways Waiver

☐ I choose to receive services in an institution (ICF/ID)

☐ I choose to receive services in a licensed nursing/rehabilitation facility

****

Acknowledgement of the choice of waiver service delivery model:

The Community Pathways Waiver offers two service delivery models including traditional/provider managed and self-directed services. Individuals may choose a combination of the two.

Please check your choice in services to be received:

☐ Traditional/Provider Managed Services
☐ Self-Directed Services
☐ Combination of Traditional and Self-Directed Services

Acknowledgement of the various waiver services and providers:

I have been advised of the various waiver services and providers licensed by the DDA and informed of my right to choose providers that meet my needs and preferences.

Signature: _____
Individual

Or: _____
Legally Authorized Representative or Guardian/Parent (if applicable)

Signature:
Resource Coordinator Date

Freedom of Choice
Revised September 19, 2014

APPENDIX E: LEVEL OF CARE FORMS

APPENDIX E-1: LOC- INITIAL CERTIFICATE OF NEED FORM

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS WAIVER

LEVEL OF CARE
INITIAL CERTIFICATE OF NEED

This is to certify that _____
(FIRST, MIDDLE, LAST)

Medical Assistance Number: _____

In accordance with DDA eligibility criteria, has been determined to need waiver services and meets the appropriate Level of Care effective: _____.

Verification of a "developmental disability" per the DDA PCIS2 Eligibility Category determined on (*insert date*).

Service Delivery Model: (*check one*)

Traditional/Provider Managed Services
____Self-Directed Services
____Combination of Traditional and Self-Directed Services

Resource Coordinator: _____ Date: _____
Signature

Resource Coordinator *(printed name)*: _____

DDA Review: _____ Date: _____
Signature

LOC- Initial Form
Revised September 19, 2014

APPENDIX E-2: LOC- ANNUAL RECERTIFICATION OF NEED

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS WAIVER

LEVEL OF CARE
RECERTIFICATION OF NEED

This is to certify that _____
(FIRST, MIDDLE, LAST)

Medical Assistance Number: _____

In accordance with DDA eligibility criteria, has been determined to need waiver services and meets the appropriate Level of Care effective: .

****

Attestation of the choice of waiver service delivery model:
The Community Pathways Waiver offers two service delivery models including traditional/provider managed and self-directed services which was reviewed with the person. Individuals may choose a combination of the two.

The participant chooses to receive services via the following model:

- ☐ Traditional/Provider Managed Services
- ☐ Self-Directed Services
- ☐ Combination of Traditional and Self-Directed Services

Acknowledgement of the various waiver services and providers:
The Community Pathways Waiver offers various waiver services and providers licensed by the DDA for which participants have the right to choose providers that meet their needs and preferences. This information was reviewed with the person.

Resource Coordinator: _____ Date: _____
Signature

Resource Coordinator *(printed name)*: _____

DDA Review: _____ Date: _____
Authorized Signature

LOC – Recertification Form
Revised September 19, 2014

APPENDIX F: WAIVER REPORTING FORMS

APPENDIX F-1: DDA2013006 TRANSMITTAL

STATE OF MARYLAND

DHMH

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

MEMORANDUM
Transmittal # DDA2013006

Date: November 6, 2013

To: Resource Coordinators

CC: DDA Assistant Directors
DDA Regional and Deputy Regional Directors
DDA Providers

From: Patrick Dooley, Acting Executive Director

Re: **Processing WC12 Forms in Conjunction with the New SFP Operating Procedure**

THIS LETTER IS AVAILABLE IN ACCESSIBLE FORMATS. TO REQUEST ANOTHER FORMAT, PLEASE CONTACT DDA.CFO@MARYLAND.GOV.

On September 1, 2013, the Developmental Disabilities Administration initiated the implementation of a new SFP Award Operating Procedure. The intention of the new SFP operating procedure is to improve the approval and award of funding and not to alter waiver reporting procedures. For clarification, the SFP Operating Procedures states:

"*The New SFP procedure does not eliminate or alter the technical requirements of the DDA or Medicaid, such as those relating to service changes, service requests, eligibility, or any other procedure outside the award of the individual's funding. All necessary steps to verify prerequisites and requirements, and to obtain documentation, remain in effect.*" (SFP Award Operating Procedure, Pg. 2)

It has come to the DDA's attention that WC12 forms (Community Pathways Waiver Reporting Forms) are not being consistently completed in all regions. WC12 forms must be completed in order to keep individuals in the waiver and ensure proper Medicaid claiming. Resource Coordinators need to continue completing WC12 forms, and, if they have not historically been doing so, need to start.

Under the Code of Maryland Regulations, COMAR 10.09.48.06 D. Resource Coordinators are responsible for monitoring and follow-up activities, which include support for the "(h) Application or re-application for necessary

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Web Site: http://dda.dhmh.maryland.gov

programs or services to prevent or remedy a gap in eligibility." It is under this regulation that Resource Coordinators should be supporting the proper completion of WC12 forms.

For consistency, steps were added to the new SFP Award Operating Procedure, to instruct Resource Coordinators to complete the proper WC12 form during their review and signature of the SFP. These forms should then be sent with the signed SFP to the provider for submission to the DDA. SFPs without accompanying WC12 forms will not be approved. If SFPs were submitted to the Regional Office without WC12 forms, Regional Offices may require Resource Coordinators to complete and submit applicable WC12 forms in order to process the SFPs.

Updates to the new SFP Operating Procedure will be published in Version 4, which will be uploaded to the DDA website under the provider tab, and emailed to the DDA community. The link can be found below:

http://dda.dhmh.maryland.gov/SitePages/providers.aspx

Attached are the relevant WC12 forms and guidance on when each should be completed.

Please contact your Regional Office if you have any other questions or comments regarding WC12 forms.

Community Pathways

Reporting Forms WC12-A, 12-B, 12-C & WC12-D
& Recertification of Need Form

WC12-A Reporting Form – Report any changes regarding the consumer's address, change in placement (transfer of services*), transfer of provider agencies, transfer of Resource Coordination agencies, and admission to a nursing home or chronic rehabilitation facility.

*If the person is transferring to a CSLA or F/ISS service, a copy of the Service Funding Plan must also be submitted.

WC12-B Discharge Reporting Form – Use this form to report a discharge from the waiver program. There may be situations when a person will be discharged from Community Pathways waiver but still receive DDA services. Please be sure to check the correct box. The actual date of discharge (last day of service) needs to be reported.

WC12-C Change in Service – This form will be completed if the person is now receiving an additional service or has had a reduction in service. If it is an additional service, please include the SFP.

WC12-D Financial Reporting – Report any changes in the person's income, insurance and/or resources. *This form is to be sent to DEWS only.

Recertification of Need – Individuals enrolled in a waiver program need to be determined to continue to need waiver services and meet the appropriate level of care at least annually, no less.

7-1-12

APPENDIX F-2: DDA2013008 TRANSMITTAL

STATE OF MARYLAND

DHMH

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

MEMORANDUM
Transmittal # DDA2013008

Date: December 11, 2013

To: Resource Coordinators

CC: DDA Assistant Directors
DDA Regional
DDA Deputy Regional Directors
DDA Providers

From: Valerie Roddy, Deputy Director VR

Re: **WC12 Form Additional Guidance**

THIS LETTER IS AVAILABLE IN ACCESSIBLE FORMATS. TO REQUEST ANOTHER FORMAT, PLEASE CONTACT DDA.CFO@MARYLAND.GOV.

WC12 form processing guidance was provided with the implementation of the Service Funding Process (SFP) Operating Procedure, however it has come to the DDA's attention that additional guidance is required for WC12 forms that do not directly relate to the SFP process. This memo seeks to provide clarification and instruction on submitting WC12 forms.

Additional Guidance on WC12 forms that Do Not Require SFPs

All WC12 forms that do not require an SFP must be submitted by resource coordinators directly to the regional office waiver units. The regional office will submit the form to the appropriate department thereafter. Examples of these circumstances are provided below:

1. Reduction in services, Form C
2. Nursing home admittances, Form A
3. Chronic Rehabilitation Facility admittances, Form A
4. Site/Provider changes, Form A
5. Discharges from services, Form B

6. Discharges from the waiver program, Form B

Clarification on Submitting WC12 Forms as outlined in the New SFP Operating Procedure

Specific to the WC12-A form, the resource coordinators must complete all fields on the WC12 form A, with the exception of the effective date. The effective date will be filled in by the regional office. All other WC12 forms should be completed in their entirety.

Please also continue to follow existing guidelines on when and what form to complete when reporting certain waiver activities.

If you have any other questions regarding the processing of WC12 forms, please email DDA.CFO@maryland.gov.

APPENDIX F-3: COMMUNITY PATHWAYS REPORTING FORM WC12−A TRADITIONAL SERVICES

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS WAIVER – Traditional Service Model
Reporting Form

TO: Terri Hartman
DDA Waiver Unit
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
Phone: (410) 767-5421 FAX: (410) 767-5850
Email: WaiverUnit@maryland.gov

INDIVIDUAL INFORMATION:

_____ _____ _____
Last Name First Name Middle Name/Initial

_____ _____ _____
Medical Assistance Number Social Security Number Jurisdiction/County

☐ Remains with _____ or _____ with a change of site address:
(Residential Provider) (Day Provider)
Address: _____ City: _____ Zip Code: _____
Date of Change: _____ Jurisdiction/County: _____

☐ Effective _____ (Date) has had a change in waiver service:
From _____ to _____ (Please write provider/address change above.)
(Type of Service) (Type of Service)
Examples: Residential Habilitation to Personal Supports; Supported Employment to Day Habilitation; FISS to Personal Supports

☐ Has moved from _____ and/or _____to a new waiver provider:
(Residential Provider) (Day Provider)
Provider: _____
Site Address: _____ City: _____ Zip Code: _____
Date of Change: _____ Jurisdiction/County: _____

☐ Has had a change in Resource Coordination Agency from _____ to
_____, _____
(Resource Coordination Agency) (Address)

☐ Has been admitted to:
☐ Nursing Facility: _____ **Admission Date**: _____ **Time**: _____
(Name of Facility)
Discharge Date: _____ **Time**: _____
☐ Chronic Rehabilitation Facility: _____ **Admission Date**: _____ **Time**: _____
(Name of Facility)
Discharge Date: _____ **Time**: _____
☐ Other: _____ **Admission Date**: _____ **Time**: _____
(Name)
Discharge Date: _____ **Time**: _____

_____ _____ _____
Completed By Agency Date

DHMH DD WC12-A-Traditional
Revised: May 19, 2014

APPENDIX F-4: COMMUNITY PATHWAYS REPORTING FORM WC12–A SELF-DIRECTED SERVICES

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS - Self Directed Services
Reporting Form

TO: Terri Hartman
DDA Waiver Unit
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
Phone: (410) 767-5421 FAX: (410) 767-5850
Email: WaiverUnit@maryland.gov

INDIVIDUAL INFORMATION:

_____ _____ _____
Last Name First Name Middle Name/Initial

_____ _____ _____
Medical Assistance Number Social Security Number Jurisdiction/County

☐ New Address: _____ City: _____ Zip Code: _____

Date of change: _____ Jurisdiction/County: _____

☐ Has had a change in Fiscal Management Services from _____

to _____; Effective Date: _____

☐ Has had a change in Support Broker:

New Support Broker: _____

Support Broker's Address: _____ City: _____ Zip Code: _____

Date of Change: _____ Email Address: _____

☐ Has had a change in Resource Coordination Agency from _____ to

_____, _____
(Resource Coordination Agency) (Address)

☐ Has been admitted to:

☐ Nursing Facility: _____ **Admission Date**: _____ **Time**: _____
(Name of Facility)
Discharge Date: _____ **Time**: _____

☐ Chronic Rehabilitation Facility: _____ **Admission Date**: _____ **Time**: _____
(Name of Facility)
Discharge Date: _____ **Time**: _____

☐ Other: _____ **Admission Date**: _____ **Time**: _____
(Name)
Discharge Date: _____ **Time**: _____

_____ _____ _____
Completed By Agency Date

DHMH DD WC12-A-Self Directed
Revised: May 19, 2014

APPENDIX F-5: DISCHARGE REPORTING FORM WC12−B

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS WAIVER
Discharge Reporting Form

TO: DDA Waiver Unit
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
Phone: (410) 767-5421 FAX: (410) 767-5850
Email: Waiver.DDA@maryland.gov

INDIVIDUAL'S INFORMATION:

_____ _____ _____
Last Name First Name Middle Name/Initial

_____ _____ _____
Medical Assistance Number Social Security Number Jurisdiction/County

☐ Discharged from **DDA Services:**

☐ Is Deceased: (Date of Death _____)
- □ Consumer was residing at site at time of death.
- □ Consumer was admitted to hospital on _____ and died in the hospital.

