State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

MICHELE K. GUHL
Commissioner

MARGARET A. MURRAY
Director

MEDICAID COMMUNICATION NO. 99-8 **DATE:** May 18, 1999

TO: County Welfare Agency Directors
Institutional Services Section (ISS)
Area Supervisors

SUBJECT: Month of Discharge Exemption
for Nursing Facility Residents

The purpose of this Communication is to advise you of a change in policy regarding month of discharge exemptions for nursing facility residents being discharged to the community. This change is being implemented as a result of Department of Health and Senior Services (DHSS) initiatives which promote the placement of nursing facility residents in less restrictive care settings.

Effective May 1, 1999, an exemption for the month of discharge <u>only</u> will be allowed equal to the amount remaining after appropriate allowance(s) for other exemptions to income and the Personal Needs Allowance (PNA). Therefore, when completing the PR-1 form for the month of discharge, 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. A completed sample PR-1 is attached for your reference. (Please note that DHSS reissued the PA-3L as PR-1 revised July 1998).

The new policy allows for the beneficiary's income in the month of discharge to be used to pay for "room and board" as well as other non-medical costs associated with his or her move to the community. In cases using the discharge exemption, Medicaid payments to the nursing facility are not reduced for the month of the beneficiary's discharge to the community.

"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 (RHCF), a Boarding Home, an Alternate Family Care Home, an Assisted Living Residence, or a Comprehensive Personal Care Home. However, "discharge to the community" does not include discharge to another Title XIX facility, including an acute care hospital.

The provision relating to the Month of Discharge Exemption previously addressed on page 6 of the instructions attached to Medicaid Communication 96-27, "New Form PA-3L, Statement of Available Income for Medicaid Payment," dated November 22, 1996, no longer applies and is replaced by the new policy.

Discharges to the community will continue to be reported on the MCNH-33 in the section entitled "Termination Information." If the discharge is to the beneficiary's home or the home of a family member or friend, "Community" will be checked in Item 5. If the discharge is to a licensed community setting, "Other" will be checked and the name and address of the licensed community setting will be noted.

We ask that you distribute this Communication to appropriate Medicaid eligibility staff involved in the processing of long-term care cases. Please direct any questions relating to the actual completion of the form to the Department of Health and Senior Services, at (609) 588-2860. For questions relating to policy, contact the Division of Medical Assistance and Health Services, Office of Beneficiary and Provider Services, at (609) 588-2556.

Sincerely,

Margaret A. Murray
Director

MAM:S
Attachment
c: Christine Grant, Commissioner Designee
Susan C. Reinhard, Ph.D., Deputy Commissioner
Department of Health and Senior Services

David C. Heins, Director
Division of Family Development

Charles Venti, Director
Division of Youth and Family Services

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

[redacted] HSP (Medicaid) Case Number [redacted] LAST, [redacted] FIRST 7/1/94 ELIG. EFF. DATE PRINT DATE

SSA Number [redacted] Redetermination Date: _____ (MM/YY) 14 COUNTY CODE

Long Term Care Facility: _____ LTCF Provider No.: _____

Address: _____

	LTCF		#1	#2	#3		Remarks
Effective Date			5/1/99				Admit, Change, Redetermination
Social Security Income			782.00				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 Adm./ Disch. Exempt			1143.00				Specify
Med. Needy Spend Down							Specify
Maint./Spouse Dependent							Specify
Discretionary Income							Specify
Total Exempt Income	$		$ 1263	$	$		
Available Income	$		$ Ø	$	$		R = Representative Payee
Resources Circle One Yes No	SPECIFY (i.e., address)						*Additional Health Insurance Policy Nos.

Discharge to COMMUNITY 5/15/99

Name and address of Representative Payee: _____

Signature: IM Worker I.M. Worker Date: 5/18/99

Supervisor: H. Boss Date: 5/19/99

PR-1
Revised 7/98

DISTRIBUTION: WHITE - DHSS PINK - Board of Social Services
CANARY - Provider GOLDENROD - Beneficiary

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