
Senior Services News

*A Newsletter
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TO: Nursing Facilities

SUBJECT: Month of Discharge Exemption for Nursing Facility Residents

PURPOSE: To inform NFs of a change in policy regarding patient payment to the NF for month of discharge when discharge is to the community.

BACKGROUND:

As you may know, one of the Department's initiatives is "Community Choice." The purpose of this initiative is to facilitate moving those NF residents who choose to move to less restrictive care settings. Medicaid payment for "room and board" is permitted only in Title XIX facilities; it is not permitted for the new setting into which an individual will move. Accordingly, the person's income, which in the NF is diverted to the cost of care, is needed to pay "room and board" as well as other non-medical costs associated with the move. Therefore, the Department is implementing a new policy for the income of a beneficiary for the month of discharge when that discharge is to the community.

The following policy is effective May 1, 1999 and is also being communicated to the County Welfare Agencies/Boards of Social Service.

In the event of a discharge to the community and for the month of discharge **only**, an exemption shall be allowed equal to the amount remaining after appropriate allowance(s) for other exemptions to income and the PNA. Thus, the amount listed in the block entitled "Total Exempt Income" should equal the amount in the block entitled "Total Gross Income" and "Available Income" should equal zero.

"Discharge to the community" includes discharge to the beneficiary's home; to the home of a family member or friend; or to a licensed community setting including a Residential Health Care Facility, a Boarding Home, an Alternate Family Care Home, an Assisted Living Residence, or a Comprehensive Personal Care Home.

"Discharge to the Community" does not include discharge to another Title XIX facility.

ACTION:

The Medicaid payment to a Nursing Facility will not be reduced for the month of discharge when the discharge is to the community. Accordingly, the beneficiary should not be billed any co-pay for the month of discharge. If the facility collects co-pay before knowing that the discharge will occur, it is the facility's responsibility to make a refund to the beneficiary.

Discharges to the community continue to be reported on the MCNH-33 in the section titled "Termination Information." If the discharge is to the beneficiary's home or the home of a family member or friend, check "Community" in item 5. If the discharge is to a licensed community setting, as defined above, check "Other" and write in the name and address of the licensed community setting.

When the Nursing Facility is the payee for the beneficiary, the facility is responsible to initiate action to change the payee. The facility shall also forward to the beneficiary any funds received after discharge.

RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "S")

New Jersey Department of Health and Senior Services
STATEMENT OF AVAILABLE INCOME FOR MEDICAID PAYMENT

1910017095-01 SMYTHE HR 7/01/94
HSP (Medicaid) Case Number LAST, FIRST ELIG. EFF. DATE PRINT DATE
 SSA Number: 160-00-8110 Redetermination Date: _____ 14
(MM/YYYY) County code
 Long Term Care Facility: _____ LTCF Prov. No.: _____
 Address: _____

	LTCF		#1	#2	#3	Remarks
Effective Date			5/1/99			Admit, Change, Redetermination
Social Security Income						Claim #
Buy-In-Amount						HIC #
Gross Social Security Benefit			782.00			
Railroad/Veteran						Claim #
Pension/Other Benefit			481.00			Specify
Indemnity						Specify
Total Other Income			481.00			Spouse's S.S.A. #
Total Gross Income			1263.00			M = Married Couple Same LTCF N = Medically Needy F = Foreign Pension G = VA A+A P = VA Improved Pension
PNA			35.00			
Health Premium (Total \$)			85.00			Policy # AARP 66666
Other						Specify
Maint./Home						Specify
Month of Admin. Disch. Exempt			1143.00			Specify
Med. Needy Spend Down						Specify
Maint./Spouse Dependent						Specify
Discretionary Income						Specify
Total Exempt Income	\$		\$ 1263.00	\$	\$	
Available Income	\$		\$ 0.00	\$	\$	R= Representative Payee
Resources Circle One Yes No	SPECIFY (i.e., address)					*Additional Health Insurance Policy No.

Note: Discharge to Community 5/15/99
 Name and Address of Representative Payee: _____
 Signature: IM Worker: _____
 Supervisor: _____

Date: _____ 5/18/99
 Date: _____ 5/18/99