| DEPARTMENT OF HUMAN RESOURCES<br>INCOME MAINTENANCE ADMINISTRATION<br>311 W. Saratoga Street<br>Baltimore, Maryland 21201 | IMA ACTION TRANSMITTAL |
|---|---|
| | EFFECTIVE DATE: IMMEDIATELY |
| ISSUANCE DATE: June 1, 1996 | CONTROL NUMBER: IMA OPA #96-38 |

**TO:** **DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES**
**DEPUTY/ASSISTANT DIRECTORS FOR INCOME MAINTENANCE**
**INCOME MAINTENANCE SUPERVISORS ELIGIBILITY STAFF**

**FROM:** **KEVIN MAHON, EXECUTIVE DIRECTOR**
**INCOME MAINTENANCE ADMINISTRATION**

**RE:** **Department of Health and Mental Hygiene Forms 206N and 216**

**PROGRAMS AFFECTED: Medical Assistance**

**ORIGINATING OFFICE: Office of Policy Administration**

## BACKGROUND

The Maryland Medicaid Management Information System (MMIS-II) is designed primarily for electronic interfaces with the CARES system. As a result, transactions from Non-CARES jurisdictions, which require manual data entry on the MMIS-II system, can become extremely cumbersome and time consuming if all pertinent eligibility data for a recipient is not received by the Department of Health and Mental Hygiene (DHMH) simultaneously. Specifically, this is in regard to the DHMH Forms 206N and 216.

## ACTION REQUIRED

As per IMA Action Transmittal OPA #90-75 (Issued 6/7/90), Non-CARES jurisdictions are instructed to attach the 206N form (**See attached example**) to the 8000 document when beginning eligibility. This will allow both sets of data to arrive simultaneously at DHMH. This will enable DHMH to enter data more efficiently. It will also help avoid the possible delay or rejection of legitimate Long Term Care claims.

Non-CARES jurisdictions are also instructed to attach the DHMH 216 form (**See attached example**) to the 8000 document for all cases under spenddown based on an inpatient hospital bill. One copy of the 216 form is marked "DHMH", and this copy shall be submitted with the 8000. Hospitals will continue to receive one copy of the 216 form for their files. They will not be required to attach a copy when submitting their claims. DHMH will notify hospital providers of this change.

The DHR/IMA 81, Administrative Error Letter need only be submitted with a provider's claim, and need not be submitted to DHMH with an 8000, 206N, or 216. If there are any questions or comments please direct them to Paul Scholz at 767-5378 from DHMH or Rufus McCrea at 767-7748, DHR Central.

cc: Ned Wollman
Jonh Stewart
Christine Gerhardt
IMA Management Staff
DHR Executive Staff
Arnold Dixon

# Long-Term Care Transaction Form

TO: DHMH/Medical Care Operations
201 West Preston Street, SS 18
Baltimore, Maryland 21201

☐ Nursing Home Section ☐ Chronic Care Section

② For LDSS Use Only

Control No. _____

③ FROM: _____
Local Department of Social Services

④ Name of Recipient _____
First Name M.I. Last Name

⑤ Name of Facility _____

Address _____
Number/Street City State Zip Code

⑥ Maryland Medicaid No. _____

⑦ Action Needed:

| | Effective Date Mo/Day/Yr | Available Income |
|---|---|---|
| ☐ Begin Co-pay | _____ | $ _____ |
| ☐ Begin Payment | _____ | $ _____ |
| ☐ Cancel Payment _____ | _____ | $ _____ |
| ☐ Change In Income | _____ | $ _____ |
| ☐ Change In Income | _____ | $ _____ |

⑧ Type of Care: ☐ Skilled ☐ Intermediate ☐ Chronic ☐ Under 21 psych.

⑨ Soc. Sec. Claim No. _____

⑩ Gross Soc. Sec. Payment $ _____

_____ _____ _____
Worker's Signature Date Telephone Number

DHMH 206N (Rev. 4/90) MCOA

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R40621

**YOU ARE MAKING FOUR COPIES**
**BEAR DOWN HARD - USE BALL POINT PEN**

MEDICAL ASSISTANCE PROGRAM

# REPORT OF PATIENT RESOURCES

GENERAL HOSPITALS ONLY

ATTACH A PHOTOSTAT COPY OF PATIENT'S MEDICAL CARD

Name of General Hospital

Street/RFD Address

City/County | State | Zip Code

The amount of the patient's responsibility and/or the amount of insurance should be reported as a collection to the Health Department by the hospital.

| | | | |
|---|---|---|---|
| **DATE ADMITTED** ► | | | 19 |
| **MA #** First 11 Digits ► | | | |
| PATIENT'S Last NAME ▼ | First ▼ | | Middle ▼ |
| Street/RFD Address | | | |
| City/County | State | | Zip Code |
| BEGIN DATE | | EXPIRATION DATE | |
| **FROM** 19 | **TO** | | 19 |

The above named patient is eligible under the Medical Assistance Program for State payment towards the cost of hospital care subject to the following: ☐ N ☐ P

☐ No Available Income.

☐ Total Income Over Scale for 6-Mo. Period.

$ ____ TOTAL AMOUNT DUE TO THE HOSPITAL FROM THE PATIENT.

☐ Patient Has Hospital Insurance With:

Name of Insurance Co.

Address | Zip Code

☐ Accident Case With Possible 3rd-Party Responsibility.

Name of Attorney

Address | Zip Code

Date | Worker | D. and T. | Local Dept. of Social Services

DESS/SSA 216 Rev. March 1972

COPY 1 STATE HEALTH DEPARTMENT