☐ Admitted to SRC/Nursing Facility/Hospital: (Date _____) (Admitting Facility: _____)

☐ Moved Out-of-State: (Date Moved _____)

☐ No Longer Receiving DDA Services: (Effective Date _____)

☐ Moved to a Non-DDA Provider: (New Provider _____) (Effective Date _____)

☐ Other Type of Discharge: (Date_____) Explanation _____
_____

☐ Discharged from **the Waiver Program** and Remains in DDA Service:

☐ Ineligible for Medical Assistance: (Date _____) (Reason _____)

☐ Receiving Fiscal Intermediary Services: (Date _____)

☐ Receiving Services from Another Waiver: (Date _____) (Waiver _____)

☐ Moved to a DDA Non-Waiver Provider: (Date _____) (Provider _____)

☐ Other type of Discharge. (Date_____) Explanation _____
_____

_____ _____ _____
Completed By Agency Date

DHMH DD WC12-B
Revised: April 9, 2014

APPENDIX F-6: CHANGE IN SERVICE REPORTING FORM WC12−C

DEVELOPMENTAL DISABILITIES ADMINISTRATION
COMMUNITY PATHWAYS

Change In Service

TO: Terri Hartman
DDA Waiver Unit
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
Phone: (410) 767-5421 FAX: (410) 767-5850
Email: Waiver.DDA@maryland.gov

INDIVIDUAL INFORMATION: SS#: _____

Name: _____ MA#: _____

Residential/CSLA Provider: _____

Day Provider: _____

Resource Coordination Agency: _____

EDD Purpose Only: Does this consumer contribute towards the Cost of Care? _____ Yes _____ No

(Check All That Apply and Provide Requested Information)

√	Waiver Service	Provider (Name or TBD)	Site Address City, County, & Zip Code	Addition or Reduction	Effective Date
	Assistive Technology & Adaptive Equipment				
	Behavioral Supports				
	Community Learning Service				
	Community Residential Habilitation				
	Community Supported Living Arrangement/ Personal Supports				
	Day Habilitation				
	Employment Discovery & Customization				
	Environmental Accessibility Adaptations				
	Environmental Assessments				
	Family and Individual Support Services				
	Live-In Caregiver Rent				
	Medical Day Care				
	Respite				
	Shared Living (formerly Individual Family Care)				
	Support Brokerage				
	Supported Employment				
	Transition Services				
	Transportation				
	Vehicle Modifications				

Signature: _____ Date: _____

DHMH DD WC12-C
Revised: May 13, 2014

APPENDIX F-7: FINANCIAL REPORTING FORM WC12–D

DEVELOPMENTAL DISABILITIES ADMINISTRATION

Notice of Case Activity - Financial Reporting

TO: Eligibility Determination Division
6 St. Paul Street, Suite 400
Baltimore, Maryland 21202
Phone: (410) 767-6603
FAX: (410) 333-0109

INDIVIDUAL'S INFORMATION:

_____
Last Name First Name Middle Name/Initial

_____ _____ _____
Medical Assistance Number Social Security Number Jurisdiction/County

☐ Has had a change in income*:

☐ New amount _____, Source _____, effective _____*

☐ Received lump sum payment of on/for the following period/
Reason _____

*It is not necessary to report the COLA (annual increase) for SSI recipients

☐ Has had a change in private insurance:

☐ Added: Insurance Company _____

☐ Cancelled: Insurance Company

☐ Changed from_____ to _____

☐ Has had a change in resources: Resources were under $2,000 and now resources exceed $2,000.
Amount to _____

_____ _____ _____
Completed By Agency Date

_____ _____
Email Telephone

DHMH DD WC12-D
Revised: April 9, 2014

APPENDIX G: MEDICAID APPLICATIONS

APPENDIX G-1: MEMO REGARDING ADVISORY MA APPLICATIONS

Developmental Disabilities Administration

Memo

To: All Regional Waiver Coordinators

From: Terri Hartman, Statewide Waiver Coordinator

CC: Rhonda Workman, Assistant Director, State and Federal Relations

Date: 8/30/2011

Re: Waiver Packets for Institutionalized Individuals

This memorandum serves as a reminder to refrain from submitting waiver packets to DDA Headquarters staff for institutionalized individuals. This includes individuals in nursing homes, prison, a State Residential Center (SRC), Spring Grove, one of the SETT units, etc. These individuals are not eligible for the waiver while they are residing in an institution.

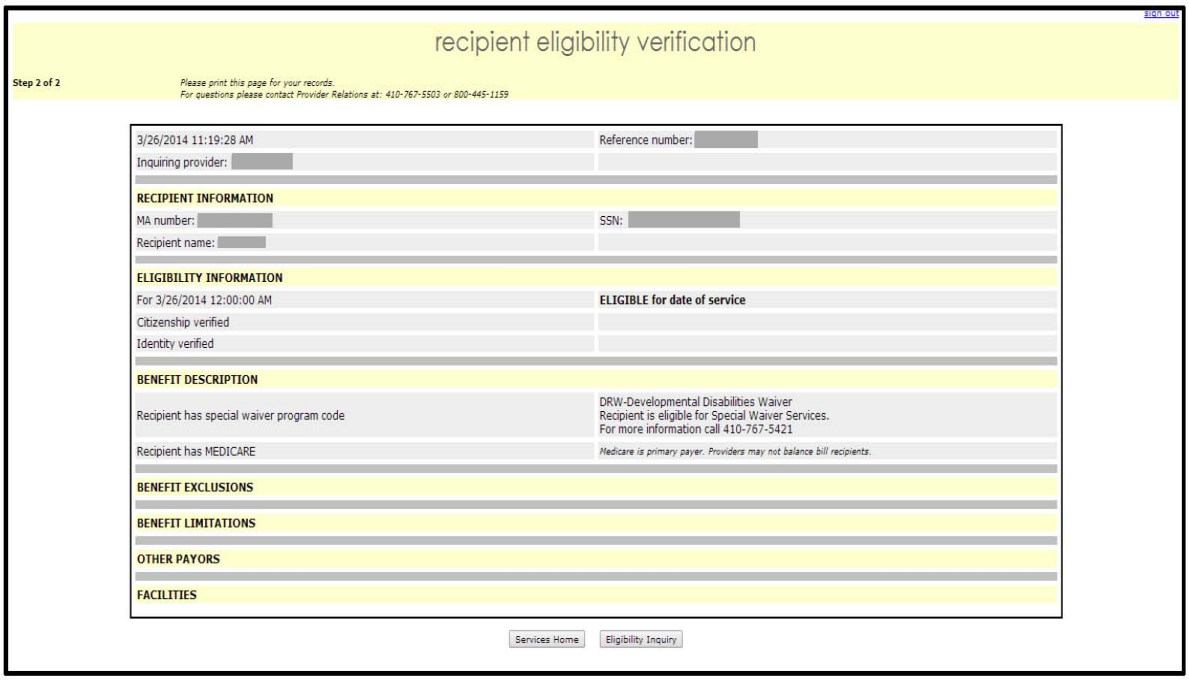
However, it is acceptable to submit ***only*** the Medical Assistance application and supporting documentation for DEWS with the completed cover sheet; which is attached to this memorandum. You must hold all remaining paperwork until the consumer is actually discharged. At the time of discharge the required waiver paperwork must be submitted along with the approved Service Funding Plan(s) and/or Individual Plan.

Please distribute this memorandum to all resource coordination supervisors.

APPENDIX G-2: e-MEDICAID – RECIPIENT ELIGIBILITY VERIFICATION

e-Medicaid – Recipient Eligibility Verification
EVS Check

Example A. Waiver Participant is ELIGIBLE for Service:



sign out

recipient eligibility verification

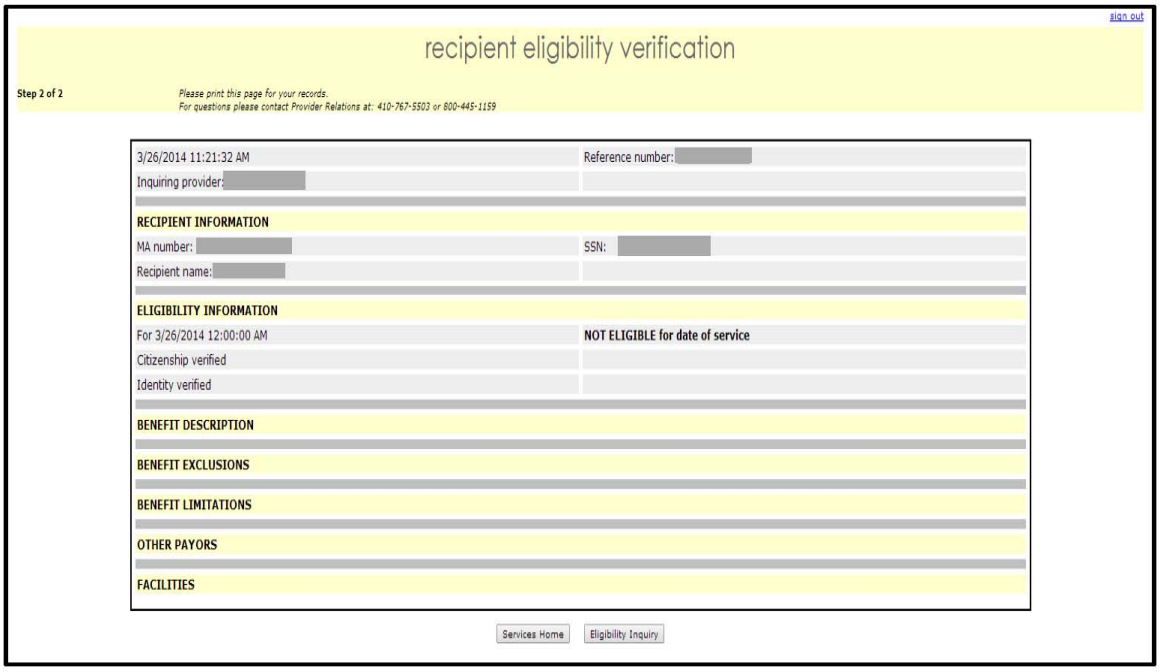
Step 2 of 2

Please print this page for your records.
For questions please contact Provider Relations at: 410-767-5503 or 800-445-1159

3/26/2014 11:19:28 AM	Reference number:
Inquiring provider:	
RECIPIENT INFORMATION	
MA number:	SSN:
Recipient name:	
ELIGIBILITY INFORMATION	
For 3/26/2014 12:00:00 AM	**ELIGIBLE for date of service**
Citizenship verified	
Identity verified	
BENEFIT DESCRIPTION	
Recipient has special waiver program code	DRW-Developmental Disabilities Waiver Recipient is eligible for Special Waiver Services. For more information call 410-767-5421
Recipient has MEDICARE	*Medicare is primary payer. Providers may not balance bill recipients.*
BENEFIT EXCLUSIONS	
BENEFIT LIMITATIONS	
OTHER PAYORS	
FACILITIES	

