STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Medical Day Care Transmittal No. 79
September 21, 2011

TO: Medical Day Care Centers

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

RE: Medical Day Care Services Waiver
Freedom of Choice Consent Form

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Effective October 1, 2011, Maryland Medicaid will require the Medical Day Care Services Waiver Freedom of Choice Consent Form to be completed at time of enrollment, and annually thereafter. The Freedom of Choice Consent Form verifies that the participant has exercised an informed choice to receive long term care services in the community through the Medical Day Care Services Waiver versus in an institutional setting. Participants who choose waiver services also must understand that they may choose from among enrolled medical day care providers to receive services. The choice must be documented when the provider re-assesses the participant to obtain annual approval for the service.

The medical day care provider is required to submit the consent form along with the Long Term Care Patient Activity Report (DHMH 257) and Continued Stay Review Certification Form to the Maryland Medical Assistance Program. If a provider has already submitted a participant's continued stay review documentation for the anniversary months of October or November, please submit the attached Freedom of Choice Consent Form for review prior to October 1, 2011.

Applicants or their authorized representative will continue to complete the initial Freedom of Choice Consent Form during the Adult Evaluation and Review Services (AERS) assessment. Attached is the updated Medical Day Care Services Waiver documentation chart to assist providers with identifying documents required for initial enrollments, continued stay reviews, transfers and discharges.

Questions regarding the Freedom of Choice Consent Form should be directed to the Medical Day Care Program staff, at (410) 767-1444.

Medical Day Care Services Waiver Documentation Chart

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

KEY

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

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

MARYLAND MEDICAL ASSISTANCE PROGRAM
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL DAY CARE SERVICES WAIVER
FREEDOM OF CHOICE CONSENT FORM

Applicant/ Participant Consent (Check one and sign below):

____ I choose to receive home and community-based services under the Medical Day Care Services Waiver as an alternative to institutional long-term care services in a nursing facility. I further understand that in order to qualify and continue to qualify for the waiver program, I must meet all eligibility criteria of the Maryland Medicaid Program and the Medical Day Care Services Waiver. I understand that I have the right to select which licensed adult medical day care center I would like to attend and that I may change medical day care centers if I decide to do so. I understand that there are alternative services for which I am eligible, including services in a nursing facility.

____ I choose to receive institutional long-term care services in a nursing facility, rather than through alternative services which have been explained to me. I further understand that in order to qualify and continue to qualify for Medicaid coverage in the nursing facility, I must meet all eligibility criteria of the Maryland Medicaid Program and for the nursing facility services.

____ I choose neither option. Explanation (optional):

I have received a copy of the "Summary of Procedures for the Fair Hearings" explaining the appeal process that I may follow in the event that I am denied access to the Medical Day Care Services Waiver or denied access to services by the provider of my choice.

Print Name: _____ MA#: _____
Applicant/ Participant

Signature: _____ Date: _____
Applicant/ Participant/Authorized Representative

Witness: _____ Date: _____
Hospital Staff/ AERS Staff/ MDC Staff