What is an appropriate referral for MLTCOP?

When Hospital Care Managers have made multiple referrals to providers that have refused to provide long-term care services for patients ready for discharge, and the patients require access to:

a. **Home health services provided by Medicare**

b. **Homeward Bound**

c. **Home and Community-Based Services for Adults with Brain Injury**

d. **Home and Community Based Services for Adults with Other Related Conditions**

e. **Home and Community Benefits for the Elderly and Adults with Disabilities**

f. **In-Home and Community Support Services for Elderly and Other Adults**

g. **Private Duty Nursing and Personal Care Services**

h. **Consumer Directed In-Home and Community Support Services for Elderly and Other Adults**

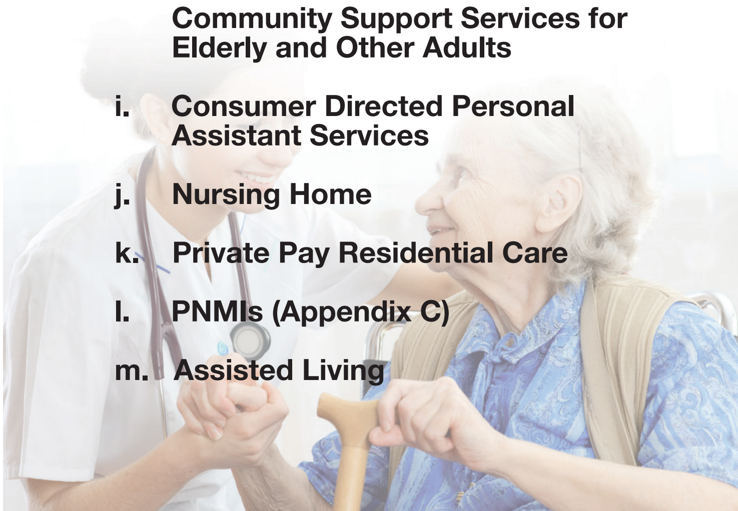
i. **Consumer Directed Personal Assistant Services**

j. **Nursing Home**

k. **Private Pay Residential Care**

l. **PNMIs (Appendix C)**

m. **Assisted Living**



The Maine Long-Term Care
OMBUDSMAN
Program
Advocates for Long-Term Care Consumers

61 Winthrop Street
Augusta, Maine 04330

207-621-1079
1-800-499-0229
Fax: 207-621-0509

MLTCOP@MaineOmbudsman.org

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Referrals to the Maine Long-Term Care Ombudsman Program:

A Guide for Hospital Care Managers

When barriers exist regarding access to long-term care services

The Maine Long-Term Care
OMBUDSMAN
Program

Advocates for patients in hospitals who need long-term care services

1-800-499-0229

What is the Maine Long-Term Care Ombudsman Program?

The Maine Long-Term Care Ombudsman Program (MLTCOP) is authorized under federal and state law to provide advocacy for long-term care consumers. The program works to resolve problems on behalf of consumers concerning access to services, quality of care, and quality of life. Each year the program assists thousands of consumers by providing advocacy services to protect their rights, health, safety, and welfare. The program serves residents of nursing homes, assisted housing including residential care and assisted living programs, as well as recipients of home care services, adult day services and homemaker services.

How can MLTCOP advocate for hospital patients?

Recently, legislation was passed to allow MLTCOP to assist patients ready for discharge from a hospital who face barriers to accessing long-term care services either in the community or in a long-term care facility. MLTCOP's mandate is to serve as a patient advocate, working closely with the patient to identify an environment where the patient will thrive. MLTCOP staff work diligently in strong partnership with the hospital care management team to address barriers and avoid any duplication. A referral to MLTCOP does not diminish the role of the Hospital Care Manager in planning a safe and appropriate discharge.

How to make a referral:

1.) OBTAIN CONSENT. MLTCOP requires consent from the patient or their legal representative before taking action. Please obtain consent before contacting MLTCOP with the referral.

2.) Call MLTCOP at 1-800-499-0229 or 207-621-1079 and ask to speak to our Intake Worker about making a referral. Referrals must come through intake for the most prompt response.

3.) Please have the following information ready for our Intake Worker:

- **Patient name**
- **Level of care**
- **Date of admission**
- **Summary of diagnoses**
- **List of providers contacted**
- **Date of birth**
- **Type of insurance**
- **Family/ legal representative contact information**
- **Summary of barriers to accessing services**

What to expect after a referral has been made:

1) MLTCOP staff will contact and meet with the patient and/or legal representative at the hospital, discuss needs and goals for discharge, and sign appropriate releases.

2) MLTCOP staff will review medical records and talk with the hospital staff to determine care needs and the appropriate services needed for discharge.

3) MLTCOP staff will review referrals made to providers who denied services or have not responded. MLTCOP staff will follow-up with facilities or community providers about services and placement. Referral information and action taken on behalf of the patient will be shared with the Office of MaineCare. MLTCOP will request assistance as needed from DHHS to achieve goals of discharge.

4) MLTCOP staff will follow up with the patient after discharge to make sure their needs are being properly met.