Services Home | Eligibility Inquiry

Example B. Waiver Participant is NOT ELIGIBLE for Service:



sign out

recipient eligibility verification

Step 2 of 2

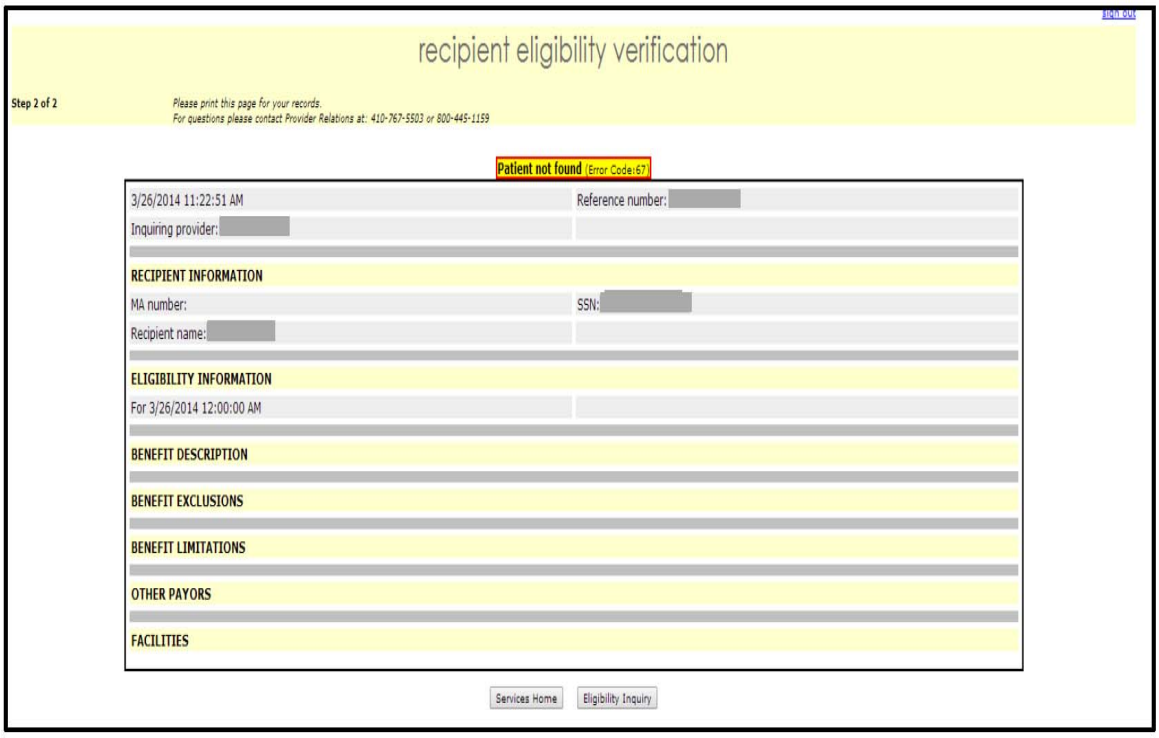
Please print this page for your records.
For questions please contact Provider Relations at: 410-767-5503 or 800-445-1159

3/26/2014 11:21:32 AM	Reference number:
Inquiring provider:	
RECIPIENT INFORMATION	
MA number:	SSN:
Recipient name:	
ELIGIBILITY INFORMATION	
For 3/26/2014 12:00:00 AM	**NOT ELIGIBLE for date of service**
Citizenship verified	
Identity verified	
BENEFIT DESCRIPTION	
BENEFIT EXCLUSIONS	
BENEFIT LIMITATIONS	
OTHER PAYORS	
FACILITIES	

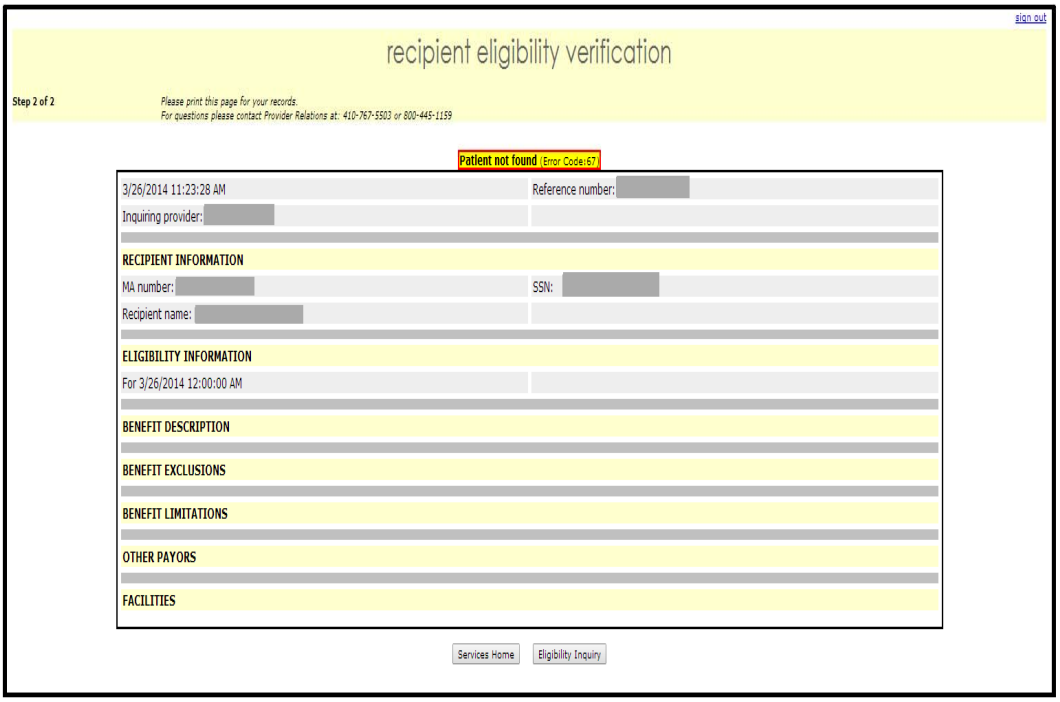
Services Home | Eligibility Inquiry

e-Medicaid – Recipient Eligibility Verification
EVS Check

Example C. Non-Waiver Participant is <u>NOT ELIGIBLE</u> for Service and NOT in MMIS:

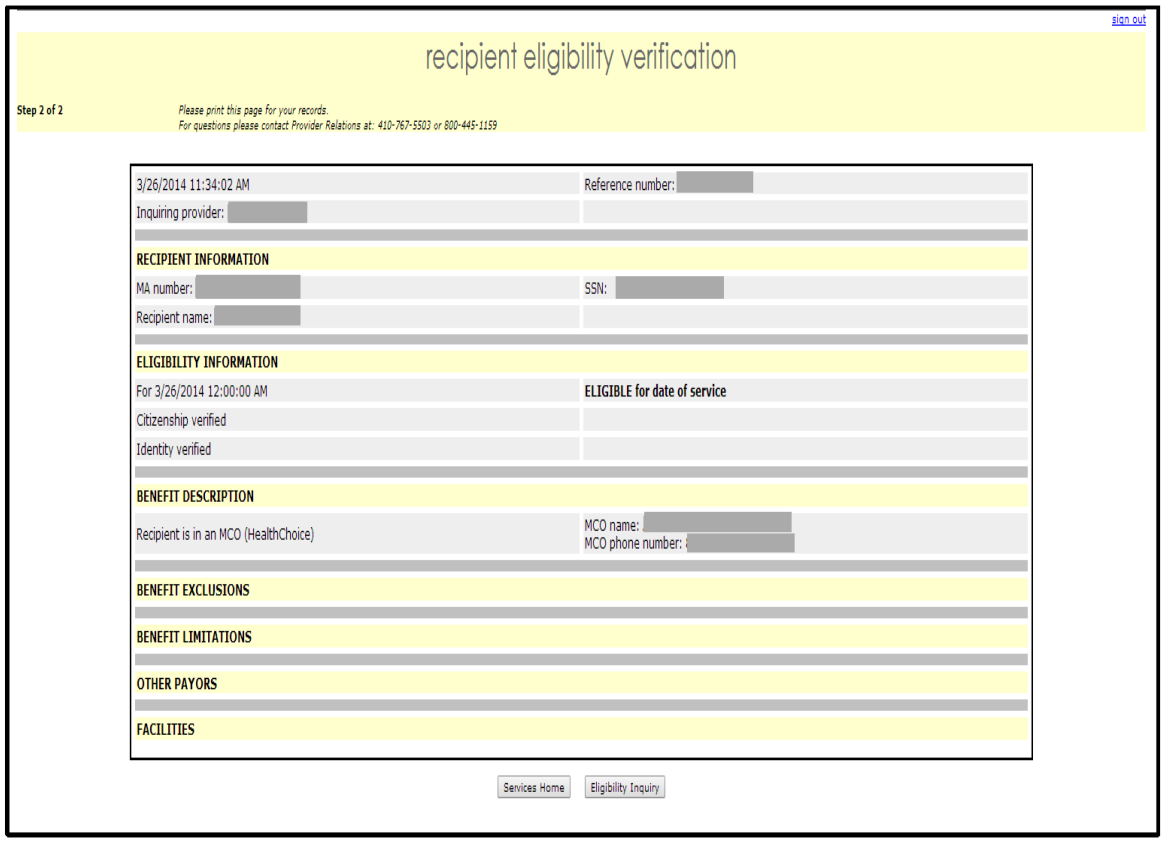


Example D. Waiver Participant is NOT ELIGIBLE for Service:



e-Medicaid – Recipient Eligibility Verification
EVS Check

Example E. Medicaid Recipient is PENDING for DD Waiver; but Eligible for State Plan Services:



sign out

recipient eligibility verification

Step 2 of 2

Please print this page for your records.
For questions please contact Provider Relations at: 410-767-5503 or 800-445-1159

3/26/2014 11:34:02 AM	Reference number:
Inquiring provider:	
RECIPIENT INFORMATION	
MA number:	SSN:
Recipient name:	
ELIGIBILITY INFORMATION	
For 3/26/2014 12:00:00 AM	**ELIGIBLE for date of service**
Citizenship verified	
Identity verified	
BENEFIT DESCRIPTION	
Recipient is in an MCO (HealthChoice)	MCO name: MCO phone number:
BENEFIT EXCLUSIONS	
BENEFIT LIMITATIONS	
OTHER PAYORS	
FACILITIES	

Services Home | Eligibility Inquiry

APPENDIX G-3: MA APPLICATION DHR/FIA 9708 – CHILD UNDER 21

RC MUST SIGN AND PUT THE DATE OF THE WAIVER MEETING IN TOP RIGHT CORNER OF THIS PAGE

MARYLAND DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION

ELIGIBILITY DETERMINATION DOCUMENT FOR A CHILD IN LONG TERM CARE, WAIVER, KINSHIP CARE OR ANY PERSON UNDER 21 NOT IN A FAMILY

FOR WORKER USE ONLY	LDSS Office/DEWS/Financial Agent	Programs Applied For/Receiving	Assistance Unit ID's
	Worker's Name		Client ID
	Application/Redetermination Date		

ANSWER THE FOLLOWING QUESTIONS HONESTLY AND COMPLETELY. FAILURE TO GIVE TRUTHFUL AND COMPLETE INFORMATION MAY RESULT IN DENIAL OF ASSISTANCE AND CRIMINAL PROSECUTION.

PLEASE PRINT ALL ANSWERS

The child is currently receiving:
☐ Cash Assistance ☐ Food Stamps
☐ Medical Assistance I.D.#
_____
☐ Other, list: _____

The Child is applying for Medical Assistance in:
☐ Long Term Care ☐ Kinship Care ☐ RTC/RICA/IMD
☐ Hospital ☐ Nursing Facility ☐ ICF/MR
☐ Waiver ☐ Community ☐ Not in family

Does the child need Medical Assistance for a prior month?
☐ Yes ☐ No

1. CHILD'S NAME [ADDR]

Last Name	First Name	Middle Name	Jr., III, etc.	Maiden Name

2. ADDRESS [ADDR] What is the child's current address?

Name of Facility/Institution (if applicable)	Number Street	Apt. No.	Floor No.

City	State	Zip Code + 4	Telephone Number

3. MAILING ADDRESS *(If Different)* [ADDR/PREV]

Name of Facility/Institution (if applicable)	Number Street	Apt. No.	Floor No.

P.O. Box	City	State	Zip Code + 4	Telephone Number

4. AUTHORIZED REPRESENTATIVE [ADDR / AREP]

First Name	Middle Name	Last Name	Jr., III, etc.

Number Street	City	State	Zip Code + 4

Telephone Number	Relationship to child

As representative, what do you want to do? ☐ Complete interview ☐ Sign Application ☐ Receive Notices ☐ Receive the child's Medical Assistance Card

5. INFORMATION ABOUT CHILD [STAT / DEM1 / DEM2/ SSNA]

Other Name	Social Security Number	Additional Social Security Number	Date of Birth

Sex ☐ Male ☐ Female	Race *(Optional)*	City & State of Birth	Hospital where born

Resident of Maryland? ☐ YES ☐ NO	Marital Status	Due Date if pregnant	Number expected

Receiving Public Assistance in another state? ☐ YES ☐ NO	Receiving Medical Assistance in another state? ☐ YES ☐ NO

U.S. Citizen ☐ YES ☐ NO	Student ☐ YES ☐ NO	Disabled or Incapacitated ☐ YES ☐ NO	Medical Insurance ☐ YES ☐ NO	Receives Medicare Part A ☐ YES ☐ NO	Receives Medicare Part B ☐ YES ☐ NO Medicare Claim #:_____

FOR WORKER USE ONLY
4. Authorized Representative Type
5.SSA Application Date Living Arrangement

DHR/FIA CARES 9708 (Revised 3/04) Previous editions are obsolete. 1

6. CITIZENSHIP [DEM2 / ALAS] If the child for whom you are applying is not a United States citizen, fill in this section:

INS Status	Newly Legalized Status Date	Sponsored Alien ☐ YES ☐ NO	Country of Origin
US Entry Date	INS Number	Refugee Resettlement Agency	

7. SCHOOL [DEM2/ALAS] If the child is in school, fill in this section.

Student Status	Educational Level	Highest Grade Completed
☐ Full Time ☐ Half time ☐ Less than halftime	☐ Elementary ☐ College ☐ Secondary ☐ Other, List _____	Expected Graduation Date *(If in High School)*

School Name			School Number
School Address	City	State	Zip Code + 4

8. DISABILITY [DEM2] If the child is disabled or incapacitated, what is the disability?

9. MEDICAL INSURANCE [DEM2/TPL1] If the child is insured, fill in this section: If more than one, place additional information on page 6.

