

Optum

Long Term Care (LTC) Psychiatric and Residential Treatment Center (RTC) Facility Process

Optum Maryland Provider Training

Participant Guide



OES 1000 (Office of Eligibility Services Form)

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

PLEASE CHECK REQUESTED ACTION:

CERTIFICATION OF INSTITUTIONALIZATION & HEALTHCHOICE DISENROLLMENT

NOTIFICATION OF DISCHARGE FROM LONG-TERM CARE

TO: DHS/LDSS/LHD Case Manager TO: MDH HealthChoice
 District Office: _____ Enrollment Section, Room L-9
 Address: _____ 201 W. Preston Street
 _____ Baltimore, Maryland 21201

Part I. Recipient Identification

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

Part II. Facility Identification

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

Part III. Recipient Under 21 Years Old

To be completed after *one full calendar month* in the facility.
 This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on ____/____/____ if enrolled in an MCO. If not enrolled in an MCO date of admission ____/____/____.

Part IV. Recipient Aged 21 Through 64

To be completed after the *30th consecutive day* in the institution or after the *60th cumulative day during a calendar year* in an institution.
 This certifies that this individual has been institutionalized in the above facility
 For 30 consecutive days, effective _____
 For 60 days during the calendar year, effective _____

Part V. Recipient 65 Years Old or Older

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

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

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

Facility Certification: Signature _____ Date _____ Phone _____
 Administrative Services Organization Authorization:
 Signature _____ Date _____ Phone _____

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

Part III. Recipient Under 21 Years Old

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

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

Check if the recipient is enrolled in an MCO.

- EVS will indicate if they are enrolled in an MCO (shown below).

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

1/6/2023 6:25:21 AM Reference number: [REDACTED]
Inquiring provider: [REDACTED]

RECIPIENT INFORMATION
MA number: [REDACTED] SSN: [REDACTED]
Recipient name: [REDACTED]

ELIGIBILITY INFORMATION
For 1/5/2023 12:00:00 AM ELIGIBLE for date of service
Recipient's Re-Determination Date is not available at this time.
Citizenship verified
Identity verified
OHR/FIA form 9709S must be completed if long term care services are required

BENEFIT DESCRIPTION
Recipient is in an MCO (HealthChoice. For additional information about MCOs or the participant's eligibility call Provider Relations at 410-767-5503 or 800-445-1159)
MCO name: [REDACTED]
MCO phone number: [REDACTED]

BENEFIT EXCLUSIONS
BENEFIT LIMITATIONS
OTHER PAVORS

BENEFIT DESCRIPTION

Recipient is in an MCO (HealthChoice. For additional information about MCOs or the participant's eligibility call Provider Relations at 410-767-5503 or 800-445-1159)

MCO name: [REDACTED]
MCO phone number: [REDACTED]

- When you review the recipient eligibility verification, you can find the MCO information under the 'benefit description' section.

Part III. Recipient Under 21 Years Old

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

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

Psychiatric Hospitals: Input the **first day** of the *next* calendar month in the shaded orange area shown above.

- For Example: If they were admitted on 5/14/23 you would input 6/1/23 on the form.
- The form should not be sent to Optum until 7/1/23.

Residential Treatment Care (RTC): If **enrolled in an MCO** input the first day of the *next* calendar month in the shaded orange area shown above.

- For Example: If they were admitted on 5/14/23 you would input 6/1/23 on the form.
- The form should not be sent to Optum until 7/1/23.

Part III. Recipient Under 21 Years Old

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

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

Residential Treatment Care: If they are **NOT** enrolled in an MCO upon admission the admit date must be the date you are requesting for.

- For Example: If they were admitted on 5/14/23 then the admission date would be 5/14/23. Place that date in the orange area shown above.

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

To be completed *upon discharge from the facility.*

This certifies that this individual was *discharged from the above facility* on _____ to

Home _____

LTCF _____

Other _____

Please check the box on where the recipient is discharging to.

Home: Please record the home's address.

LTCF (Long Term Care Facility): Please write the name of the facility they are going to.

Other: Please note down the exact specifics.

Have the appropriate individuals sign in this section below.


Facility Certification: Signature _____ Date _____ Phone _____

Administrative Services Organization Authorization:

Signature _____ Date _____ Phone _____

Long Term Care Admission Application

- 1 Access the admission form at the link below:
[LTC 9709](#)
- 2 Any section of the form that applies to the applicant only must be completed.
- 3 Enter N/A or 0 for any fields that do not apply.
- 4 The facility's authorized representative must sign and date the form.
- 5 Submit this application with the OES 1000 to MDH upon admission to a Psychiatric Hospital or Residential Treatment Center (RTC) once the recipient has met the appropriate timeline. The OES must be sent to MDH upon discharge.