Policy Number	Group Number	Policy Holder Name
Relationship to Policy Holder		Policy Effective Dates From: To:

POLICY HOLDER ADDRESS

Number Street			
City	State	Zip Code + 4	Telephone Number

INSURANCE COMPANY

Insurance Company Name			
Number Street			
City	State	Zip Code + 4	Telephone Number

UNION

Union Name			Union Local Number
Number Street			
City	State	Zip Code + 4	Telephone Number

10. LONG TERM CARE [INST] To be completed for a child in a Long Term Care Facility:

Date of admission to this facility	Date of discharge from this facility	Date for which Medical Assistance is requested
Child's address prior to admission to this facility		
Is any health insurance coverage in the child's own name? ☐ YES ☐ NO	If yes, who pays the premium? Name:	Relationship to child:
Amount of premium	How often paid?	Is the child expected to return home? ☐ YES ☐ NO
If yes, expected date of return?	Address to which the child will return?	

FOR WORKER USE ONLY	8. Disability Approval Source _____	Disability Begin Date _____
	Disability Approval Date _____	Disability End Date _____

2

11. CHILD SUPPORT INFORMATION FOR MEDICAL ASSISTANCE Complete this section for each parent, whether absent or deceased.

MOTHER'S INFORMATION [DEM1/APID/APAD/APDE]

Name of Mother *(First, middle, last, etc.)*	Relationship of Parent to You

MARITAL STATUS OF CHILD'S PARENTS WHEN THE CHILD WAS BORN	IF MARRIED	Marriage Date	Place *(City, State)*
☐ Married ☐ Divorced ☐ Unknown ☐ Separated ☐ Never Married			

Social Security Number	Other Name	Driver's License State	Car License Plate State	Car License Plate Number

CURRENT ADDRESS	Number Street			PREVIOUS ADDRESS	Number Street		
	City	State	Zip Code + 4		City	State	Zip Code + 4
	Telephone	Date at Address			Telephone	Date at Address	

Date of Birth	Age	Birth Place *(City State)*	Race	Height

Hair Color	Eye Color	Weight	Veteran Status	Military ID Number	Military Branch

CURRENT PRIOR MILITARY DATES	From	To	Paying Military Allotment? ☐ YES ☐ NO	To Whom?

Incarcerated ☐ Currently ☐ Previously ☐ Never	Institution Name

MOTHER'S INCOME INFORMATION [APEM]

Employer Name	Occupation	EMPLOYMENT DATES	From	To
Number Street	**City**	**State**	**Zip Code +4**	**Telephone**
Second Employer Name	Occupation	EMPLOYMENT DATES	From	To
Number Street	City	State	Zip Code +4	Telephone
Former Employer Name	Occupation	EMPLOYMENT DATES	From	To
Number Street	City	State	Zip Code +4	Telephone

Other Income/benefits:

☐ Social Security ☐ SSI ☐ Veteran's Pension ☐ Unemployment
☐ Worker's Compensation ☐ Pension / Retirement ☐ Union Benefits ☐ Other, list_____

MOTHER'S COURT ORDER INFORMATION [APCO]

Paying Support ☐ YES ☐ NO	To Whom	Last Paid Date	Payment Amount $	Agency / Court Name

COURT ORDER	Docket Number	Support Obligation $	How Often

FOR WORKER USE ONLY	11. Legal Relationship_____ Marriage Status _____ Assignment of Rights Indicator _____ IV-D Cooperation Indicator _____

3

11. CHILD SUPPORT INFORMATION FOR MEDICAL ASSISTANCE Complete this section for each parent, whether absent or deceased.

FATHER'S INFORMATION [DEM1/APID/APAD/APDE]

Name of Father *(First, middle, last, etc.)*			Relationship of Parent to You
MARITAL STATUS OF CHILD'S PARENTS WHEN THE CHILD WAS BORN ☐ Married ☐ Divorced ☐ Unknown ☐ Separated ☐ Never Married	IF MARRIED	Marriage Date	Place *(City, State)*

Social Security Number	Other Name	Driver's License State	Car License Plate State	Car License Plate Number

CURRENT ADDRESS	Number Street			PREVIOUS ADDRESS	Number Street		
	City	State	Zip Code + 4		City	State	Zip Code + 4
	Telephone	Date at Address			Telephone	Date at Address	

Date of Birth	Age	Birth Place *(City State)*	Race	Height

Hair Color	Eye Color	Weight	Veteran Status	Military ID Number	Military Branch

CURRENT PRIOR MILITARY DATES	From	To	Paying Military Allotment? ☐ YES ☐ NO	To Whom?

Incarcerated ☐ Currently ☐ Previously ☐ Never	Institution Name

FATHER'S INCOME INFORMATION [AFEM]

Employer Name	Occupation	EMPLOYMENT DATES	From	To
Number Street	City	State	Zip Code +4	Telephone
Second Employer Name	Occupation	EMPLOYMENT DATES	From	To
Number Street	City	State	Zip Code +4	Telephone
Former Employer Name	Occupation	EMPLOYMENT DATES	From	To
Number Street	City	State	Zip Code +4	Telephone

Other Income/benefits:

☐ Social Security ☐ SSI ☐ Veteran's Pension ☐ Unemployment
☐ Worker's Compensation ☐ Pension / Retirement ☐ Union Benefits ☐ Other, list_____

FATHER'S COURT ORDER INFORMATION [APCO]

Paying Support ☐ YES ☐ NO	To Whom	Last Paid Date	Payment Amount $	Agency / Court Name

COURT ORDER	Docket Number	Support Obligation $	How Often

FOR WORKER USE ONLY	11. Legal Relationship_____	Marriage Status _____
	Assignment of Rights Indicator _____	IV-D Cooperation Indicator _____

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FOR WORKER USE ONLY	12. Life Insurance Type 13. Life Insurance Type 14. Vehicle FMV Amount 15. Date Lien Agreements Signed

12. LIQUID ASSETS [AST1] Complete for assets as of the 1st day of this month. Check Yes or No for each ASSET TYPE. If you check YES, fill in the other boxes.

ASSET TYPE	CHECK ONE	OWNER	AMOUNT	ACCOUNT #	FDIC NUMBER	INSTITUTION NAME
Cash on Hand	☐ YES ☐ NO		$	N/A	N/A	N/A
Checking Account	☐ YES ☐ NO		$			
Savings Account	☐ YES ☐ NO		$			
Credit Union Accounts	☐ YES ☐ NO		$			
Trust Funds	☐ YES ☐ NO		$			
IRA or Keogh Accounts	☐ YES ☐ NO		$			
Stocks, bonds, Certificates, Money Market Funds, Treasury or Other Notes	☐ YES ☐ NO		$			
Other, List: _____	☐ YES ☐ NO		$			
Other, List: _____	☐ YES ☐ NO		$			

13. LIFE INSURANCE AND FUNERAL PLANS [AST1] If the child has any life insurance or pre-paid burial plans or funds, fill in this section. List all policies and plans no matter who pays for them.

NAME OF PERSON WHO PAYS	ORIGINAL FACE VALUE OR VALUE OF PLAN	CURRENT CASH VALUE	LIFE INSURANCE BURIAL PLAN	POLICY NUMBER OR ACCOUNT NUMBER	COMPANY, FUNERAL HOME OR BANK NAME
	$	$			
	$	$			
	$	$			
	$	$			

14. MOTOR VEHICLE [AST2] If the child has a boat, camper, trailer, and/or recreational vehicle, fill in this section. Complete for licensed and/or unlicensed vehicles.

Type of Vehicle		How Used		Amount Owed
				$
Year	**Make / Model**	**License Plate Number**	**Registration Number**	**Vehicle Identification Number**

15. REAL PROPERTY [AST2] If child owns or is purchasing property, fill in this section. Include burial plots.

Number	Street	City	State	Zip Code + 4

How Used?	Current Fair Market Amount	Owner	Amount Owed Now	Trying to Sell
	$		$	☐ YES ☐ NO

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16. OTHER ASSETS [AST3] If the child owns other assets not listed, such as antiques, coin collections, furs, jewelry, livestock, or stamp collections, fill in this section:

ASSET TYPE	CURRENT FAIR MARKET VALUE	AMOUNT OWED	Owner
	$	$	
	$	$	

17. POTENTIAL ASSET OR INCOME If the child is expecting to receive an accident settlement, trust fund, inheritance or other money or property, fill in this section:

Type	Lawyer Name
Explanation	Lawyer 's Telephone

18. TRANSFER OF ASSETS [TRAN] If any property, motor vehicles, stocks, bonds, cash or other assets belonging to the child were sold traded or given away in the past 36 months, 60 months for a trust, fill in this section:

Transfer Date	Who Received the Asset	Type of Asset
Fair Market Value when transferred	Amount Received	Reason for Transfer

19. INCOME FROM WORKING [ERN1 / ERN2] If the child is working now, fill in this section. If not, list the last job held. Include full-time, part-time or temporary work.

Employer Name					Federal ID	
Employer Name - Number	Street	City	State	Zip Code + 4	Telephone	Type of Job

Date Job Began	Date Job Ended	Reason For Leaving	Date Last Pay Received if Job Ended	Gross Wages before deductions per Pay Period *(include tips, commissions)* $
Hours Per Pay Period	How Often Paid	**SELF EMPLOYMENT OR HANDICAPPED WORK EXPENSES**	Type	
			Amount	$

20. OTHER INCOME AND BENEFITS [UINC] Check if the child is receiving, has applied for or has been denied any of the following:

TYPE OF BENEFIT	RECEIVING BENEFITS	AMOUNT	APPLICATION STATUS	APPLICATION OR DENIAL DATE
Child Support	☐YES ☐NO	$	☐Applied for ☐Denied	
IV-E foster Care or IV-E Subsidized Adoption Payment	☐YES ☐NO	$	☐Applied for ☐Denied	
State -subsidized adoption or state-subsidized foster care payment	☐YES ☐NO	$	☐Applied for ☐Denied	
Social Security Claim No:	☐YES ☐NO	$	☐Applied for ☐Denied	
SSI (Supplemental Security Income) Claim No:	☐YES ☐NO	$	☐Applied for ☐Denied	
Railroad Benefits Claim No:	☐YES ☐NO	$	☐Applied for ☐Denied	
Veteran's Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Unemployment Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Worker's Compensation	☐YES ☐NO	$	☐Applied for ☐Denied	
Pension/Retirement/Survivor's Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Disability /Sick/Maternity Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Union Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Military Allotment	☐YES ☐NO	$	☐Applied for ☐Denied	
Black Lung Benefits	☐YES ☐NO	$	☐Applied for ☐Denied	
Lump sum Amounts	☐YES ☐NO	$	☐Applied for ☐Denied	
Civil Service Annuity	☐YES ☐NO	$	☐Applied for ☐Denied	
Public Assistance/State Disability Benefits from Another State	☐YES ☐NO	$	☐Applied for ☐Denied	
Interest or Dividends from Stocks, Bonds, Savings, or Other Investments	☐YES ☐NO	$	☐Applied for ☐Denied	
Other Income *(not listed above)* Type:	☐YES ☐NO	$	☐Applied for ☐Denied	
Other Income *(not listed above)* Type:	☐YES ☐NO	$	☐Applied for ☐Denied	

21. ADDITIONAL INFORMATION

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YOU HAVE THE FOLLOWING RIGHTS:

RIGHT TO APPEAL - You have a right to a timely decision of your Medical Assistance eligibilty. You can appeal any action taken by the Department. Ask for a hearing if you disagree with the Department's decision or wish to appeal any action or delay in the Department's action related to your application. Your case manager can help you write your appeal. Please explain in your request your reason for requesting a fair hearing. You may call the Department at 1-800-332-6347 for help to request a hearing. At the hearing, you can speak for yourself or bring a lawyer, friend, or relative to speak for you.

RIGHT TO WRITTEN NOTICE - We must always give you a written notice explaining your benefits when we approve your case. We must always give you written notice when we change your benefits, deny, or close your case. You have 90 days from the notice date to ask for a hearing. If you ask for a hearing within 10 days, you may be able to keep getting benefits while you wait for a hearing.

EQUAL RIGHTS - The Department may not discriminate against you.

YOU HAVE THE FOLLOWING RESPONSIBILITIES:

PROVIDE INFORMATION - You must give true and complete information. You must provide proof of this information. We will keep this information private.

PROVIDE SOCIAL SECURITY NUMBER(S) - You must give a Social Security number for the child for whom Medical Assistance is requested. We will use the Social Security numbers and other information you give us to do computer matching and program reviews. We will do this to make sure the child is eligible. We may contact the child's employer, bank or other party. We may also contact local, state or federal agencies to be sure the information you give us is correct. If you do not have a Social Security number, we will help you get one.

REPORT CHANGES - You must report all changes within ten (10) days. Examples are changes in address, income, employment, health insurance, and assets. You may report changes in person, by telephone, or by mail to the Department.

USE YOUR MEDICAL ASSISTANCE CARD(S) PROPERLY - You may keep the Medical Assistance cards only for the person eligible.

PENALTIES - If you do not report correct information or changes, we may deny, stop, or reduce your benefits. A judge may fine you and/or imprison you if you intentionally do not give correct information or report changes.

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ASSIGNMENT OF SUPPORT RIGHTS

When eligibility for Medical Assistance is established:

- I assign all rights, title, and interest in medical support and health insurance payments I may have for myself or any person receiving Medical Assistance. This includes overdue medical support or health insurance payments that have not been collected.
- I agree to have the child support agency collect medical support payments owed to me and to keep up to the amount of Medical Assistance payments that have been made for me.
- I agree to turn over to the State of Maryland any medical support or health insurance payments I receive.

To continue to receive Medical Assistance:

- I will cooperate with the child support agency to the best of my ability and Knowledge.

I HAVE READ THESE STATEMENTS OR SOMEONE HAS READ THEM TO ME. I UNDERSTAND WHAT THEY MEAN. BY SIGNING MY NAME BELOW, I AGREE TO FOLLOW WHAT THEY SAY.

Signature	Date

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READ BEFORE SIGNING:

I understand that I can be punished by fine, imprisonment or reduction of benefits for making false statements. I also know I can be punished for not reporting changes which may affect the child's eligibility or benefit amount. I know the Department can use the application against me in a court of law for fraud prosecution.

I understand that the Department may select my case for a spot check. I agree to allow any representative from the Department to visit me at home. I will help them get all proofs needed from any source.

If I am accepting Medical Assistance, I understand by signing this application, I:

- Authorize payment under Medicare Part B to be made directly to doctors and medical suppliers.
- Give the Department the right to seek payment from private or public health insurance and any liable third party. The Department can seek payment without legal action, providing it does not keep more than the amount Medical Assistance paid.
- Give the Department the right to inspect, review and copy all medical records for services received through the Medical Assistance Program.

PENALTIES FOR MEDICAL ASSISTANCE FRAUD

Every person convicted of the crime of "Medical Assistance Fraud" in which the value of the money, services, or goods involved is $500.00 or more is guilty of a felony, and shall:

1. Make full restitution of the money, services or goods; or the value of those services or goods unlawfully received;
2. Be subject to a fine of not more than $10,000, and imprisoned for a period not to exceed five years, or both.

Every person convicted of the crime of "Medical Assistance Fraud" in which the value of the money, services or goods is less than $500.00 is guilty of a misdemeanor, and shall:

1. Make full restitution of the money, services or goods; or the value of those services or goods unlawfully r received;
2. Be subject to a fine of not more than $1,000, and imprisoned for a period not to exceed three years, or both.

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SIGNATURE PAGE

I swear or affirm that I have read or had read to me this entire application. I also swear or affirm under penalty of 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 this child's 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 this child's eligibility for benefits. I certify, under penalty of perjury, by signing my name below, that this child is a U.S. citizen or lawfully admitted immigrant.

YOU HAVE THE FOLLOWING RESPONSIBILITIES:

You are providing personal information (Name, Address, Date of Birth, Social Security Number, Income History, Employee History, etc.) in this application for Medical Assistance. The purpose of requesting this personal information is to determine this child's eligibility for Medical Assistance. If you do not provide this personal information, the Medical Assistance Program may deny your application for benefits. You have a right to inspect, amend or correct this personal information. The Medical Assistance Program will not permit inspection of personal information, or make it available to others, except as permitted by federal and state laws.

Signature of Applicant / Recipient	Date
Signature of Witness (If you Signed an X)	Date
Signature of Spouse (If Applicable)	Date
Signature of Authorized Representative	Date

☐ I withdraw my application for Medical Assistance

Signature of Applicant / Recipient/Authorized Representative	Date

FOR WORKER USE ONLY

Program / Medical Coverage Group _____ AU ID _____

Signature of Case Manager	Date

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YOU HAVE THE FOLLOWING RIGHTS:

RIGHT TO APPEAL - You have a right to a timely decision of your Medical Assistance eligibilty. You can appeal any action taken by the Department. Ask for a hearing if you disagree with the Department's decision or wish to appeal any action or delay in the Department's action related to your application. Your case manager can help you write your appeal. Please explain in your request your reason for requesting a fair hearing. You may call the Department at 1-800-332-6347 for help to request a hearing. At the hearing, you can speak for yourself or bring a lawyer, friend, or relative to speak for you.

RIGHT TO WRITTEN NOTICE - We must always give you a written notice explaining your benefits when we approve your case. We must always give you written notice when we change your benefits, deny, or close your case. You have 90 days from the notice date to ask for a hearing. if you ask for a hearing within 10 days, you may be able to keep getting benefits while you wait for a hearing.

EQUAL RIGHTS - The Department may not discriminate against you.

RIGHT TO REFUSE HELP - You do not have to accept help from a religious organization if it violates your religious beliefs.

YOU HAVE THE FOLLOWING RESPONSIBILITIES:

PROVIDE INFORMATION - You must give true and complete information. You must provide proof of this information. We will keep this information private.

PROVIDE SOCIAL SECURITY NUMBER(S) - You must give a Social Security number for the child for whom Medical Assistance is requested. We may deny, stop or reduce the child's benefits if you do not. We will also ask you to give a Social Security number for anyone whose income and assets affect your child's eligibility. We will use the Social Security numbers and other information you give us to do computer matching and program reviews. We will do this to make sure the child is eligible. We may contact the child's employer, bank or other party. We may also contact local, state or federal agencies to be sure the information you give us is correct. If you do not have a Social Security number, we will help you get one.

REPORT CHANGES - You must report all changes within ten (10) days. Examples are changes in address, income, employment, health insurance, and assets. You may report changes in person, by telephone, or by mail to the Department.

USE YOUR MEDICAL ASSISTANCE CARD(S) PROPERLY - You may use the Medical Assistance cards only for the person eligible.

PENALTIES - If you do not report correct information or changes, we may deny, stop, or reduce your benefits. A judge may fine you and/or imprison you if you intentionally do not give correct information or report changes.

APPENDIX G-4: MA APPLICATION "LONG" DHR/FIA CARES 9709

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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REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

RC MUST SIGN AND PUT THE DATE OF THE WAIVER MEETING IN TOP RIGHT CORNER OF THIS PAGE

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

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

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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?	What is your Country of Origin?
_____	_____/_____/_____	☐ YES ☐ NO	_____

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

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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 _____

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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 (Jr., Sr., etc.)	Maiden Name or Other Name

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: _____

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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 _____

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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	

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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		$		

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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
_____	_____

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SECTION O – POTENTIAL ASSET OR INCOME (continued)	
Explanation Anticipated Date of Receipt _____	Lawyer Telephone #

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	$	$

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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	

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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		$		

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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
			$		$	

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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.*

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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: _____

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

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.

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- **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

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

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

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APPENDIX G-5: MA APPLICATION "SHORT" DHR/FIA 9709S

Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	Family Investment Administration **ACTION TRANSMITTAL**
Control Number: 13-13	Effective Date: Immediately Upon Receipt
	Issuance Date: May 16, 2013

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

FROM: DEBBIE RUPPERT, EXECUTIVE DIRECTOR, DHMH/OES Debbie Ruppert
ROSEMARY MALONE, EXECUTIVE DIRECTOR, FIA Rosemary Malone

RE: PROCEDURAL CHANGES FOR EXPEDITING LONG TERM CARE (LTC) AND HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS FOR SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS AND COMMUNITY-ELIGIBLE INDIVIDUALS

PROGRAM AFFECTED: MEDICAL ASSISTANCE

ORIGINATING OFFICE: OFFICE OF ELIGIBILITY SERVICES

SUMMARY

The Deficit Reduction Act (DRA) of 2005 lengthened the 36-month look-back period for initial long term care (LTC) applications to 60 months prior to the month of the initial application. This resulted in an increased workload for case managers when determining an applicant's initial eligibility. The extra work on the applications adversely affected the timely processing of the LTC applications. DHMH and DHR, in conjunction with long term care providers and client advocates, continue to collaborate to develop strategies to improve the timely processing of LTC applications and redeterminations.

This Action Transmittal (AT) introduces the streamlined application for Supplemental Security Income (SSI) recipients and Community-eligible individuals to use to apply for expedited eligibility for Medical Assistance (MA) for Long Term Care and Home and Community-Based Services (HCBS) Waivers. The intent of the streamlining effort is to maintain program integrity while reducing access barriers related to documentation and

verification requirements that are not applicable to SSI recipients or were previously verified during the application process for a Community- eligible individual.

The new streamlined application is designed to make the existing verification policy specific to Long Term Care (LTC) Eligibility more effective. When it can be verified that the LTC applicant was a recipient of a needs-based public benefit at any time during the 5 year period before the month of application, verification of the value of resources during the look- back period is not required. Resources still need to be verified as of the month of application.

ACTION REQUIRED:

Begin using the new application form (Form 9709S) upon receipt. This streamlined application form is also available in electronic format, which is designed to be user friendly for both the applicant (or representative) and the case manager. DHMH is scheduling training on the streamlined application process and the new application form this month.

Application Procedures

Upon receipt of the streamlined application the case manager will:

1. Complete a SVES, SDX and SOLQ clearance to verify SSI income.
2. Compare information received from clearances to information received from the applicant.
3. Request appropriate verification if a discrepancy exists or if information is questionable.
4. Process the application according to standard procedures.

Please Note: General application procedures for individuals applying for Medical Assistance have not changed.

ATTACHMENT:

Form 9709S SSI Recipient/Community- Eligible Application

INQUIRIES:

Please direct policy questions to DHMH Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231 (select option 2 and request extension 1463).

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

MARYLAND DEPARTMENT of HUMAN RESOURCES
MARYLAND DEPARTMENT of HEALTH AND MENTAL HYGIENE
SSI RECIPIENT/COMMUNITY- ELIGIBLE
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE

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

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

- □ Bank and Financial statements on all accounts owned and co-owned as of the first of the month
- □ Power of Attorney of Legal Guardianship Documents (if any)
- □ Long-Term Care Insurance Policies
- □ Current statement of retirement accounts
- □ Current statement of IRA or Keogh Accounts
- □ Current statements of:
  - □ Stock
  - □ 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)
- □ Private Health Insurance Cards including Medicare (copy of both sides)
- □ Health Insurance premium amounts

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

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

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

RC MUST SIGN AND PUT THE DATE OF THE WAIVER MEETING IN TOP RIGHT CORNER OF THIS PAGE

MARYLAND

MARYLAND DEPARTMENT of HUMAN RESOURCES
MARYLAND DEPARTMENT of HEALTH AND MENTAL HYGIENE
SSI RECIPIENT/COMMUNITY- ELIGIBLE
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE
APPLICATION

Date Sign
Received in
MUST BE DA

Worker Name

Case Number

S

USE THIS FORM ONLY FOR SSI RECIPENT/COMMUNITY- ELIGIBLE

SECTION A – APPLICANT INFORMATION: Please tell us about yourself.

I am applying for:

□ Long-Term Care Facility and/or □ Home and Community-Based Services Waiver

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

Social Security Number _____ Date of Birth: (Month,Day,Year) _____

What is your home address or the address of your nursing facility? Gender □ Male □ Female

Street _____ City _____ State _____ Zip _____

Telephone Number _____

Is this your mailing address? □ Yes □ No
*(If, no please provide your mailing address information in **Section P**)*

Previous Address:

Street _____ City _____ State _____ Zip _____

Did you or your spouse own this home?
□ Yes □ No

Marital Status
□ Single
□ Married
□ Divorced
□ Separated
□ Widowed

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

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SECTION B – BENEFIT STATUS:

Are you currently receiving Medicaid (Medical Assistance)? □ Yes □ No

If yes, please provide your Medicaid (Medical Assistance) ID # _____

Are you a resident of Maryland? □ Yes □ No

Are you receiving Medicaid (Medical Assistance) benefits from another state? □ Yes □ No If yes, please list the state. _____

Do you need Medicaid (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

SECTION C – SPOUSE INFORMATION: Tell us about your spouse.