 **MARYLAND DEPARTMENT OF HUMAN SERVICES
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:

<input type="checkbox"/> Type of asset	<input type="checkbox"/> Reason for transfer
<input type="checkbox"/> Value of asset	<input type="checkbox"/> Who received the asset
<input type="checkbox"/> Amount received for the asset	

If you want to find out if your spouse can keep some of your monthly income, please provide:


<input type="checkbox"/> Spouse's gross monthly income	<input type="checkbox"/> Property tax bill
<input type="checkbox"/> Condo fees	<input type="checkbox"/> Rent
<input type="checkbox"/> Mortgage	<input type="checkbox"/> Electric bill
<input type="checkbox"/> Lot Rent	

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

<input type="checkbox"/> 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.	<input type="checkbox"/> Current gross monthly income from all sources including: <input type="checkbox"/> VA Pensions <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Pensions <input type="checkbox"/> Annuities
<input type="checkbox"/> Bank and Financial statements on all accounts owned and co-owned: <input type="checkbox"/> Current Month (month of application) <input type="checkbox"/> Previous Month (month prior to application) <input type="checkbox"/> The last five years of the anniversary month of the application	<input type="checkbox"/> Face and cash value of Life Insurance policies (current annual statement) <input type="checkbox"/> Current statement for burial accounts <input type="checkbox"/> Burial Plot Deeds <input type="checkbox"/> Life Estate Deeds <input type="checkbox"/> Promissory Notes <input type="checkbox"/> Mortgage Notes and Mortgage Deeds <input type="checkbox"/> Trusts (including appendices, schedules, annual accountings, and amendments for the past five years)
<input type="checkbox"/> Current statement of retirement accounts <input type="checkbox"/> Current statement of IRA or Keogh Accounts <input type="checkbox"/> Current statements of: <input type="checkbox"/> Stocks <input type="checkbox"/> Bonds <input type="checkbox"/> Money Market Funds <input type="checkbox"/> Mutual Funds, Treasury, or Other Notes	<input type="checkbox"/> Private Health Insurance Cards including Medicare (copy of both sides) <input type="checkbox"/> Health Insurance premium amounts <input type="checkbox"/> Power of Attorney or Legal Guardianship

Long Term Care Redetermination Application

- 1 Access the admission form at the link below:
[LTC 9709R](#)
- 2 Any section of the form that applies to the applicant only must be completed.
- 3 Enter N/A or 0 for any fields that do not apply.
- 4 The facility's authorized representative must sign and date the form.
- 5 Submit this application to MDH upon admission to a Psychiatric Hospital or Residential Treatment Center (RTC) once the recipient has met the appropriate timeline.

 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:

<input type="checkbox"/> Type of asset	<input type="checkbox"/> Reason for transfer
<input type="checkbox"/> Value of asset	<input type="checkbox"/> Who received the asset
<input type="checkbox"/> Amount received for 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:

<input type="checkbox"/> Spouse's gross monthly income	<input type="checkbox"/> Property tax bill
<input type="checkbox"/> Condo fees	<input type="checkbox"/> Rent
<input type="checkbox"/> Mortgage	<input type="checkbox"/> Electric bill
<input type="checkbox"/> Lot Rent	

Submit copies of the following items:

<input type="checkbox"/> 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.	<input type="checkbox"/> Current gross monthly income from all sources including: <ul style="list-style-type: none"><input type="checkbox"/> VA Pensions<input type="checkbox"/> Railroad Retirement<input type="checkbox"/> Pensions<input type="checkbox"/> Annuities
<input type="checkbox"/> 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.	<input type="checkbox"/> Mortgage Notes and Mortgage Deeds
<input type="checkbox"/> Current statements of: <ul style="list-style-type: none"><input type="checkbox"/> Stocks<input type="checkbox"/> Bonds<input type="checkbox"/> Money Market Funds<input type="checkbox"/> Mutual Funds, Treasury, or Other Notes<input type="checkbox"/> Certificates<input type="checkbox"/> Retirement account<input type="checkbox"/> IRA or Keogh accounts	<input type="checkbox"/> Trusts (including appendices, schedules, annual accountings, and amendments for the past 12 months)
	<input type="checkbox"/> Private Health Insurance Cards including Medicare (copy of both sides)
	<input type="checkbox"/> Health Insurance premium amounts
	<input type="checkbox"/> Power of Attorney or Legal Guardianship Documents (if any)
	<input type="checkbox"/> Face and cash value of Life Insurance policies (current annual statement)
	<input type="checkbox"/> Life Estate Deeds

LTC/OES Process

A. Send the OES 1000 to Optum for authorization and signature.

B. Send the signed OES 1000 form and application to:

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

C. Send a copy of the OES 1000 form to:

MDH Healthchoice
Enrollment Section, Room L-9
201 Preston Street
Baltimore, MD 21201

D. Please keep a copy of the document at the facility for the child's case file.

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- *The MDH Waiver unit has 45 days from receipt to process the LTC App & OES.*
 - *The MDH Waiver unit can only retro LTC back 3 months from the date of receipt of the properly completed LTC Application and OES 1000 forms.*
 - *It is very important to follow the required timelines as no backdating past these time frames will be permitted.*

Optum

Changes to business policies and procedures may cause the information provided here to become out-of-date. Always refer to the policy and procedure documentation provided to you within your business unit and/or consult with your manager or team lead if you have any questions and to validate sources of truth.

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