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

Spouse's Social Security Number _____

Street _____ City _____ State _____ Zip _____

Telephone Number _____

Do you or your spouse own this home?
□ Yes □ No

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

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

Street _____ City _____ State _____ Zip _____

Telephone Number _____

What is the authorized representative's relationship to you?

_____

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

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 Number _____

Insurance Company

Insurance Company Name _____

Street _____ City _____ State _____ Zip _____

Telephone Number _____

SECTION G – BENEFITS AND OTHER INCOME OF APPLICANT OR SPOUSE: Please tell us about any income or benefits that you or your spouse are currently receiving, have applied for, or have been denied. Check all below that apply. If you check a benefit, fill in the details in the boxes below.

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

- □ SSI (Supplemental Security Income) Please write your claim # _____
- □ SSI (Supplemental Security Income): **Spouse,** Please write the claim # _____
- □ Social Security Income: Please write your claim # _____
- □ Social Security Income: **Spouse,** Please write the claim # _____
- □ Railroad Retirement Benefit: Please write your claim # _____
- □ Railroad Retirement Benefit: **Spouse,** Please write the claim # _____
- □ Alimony
- □ Worker's Compensation
- □ Union Benefits
- □ Unemployment Benefits
- □ Business Income
- □ Rental Income
- □ Compensation from a Legal Settlement
- □ Lump Sum Cash Amount
- □ Black Lung Benefits
- □ Veteran's Pension/Benefits/Compensation/Aid and Attendance
- □ Pension or Retirement
- □ Disability/Sick Benefits
- □ Civil Service Annuity
- □ Other (Please Describe) _____

Type of Benefit or Income	Receiving Income or Benefits?	Person(s) Receiving Income or Benefits	Amount	Application Status	Application or Denial Date
	□ Yes □ No	□ Self □ Spouse	$ $	□ Applied for □ Denied	
	□ Yes □ No	□ Self □ Spouse	$ $	□ Applied for □ Denied	
	□ Yes □ No	□ Self □ Spouse	$ $	□ Applied for □ Denied	
	□ Yes □ No	□ Self □ Spouse	$ $	□ Applied for □ Denied	

SECTION H – 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 P*** *or attach additional sheets.*

Employer Name _____	Type of Job _____
Employer Address Street _____ City _____ State _____ Zip _____ Telephone Number _____	

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 I – ASSETS: Please tell us about your assets as of the first of the month. Please check all below that apply for each asset. 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, check the "Other" boxes below.

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

□ Cash on Hand □ Checking Account □ Savings Account □ Credit Union Account □ Trust Account
□ IRA or Keogh Account □ Other Retirement Account □ Stocks and Bonds □ Treasury or Other Notes □ Annuity
□ Ownership in Company □ Patient Fund Account □ Other _____ □ Other _____

Asset Type	Owner	Amount	Account Number	Institution Name
_____	_____	$ _____	_____	_____
_____	_____	$ _____	_____	_____
_____	_____	$ _____	_____	_____

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SECTION J – 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	Owners (s)
	$	$	
	$	$	

SECTION K – POTENTIAL ASSET OR INCOME: Please tell us about any accident settlement, trust fund, inheritance, or any other money, 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 _____
Explanation _____	Lawyer Telephone Number _____
Anticipated Date of Receipt _____	

SECTION L – TRANSFER OF ASSETS: Please tell us about any assets that you sold, traded, gifted, or disposed of as of the first of the month. 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 P*** *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
				$
				$

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SECTION M – LIFE INSURANCE, LONG-TERM CARE INSURANCE AND FUNERAL PLANS: Please tell us about any life insurance, Long-Term Care (LTC) 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 □ LTC Insurance □ Burial Plan			
$	$	□ Life Insurance □ LTC Insurance □ Burial Plan			

SECTION N – 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.*

□ Cash on Hand □ Checking Account □ Savings Account □ Credit Union Account □ Trust Fund
□ IRA or Keogh Account □ Other Retirement Accounts □ Stocks and Bonds □ Treasury or Other Notes
□ Annuity □ Ownership in a Company □ Patient Fund Account □ Other

Asset Type	Owner	Amount	Account Number	Institution Name
_____	_____	$ _____	_____	_____
_____	_____	$_____	_____	_____
_____	_____	$_____	_____	_____
_____	_____	$_____	_____	_____
_____	_____	$_____	_____	_____

SECTION O – 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 P** or attach additional sheets.

Name	Relationship	Age	Gross Monthly Income SEND PROOF	Type of Income	Value of Asset SEND PROOF	Asset Type
			$			
			$			
			$			

If the 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:

Rent/Mortgage	Utilities	Heat (If separate from utilities)	Property Taxes
$ _____	$ _____	$ _____	$ _____

Home Owners Insurance	Condo Fees	Other Shelter Costs (Specify)	Other Shelter Costs (Specify)
$ _____	$ _____	$ _____	$ _____

SECTION P – ADDITIONAL INFORMATION: Please use this area for any information that would not fit in the space provided. Identify the section(s) the provided information pertains to in this application.

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SECTION Q – 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 the time.

Signature: _____ (Applicant)

Date: _____

Signature: _____ (Authorized Representative)

Date: _____

MARYLAND DEPARTMENT of HUMAN RESOURCES
MARYLAND DEPARTMENT of HEALTH AND MENTAL HYGIENE
SSI RECIPIENT/COMMUNITY- ELIGIBLE
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE APPLICATION

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 of 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

MARYLAND

MARYLAND DEPARTMENT of HUMAN RESOURCES
MARYLAND DEPARTMENT of HEALTH AND MENTAL HYGIENE
SSI RECIPIENT/COMMUNITY- ELIGIBLE
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE APPLICATION

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 healthcare 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 you Signed an X) _____ Date _____

Signature of Spouse (If applicable) _____ Date _____

Signature of Authorized Representative (if applicable) _____ Date _____

DHR/FIA 9709S (4/1/13) Page **12** of **12**

APPENDIX G-6: INTENT TO APPLY FOR WAIVER SERVICES (OES014)

Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	FIA ACTION TRANSMITTAL
Control Number: #14-12	Effective Date: IMMEDIATELY
	Issuance Date: March 11, 2014

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

FROM: DEBBIE RUPPERT, EXECUTIVE DIRECTOR, DHMH/OES Debbie Ruppert
ROSEMARY MALONE, EXECUTIVE DIRECTOR, FIA Rosemary Malone

RE: LONG-TERM CARE WITH WAIVER SERVICES

PROGRAM AFFECTED: MEDICAL ASSISTANCE

ORIGINATING OFFICE: OFFICE OF ELIGIBILITY SERVICES

BACKGROUND: This action transmittal addresses applicants who submit initial Medical Assistance (MA) applications to the Eligibility Determinations Division (EDD), {formerly known as the Division of Eligibility and Waiver Services (DEWS)}, requesting LTC and Waiver Services. It also applies to applicants who previously submitted Long-Term Care (LTC) applications to the Bureau of Long-Term Care or the Local Department of Social Services and later apply for Waiver Services within the six (6) month consideration period. In lieu of completing an additional application for Waiver Services, the new OES 014 Intent to Apply for Waiver Services form provides the necessary application date for the Waiver Services application. EDD will accept the OES 014 Intent to Apply for Waiver Services form to begin the Waiver Services application using the information from the DHR/FIA 9709 previously submitted for the MA-LTC application. In some circumstances, EDD may need to request additional information. A new unit has been established at EDD to accept and expedite eligibility **for waiver services only** for LTC applicants.

ACTION REQUIRED: When the OES 014 Intent to Apply for Waiver Services form and the DHR/FIA 9709 are received by EDD, both the LTC and the Waiver Service cases are to be completed by EDD. When the Intent to Apply for Waiver Services form is received by EDD, only the Waiver Services case must be completed by EDD due to the fact that active LTC coverage exists. The following actions are required by the EDD case managers.

REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

I. Eligibility Determinations Division Procedures when the DHR/FIA 9709 and the OES 014 Intent to Apply for Waiver Services form are received:

- The case manager reviews the application and form, obtains all required clearances and requests the necessary verifications
- The case manager reviews the information/verifications, and completes the standard eligibility process for the LTC application in accordance with COMAR within 30 days, using the standard eligibility process
- After the LTC application has been completed on CARES, the case manager processes the OES 014 Intent to Apply for Waiver Services form
- The case manager uses the existing applicant/recipient clearances and verifications from the LTC case to process the waiver case
- When an Authorization to Participate (ATP) in a waiver program is received, the case manager updates CARES with the information provided on the 257 and the ATP to open the Waiver Services program and close the LTC case
- The case manager narrates the closure of the LTC coverage on CARES and specifies which waiver services coverage should be opened
- The case manager completes the necessary forms to update screens 1, 4, and 8 of MMIS as required to assure the appropriate waiver span is placed online for the waiver coverage
- The case manager updates the EDD database and/or the Long-Term Services & Support (LTSS) Secure Access Services tracking system as required for each case record
- The case manager completes the necessary notices based on the application outcome and mails the notices to the applicant, recipient, and the authorized representative as required

II. Eligibility Determinations Division Procedures for when the OES 014 Intent to Apply for Waiver Services form only is received:

- The case manager uses the OES 014 Intent to Apply for Waiver Services form in conjunction with the existing LTC application date on file at the Bureau of Long-Term Care or the Local Department of Social Services if the OES 014 Intent to Apply for Waiver Services form is received by EDD within the six (6) month consideration period of the current LTC application on file
- The case manager reviews the form, obtains all required clearances, and requests the necessary verifications
- The EDD case manager uses the date on the OES 014 Intent to Apply for Waiver Services form as the application date to initiate waiver services
- The case manager requests the LTC case be transferred to the appropriate waiver district office
- The case manager receives the Authorization to Participate (ATP) in a waiver program, updates CARES with the information provided on the 257 and the ATP, opens the Waiver Services program and closes the LTC case
- The case manager narrates the closure of the LTC coverage on CARES and specifies which waiver services coverage should be opened

- The case manager completes the necessary forms to update screens 1, 4, and 8 of MMIS as required to assure the appropriate waiver span is placed online for the waiver coverage
- The case manager updates the EDD database and/or the Long-Term Services & Support (LTSS) Secure Access Services tracking system as required for each case record
- The case manager completes the necessary notices based on the application outcome and mails the notices to the applicant, recipient, and the authorized representative as required

III. Eligibility Determinations Division Procedures when Waiver Services are not approved:

- The case manager transfers the active LTC cases that fail to become eligible for waiver services to the appropriate district office to allow for appropriate case management
- The case manager updates the CARES narration, the EDD database, and the LTSS system with the outcome of the waiver application
- The case manager completes the necessary notices to the applicant, recipient, authorized representative as required

IV. Procedures for Bureau of Long-Term Care or Local Department of Social Services staff who receive LTC/Waiver Applications and OES 014 Intent to Apply for Waiver Services forms:

- If the case manager receives the completed DHR/FIA 9709 and the completed OES 014 Intent to Apply for Waiver Services forms together and the applicant is requesting LTC and Waiver Services at the same time, case manager forwards both forms to the EDD office
- If the case manager receives the completed OES 014 Intent to Apply for Waiver Services form from a requestor with active LTC coverage completed by the Bureau of Long-Term or the Local Department of Social Services, that is within the six (6) month consideration period of the current DHR/FIA 9709 application, case manager forwards the form to the EDD office for waiver processing

INQUIRIES:
Please direct Medical Assistance policy questions the DHMH Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231 (select option 2 and request extension 1463).

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

For Office Use Only/Date Stamp

Intent to Apply For Waiver Services

This form is to be utilized for individuals who have already applied for LTC Medicaid and now intend to apply for waiver services within the six month consideration period of the LTC application. This form is forwarded to the Eligibility Determinations Divisions (EDD) located at 6 Saint Paul Street, Suite 400, Baltimore, MD 21202.

Applicant/Recipient Information: (Please Print)

Last Name: _____ First Name: _____ Middle Name: _____

CID #: _____ DOB: _____/_____/_____
Month Day Year

What waiver are you applying for?

☐ Home and Community Based Options Waiver ☐ Adults with Traumatic Brain Injury

☐ Community Pathways & New Direction Waivers for Individuals with Developmental Disabilities

Have you completed a Long-Term Care application?

☐ Yes If yes, please provide the date the application was completed: ____/_____/____

☐ No (A long-term care application must be completed prior to submitting this form.)

Are you currently enrolled in a Medical Assistance Program? ☐ Yes ☐ No

Authorization to Release Information:

I give permission to the State of Maryland as an applicant/recipient of Medical Assistance to release information to assist in the waiver application process. This authorization is valid for 12 months from the date of signature.

Applicant/Representative Signature: _____ Date: _____

Authorized agency/person to assist in the waiver application process:

Name: _____ Agency/Facility: _____

Phone Number: _____-_____-_____ Signature: _____

OES 014

APPENDIX G-7: DHR/FIA 9709-R REDETERMINATION APPLICATION

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

Check List of Items Needed for the Recipient's Long-Term Care / Waiver Redetermination Application
(Please keep this page for the recipient's records)

SEND PROOF We have provided a check list of items to help the recipient and/or their authorized representative gather the information needed to process the recipient's redetermination application. Please send copies of the recipient's documents along with the recipient's redetermination application. **Do not send originals.** In some cases, we may need to request additional documents not listed below. If so, we will give the recipient time to supply the additional documents.

Has the recipient, spouse, or anyone sold, traded, gifted, or disposed of recipient's property, motor vehicles, stocks, bonds, cash or other assets in the past 12 months? If so, the recipient will need to provide the following:

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

If the recipient wants to find out if their spouse can keep some of the recipient's monthly income, please provide current statements for:

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

Submit copies of the following items:

- ☐ Federal Tax Return for the tax current year (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 the recipient's Federal tax return cannot be located.
- ☐ A Wage and Income Transcript can be obtained from the IRS free of charge by calling 1-800-908-9946 if the recipient filed a joint Federal tax return for the current tax year.
- ☐ Current statements of:
  - ☐ Stocks
  - ☐ Bonds
  - ☐ Money Market Funds
  - ☐ Mutual Funds, Treasury, or Other Notes
  - ☐ Certificates
  - ☐ Retirement account
  - ☐ IRA or Keogh accounts
  - ☐ Bank and financial accounts owned and co-owned
- ☐ Current statement for burial accounts
- ☐ Burial Plot Deeds
- ☐ Current gross monthly income from all sources including:
  - ☐ VA Pensions
  - ☐ Railroad Retirement
  - ☐ Pensions
  - ☐ Annuities
- ☐ Mortgage Notes and Mortgage Deeds
- ☐ Trusts (including appendices, schedules, annual accountings, and amendments for the past 12 months)
- ☐ Private Health Insurance Cards including Medicare (copy of both sides)
- ☐ Health Insurance premium amounts
- ☐ Power of Attorney or Legal Guardianship Documents (if any)
- ☐ Face and cash value of Life Insurance policies (current annual statement)
- ☐ Life Estate Deeds
- ☐ Promissory Notes

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

DHR/FIA 9709R (REVISED 7-1-11)

MARYLAND

MARYLAND DEPARTMENT OF HUMAN RESOURCES
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LONG-TERM CARE / WAIVER MEDICAL ASSISTANCE

REDETERMINATION APPLICATION

Date Signed Application Received in Local Department MUST BE DATE STAMPED

Worker Name

Case Number

R

USE THIS FORM ONLY FOR THE REDETERMINATION PROCESS. SEND PROOF Attach current verifications of all income and resources. Failure to complete the redetermination will result in cancellation of Medical Assistance coverage.

A. Identifying Information:

Recipient's Name: _____ Social Security # _____

Is the recipient a resident of Maryland? ☐Yes ☐No

Date of Birth: _____ Telephone # _____

Address (where recipient actually lives): _____

Mailing address (if different):
_____

Marital Status: ☐Never married ☐Married ☐Separated ☐Divorced ☐Widowed

Is the recipient a U.S. citizen? ☐Yes ☐No

If not a U.S. citizen, alien status: _____ Status effective date: _____

Name of nursing facility,
state institution, or
community-based care provider: _____

If the recipient is married or separated:

Spouse's Name: _____

Spouse's Address (if different):
_____

Spouse's Telephone # _____ Spouse's Social Security # _____

Has the recipient's Authorized Representative changed in the last 12 months? ☐Yes ☐No If Yes, complete the information below:

Authorized
Representative Name: _____ Telephone #: _____

Address: _____

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B. Recipient's Income: (Attach Current Verification)

SEND PROOF				Verification Method/Date	Amount
Social Security	$_____	SSI	$_____	____/____	$_____
Civil Service	$_____	VA	$_____	____/____	$_____
Retirement/Pension	$_____	Disability	$_____	____/____	$_____
Wages	$_____	Other	$_____	____/____	$_____
Business Income	$_____	*(Examples: Trusts, Stocks, Annuities, Dividends, Interest, Bonds, CD's)*		Recipient's Total Income	$_____

C. Spouse's Income: (Attach Current Verification)

SEND PROOF				Verification Method/Date	Amount
Social Security	$_____	SSI	$_____	____/____	$_____
Civil Service	$_____	VA	$_____	____/____	$_____
Retirement/Pension	$_____	Disability	$_____	____/____	$_____
Wages	$_____	Other	$_____	____/____	$_____
Business Income	$_____	*(Examples: Trusts, Stocks, Annuities, Dividends, Interest, Bonds, CD's)*		Spouse's Total Income	$_____

D. Spouse's Shelter Expenses: (Attach Current Verification)

SEND PROOF				Verification Method/Date	Amount
Is there a spouse, child under 21, or any other dependent relative residing in the recipient's home? ☐Yes ☐No If yes, complete the information below:					
Rent/Mortgage	$_____	Utilities	☐Yes ☐No	____/____	$_____
Homeowner's/Renters Insurance	$_____	Real Estate Taxes	$_____	____/____	$_____
Maintenance Charges for Condominium			$_____	Spouse's Shelter Expenses	$_____
Other _____			$_____		

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E. Dependent's Income: (Attach Current Verification)

SEND PROOF				*Verification Method/Date*	*Amount*
Social Security	$_____	SSI	$_____	____/____	$_____
Civil Service	$_____	VA	$_____	____/____	$_____
Retirement/Pension	$_____	Disability	$_____	____/____	$_____
Wages	$_____	Other	$_____	____/____	$_____
Business Income	$_____	*(Examples: Trusts, Stocks, Annuities, Dividends, Interest, Bonds, CD's)*		Dependent's Total Income	$_____

F. Assets: (Attach Current Verification)

SEND PROOF Does the recipient have:				*Verification Method/Date*	*Amount*
Cash	☐Yes ☐No	Amount	$_____	____/____	$_____
Patient Fund Acct.	☐Yes ☐No	Amount	$_____	____/____	$_____
Checking Acct.	☐Yes ☐No	Amount	$_____	____/____	$_____
Bank Name _____		Acct # _____			
Savings Acct.	☐Yes ☐No	Amount	$_____	____/____	$_____
Bank Name _____		Acct # _____			
Burial Fund/Prearrangement		☐Yes ☐No		____/____	$_____
Company Name _____		Amount	$_____		
Other (CD, stocks, bonds, etc.)	☐Yes ☐No	Amount	$_____	____/____	$_____
Company Name _____		Acct # _____			

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F. Assets: (continued) Attach Current Verification

	Verification Method/Date	*Amount*
Did the recipient purchase or anyone purchase on behalf of the recipient any life insurance not already reported as burial funds? ☐Yes ☐No If Yes:		
Company _____ Policy # _____	____/____	$____
Policy Face Value $_____ Policy Cash Value $ _____		
Company _____ Policy # _____	____/____	$____
Policy Face Value $ _____ Policy Cash Value $_____	____/____	$____
Does the recipient own or have ownership interest in any real or personal property in or out of the state of Maryland (such as land, deeds of trust, buildings, mobile homes, rental or vacation property, recreational vehicles, and collections of antiques, coins, jewelry, or stamps)? ☐Yes ☐No If Yes:		
Name Items: _____	____/____	$____
Value $ _____	Total	$____
Has the recipient, their spouse, or anyone sold, traded, gifted, or disposed of any of the recipient's assets and/or real property (such as income, land, building, stocks, trust funds, money, cars, etc.) during the past 12 months? ☐Yes ☐No If Yes:		
Name Items: _____		
Value $ _____ Date: _____	____/____	$____
Has the recipient received or is expected to receive or inherit any money or property from any source? ☐Yes ☐No If Yes:		
Source: _____		
Value $ _____ Date: _____	____/____	$____

G: Medical Expenses for Non-Covered Services:

Does the recipient have any non-covered medical bills (e.g., dentistry, audiology, vision) that he/she incurred in the last 12 months? ☐ YES ☐ NO

SEND PROOF *If the recipient answered yes, provide newly dated, itemized medical bill(s) that the recipient incurred within the 12 months prior to this redetermination application. The bill must contain a service date, the charge, and a detailed description for each service provided. Attach copies of the bill(s) with the recipient's Long-Term Care Medical Assistance Redetermination application.*

H: Medical Expenses: (Attach Premium Notice or Statement)

SEND PROOF
Does the recipient have Medicare?:

Verification Method/Date | *Amount*

Medicare Part A: ☐Yes ☐No Part B: ☐Yes ☐No _____/_____ $_____

Part C: ☐Yes ☐No Part D: ☐Yes ☐No

If yes, provide Medicare Claim Number: _____

Other health insurance? ☐Yes ☐No If Yes:

Company _____ Policy # _____

Coverage Type _____ Premium Amount $_____ _____/_____ $_____

Company _____ Policy # _____

Coverage Type _____ Premium Amount $_____ _____/_____ $_____

Medical expenses other than insurance premiums? ☐Yes ☐No _____/_____ $_____

Describe _____ Amount $ _____ Total Medical Expenses $_____

Has the recipient had an accident or does the recipient have a lawsuit pending where someone else is liable? ☐Yes ☐No

If yes, explain: _____ If yes, date: _____

I: Tax Returns: (Attach Required Documentation)

SEND PROOF Did the recipient file a Federal income tax return in the last 12 months? ☐Yes ☐No _____/_____

If yes, attach a copy of the recipient's Federal tax return for the current tax year, including all forms and schedules. If the recipient filed a joint Federal tax return, do not send the Federal tax return. The recipient will need to provide a Wage and Income Transcript which can be obtained from the IRS free of charge by calling 1-800-908-9946.
If no, attach quarterly bank and financial statements for the past 12 months.

Is additional information needed? ☐Yes ☐No

J: Voter Registration

If the recipient is not registered to vote, would the recipient like to receive a voter registration form? ☐ YES ☐ NO ☐ Already registered to vote

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MARYLAND DEPARTMENT OF HUMAN RESOURCES
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE

REDETERMINATION APPLICATION

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.

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- **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 Recipient or Authorized Representative Date

Signature of Case Manager	Date

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MARYLAND DEPARTMENT OF HUMAN RESOURCES
MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
LONG-TERM CARE/WAIVER MEDICAL ASSISTANCE

REDETERMINATION APPLICATION

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 that have occurred within the last 12 months prior to my redetermination 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 _____

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APPENDIX H: STATE REVIEW TEAM DOCUMENTS

APPENDIX H-1: CUSTOMER DECLARATION OF DISABILITY FORM DHR/FIA 700

CUSTOMER DECLARATION OF DISABILITY FORM

LOCAL DEPARTMENT USE ONLY
AU#
CLIENT ID#

Please complete all sections (front and back) of this form and sign where indicated. If you need help completing this form, please contact your case manager and have the form with you when you call. You **must** return the completed form to the person and address below.

at: _____

Case Manager Name _____
First **Last**

Local Department Address _____

_____
City **State** **Zip Code**

If the person completing this form is someone other than the disabled person, please complete the following information:

Name _____

Relationship to Disabled Person _____

Daytime Phone Number _____

Address _____

_____
City **State** **Zip Code**

SIGN HERE _____ **DATE** _____
YOUR SIGNATURE

DHR/FIA 700 04 /09

TO BE COMPLETED BY THE DISABLED PERSON:

Name _____
Last First

Social Security Number _____ Date of Birth _____

Address _____

_____
City State Zip Code

1. Has there been any change (for better or worse) in your illnesses, injuries, or conditions since you last applied for Social Security disability benefits? ☐Yes ☐No
If "Yes", please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	DAY	YEAR

2. Do you have any new physical or mental limitations as a result of your illnesses, injuries or conditions since you last applied for Social Security disability benefits? ☐Yes ☐No
If "Yes", please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	DAY	YEAR

3. Do you have any new illnesses, injuries or conditions since you last applied for Social Security disability benefits? ☐Yes ☐No
If "Yes", please describe in detail:

_____
_____
_____

Approximate date the changes occurred		
MONTH	DAY	YEAR

SIGN HERE _____ DATE _____
YOUR SIGNATURE

DHR/FIA 700 04 /09

APPENDIX H-2: DISABILITY REPORT DHR/FIA 3368

DISABILITY REPORT

For Local Department and State Review Team use Only
Do not write in this box.

Client ID# _____

Medical Assistance AU# _____

SECTION 1 – INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** (First, Middle Initial, Last)

B. **SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

_____ (Area Code) _____ (Number) (Your Number (Message Number

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help with your application.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____ (City) _____ (State) _____ (Zip)

DAYTIME PHONE _____ (Area Code) _____ (Number)

E. What is your **height** without shoes? _____ feet _____ inches

F. What is your **weight** without shoes? _____ pounds

G. Have you applied for Social Security benefits? ☐ NO ☐ YES If **YES** when:

MONTH	DAY	YEAR

H. Can you **speak and understand English?** ☐ YES ☐ NO

If you cannot **speak and understand English**, is there someone we may contact who speaks and understands English and will give you messages? ☐ YES ☐ NO (If "YES", and that person is the same as in "D" above write "SAME" here: _____ . If not, complete the following information.)

NAME _____ **RELATIONSHIP** _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____ (City) _____ (State) _____ (Zip)

DAYTIME PHONE _____ (Area Code) _____ (Number)

I. Can you **read and understand English?** ☐ YES ☐ NO

J. Can you **write more than your name in English?** ☐ YES ☐ NO

K. Can you Speak English? ☐ YES ☐ NO

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SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the illnesses, injuries or conditions that limit your ability to work?

B. How do your illnesses, injuries or conditions limit your ability to work?

C. Do your illnesses, injuries or conditions cause you **pain** or **other symptoms**? ☐ YES ☐ NO

D. When did your illnesses, injuries or conditions **first interfere with your ability to work?**

MONTH	DAY	YEAR

E. When did you become **unable to work** because of your illnesses, injuries or conditions?

MONTH	DAY	YEAR

F. Have you **ever worked**? ☐ YES ☐ NO (If "NO," go to Section 4.)

G. Did you **work at any time** after the date of your illnesses injuries or conditions first interfered with your ability to work? ☐ YES ☐ NO

H. If "YES", did your illnesses, injuries or conditions cause you to: *(check all that apply)*

☐ **work fewer hours?** *(Explain below)*
☐ **change your job duties?** *(Explain below)*
☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. Are you **working now**? ☐ YES ☐ NO

If "NO," when did you stop working?

MONTH	DAY	YEAR

J. Why did you stop working?

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SECTION 3 – INFORMATION ABOUT YOUR WORK

A. List all the jobs that you had in the 15 years before you became unable to work because of your illnesses, injuries or conditions.

JOB TITLE (Example: Cook)	TYPE OF BUSINESS (Example: Restaurant)	DATES WORKED (month & year)		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY (per hour, day, week, month or year)	
		From	To				
						$	
						$	
						$	
						$	
						$	
						$	
						$	

B. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

_____

_____

D. In **this job**, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform duties like this? ☐ YES ☐ NO

E. In **this job**, how many total hours each day did you:

Walk? _____ Stoop? *(Bend down & forward at waist.)* _____ Handle, grab or grasp big objects? _____

Stand? _____ Kneel? *(Bend legs to rest on knees.)* _____ Reach? _____

Sit? _____ Crouch? *(Bend legs & down & forward.)* _____ Write, type or handle small objects? _____

Climb? _____ Crawl? *(Move on Hands & knees.)* _____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

G. Check **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs or more ☐ Other _____

H. Check weight **often** lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs or more ☐ Other _____

I. Did you supervise other people in this job? ☐ YES *(Complete items below.)* ☐ NO *(If No, go to J.)*

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

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SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5

C. List other names you have used on your medical records. _____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment**.

1.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number		**PATIENT ID #** (if known)	NEXT **APPOINTMENT**
REASON FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

2.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number		**PATIENT ID #** (if known)	NEXT **APPOINTMENT**
REASON FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

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DOCTOR/HMO/THERAPIST/OTHER

SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS

3.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	STATE	ZIP	**LAST** SEEN
PHONE Area Code Phone Number		**PATIENT ID #** (if known)	NEXT **APPOINTMENT**
REASON FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

If you need more space, use Section 9

E. **List each HOSPITAL/CLINIC. Include your next appointment.**

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT
STREET ADDRESS				DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP	☐ OUTPATIENT VISITS (Sent home same day)	DATE OF VISITS	
PHONE Area Code Phone Number			☐ EMERGENCY ROOM VISITS		

Next **appointment** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

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SECTION 4 – INFORMATION ABOUT YOUR MEDICAL RECORDS
List any Hospital/Clinic that may have your medical records

HOSPITAL/CLINIC

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ INPATIENT STAYS (Stayed at least overnight)	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ OUTPATIENT VISITS (Sent home same day)	DATE FIRST VISIT	DATE LAST VISIT
				DATE OF VISITS	
PHONE ____ Area Code ____ Phone Number			☐ EMERGENCY ROOM VISITS		

Next **appointment** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does anyone else have medical records or information about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES (If "YES," complete information below.) ☐ NO

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE ____ Area Code ____ Phone Number		**PATIENT ID #** (if known)	NEXT **APPOINTMENT**

CLAIM NUMBER (If any) _____

REASON FOR VISITS _____

If you need more space, use Remarks, Section 9.

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SECTION 5 – MEDICATIONS

Do you currently take any medications for your illnesses, injuries or conditions? ☐ YES
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* ☐ NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 – TEST

Have you had, or will you have any medical test for your illnesses, injuries or conditions?
☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	DATE WHEN DONE, OR WHEN IT WILL BE DONE? (Month, day, year)	WHERE WAS IT DONE? (Name of Hospital/Clinic)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY – Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY – Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you have had other test, list them in Remarks, Section 9.

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SECTION 7 – EDUCATION/TRAINING INFORMATION

A. Check the highest grade of school completed.

Grade school:

0	1	2	3	4	5	6	7	8	9	10	12	GED
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

College:

1	2	3	4 or more
☐	☐	☐	☐

Approximate date completed: _____

B. Did you attend special education classes? ☐ YES ☐ NO (If "NO," go to part C)

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____
City State Zip

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of special job training, trade or vocational school?
☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 – VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Have you participated, or are you participating in:

- an individual work plan with an employment network under the Ticket to Work Program;
- an individualized plan for employment with a vocational rehabilitation agency or any other organization;
- a Plan to Achieve Self-Support
- an individualized education program through an educational institution (if a student age 18 – 21); or
- any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____
(Number, Street, Apt. No. (If any), P.O. Box, or Rural Route)

_____
City State Zip

DAYTIME PHONE NUMBER _____ _____
Area Code Phone Number

DATES SEEN _____ TO _____

TYPES OF SERVICES OR TEST PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

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SECTION 9 – REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are finished with this section (or if you don't have anything to add), be sure to complete the information at the bottom of this page.

If the person completing this form is someone other than the disabled person or the person identified in Section 1, Item D, please complete the following information

Name of person completing this form if other than the disabled person *(Please Print)*	**Date Form Completed** *(Month, day, year)*
Address (Number and street)	**e-mail address** *(optional)*
City **State** **Zip Code**	

Relationship to Disabled Person	**Daytime Telephone Number** ( ) -

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APPENDIX H-3: SUBSTANTIAL GAINFUL ACTIVITY WORKSHEET

SUBSTANTIAL GAINFUL ACTIVITY WORKSHEET

Name of Disabled Person: _____ **Social Security Number:** _____

Disability: ☐ Blindness ☐ Other

1. **Gross** Earned Income (Please attach verification) $ _____ per month

2. **Employer Subsidy** (if any) included in your pay (e.g., some employers employ disabled persons and subsidize their wages by paying them the same wages as a nondisabled employee though they may be performing less strenuous work, or working less hours) $ _____ per month

3. **Impairment-Related Work Expenses** per month (see attached for description)
   a. Attendant Care Services $ _____
   b. Transportation Costs _____
   c. Medical Devices _____
   d. Work-Related Equipment _____
   e. Prosthesis _____
   f. Residential Modifications _____
   g. Routine Drugs and Routine Medical Services _____
   h. Diagnostic Procedures _____
   i. Nonmedical Applications and Devices _____
   j. Assistants (e.g., if visually impaired, cost to hire reader) _____
   k. Other Items and Services _____

++

Office Use only (Case Manager complete below)

4. **TOTAL Impairment-Related Work Expenses**

   Add together all that apply (total of 3a through 3k) $ _____ per month

5. **Net Countable Earnings** (from 1 subtract 2 and 4) $ _____ per month

- Are current countable earnings (line 5) greater than
  - Blind SGA Amount $ 1,640 ? _____ Yes _____ No
  - Non Blind SGA Amount $ 1,000 ? _____ Yes _____ No

  (2010 SGA amounts)
- If the answer is No, the customer must apply for Social Security benefits
- If the answer is Yes, the client is engaging in SGA. Deny the MA application.

_____ Case Manager Signature

_____ Telephone Number

_____ Date

Address: _____

_____

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REFERENCE GUIDELINES FOR RESOURCE COORDINATORS: COMMUNITY PATHWAYS WAIVER APPLICATION & REQUIREMENTS

APPENDIX H-4: AUTHORIZATION AND CONSENT DHR/FIA 827

WHOSE Record to be Disclosed	
Name (First, Middle, Last)	
SSN - -	Birthday (mm/dd/yy)

AUTHORIZATION TO DISCLOSE INFORMATION TO THE DEPARTMENT OF HUMAN RESOURCES (DHR) FAMILY INVESTMENT ADMINISTRATION (FIA) STATE REVIEW TEAM (SRT)

****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release;

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, Acquired Immune Deficiency Syndrome (AIDS): and tests for HIV.
   - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Plans (IEP), trienneial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by FIA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX IS TO BE COMPLETED BY SRT Additional information to identify the subject (e.g., other names used) the specific sources, or the material to be disclosed:

TO WHOM **The Department of Human Resources and to the State agency authorized to process my case** (usually called "Family Investment Administration"), **including contract copy services, and doctors or other professionals consulted during the process**

PURPOSE Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet the definition of disability.

EXPIRES WHEN This authorization is good for 12 months from the date signed that appears below.

- I authorize the use of a copy (including electronic copy) of this form for disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to FIA and my sources to revoke this authorization at any time (see page 2 for details).
- FIA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY INDIVIDUAL authorizing disclosure SIGN →	IF not signed by subject of disclosure, specify basis for authority to sign ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain) SIGN HERE:

Date Signed	Street Address		
Phone Number (with area code)	City	State	Zip

WITNESS I know the person signing this form or am satisfied of this person's identity:
SIGN → (OPTIONAL)

Phone Number (or Address)	

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA") 45 CFR parts 160 and 164.42 U.S. Code section 290dd-2: 42 CFR part 2; 38 U.S. Code section 7332, 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; Md. Code Ann., Human Services Art. §1-201, Health-General Art.§§4-302-03 and 4-307.

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APPENDIX I: WAIVER COVERED SERVICES

WAIVER COVERED SERVICES

Individuals who are approved ongoing funding under the Community Pathways Waiver, may receive one or more of the following types of services. The person will have an Individual Plan (IP) showing what services they are to receive, who will provide them, and how often.

Each service has limitations on the amount of time, funds, or people who can deliver them. Some can be self-directed and some cannot.

The DDA also administers the Low Intensity Support Services (LISS) that is not included under the Community Pathways Waiver or DDA's ongoing State funded system. Additional information about this service can be provided by the resource coordinator and found on the DDA website.

What services are funded by the DDA?

The following services are provided under the Community Pathways Waiver:

1. Assistive Technology and Adaptive Equipment
2. Behavioral Supports
3. Community Learning Services
4. Community Residential Habilitation Services
5. Day Habilitation – Traditional
6. Employment Discovery and Customization
7. Environmental Accessibility Adaptations
8. Environmental Assessment
9. Family and Individual Support Services
10. Live-In Caregiver Rent
11. Medical Day Care
12. Personal Supports
13. Respite
14. Shared Living
15. Support Brokerage
16. Supported Employment
17. Transition Services
18. Transportation
19. Vehicle Modifications

A brief description of the 19 services, who can provide the service, whether they can be self-directed, and any limitations are noted below. Additional information and specific requirements can be reviewed within the Community Pathway's federally approved waiver application, Community Pathways regulations (COMAR 10.09.26), and the DDA regulations (COMAR 10.22).