Using the 5615

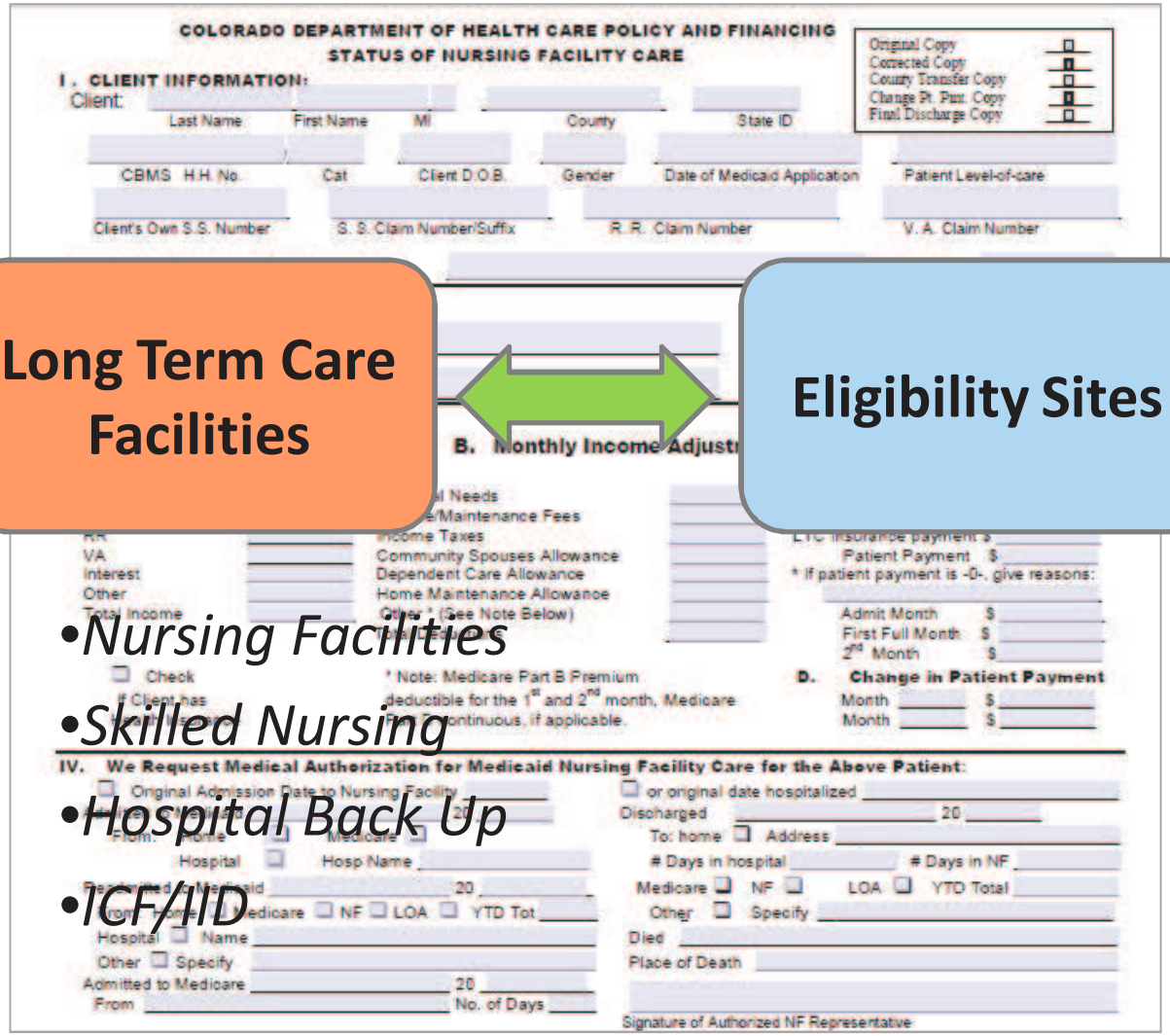
Nursing Facilities Advisory Council

December 2012

What You Will Learn

- Roles and Responsibilities
- Key Fields
  - Admitted to Medicaid Date
  - Medicare Part B / co-pay days
  - Veterans' (VA) benefits
- Tips and Best Practices
  - Form
  - Communication

What is the 5615 ?


COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
STATUS OF NURSING FACILITY CARE

I. CLIENT INFORMATION:

Original Copy
Corrected Copy
County Transfer Copy
Change Pt. Pmt. Copy
Final Discharge Copy

Client: Last Name | First Name | MI | County | State ID

CBMS H.H. No. | Cat | Client D.O.B. | Gender | Date of Medicaid Application | Patient Level-of-care

Client's Own S.S. Number | S. S. Claim Number/Suffix | R.R. Claim Number | V. A. Claim Number

B. Monthly Income Adjust

Needs
/Maintenance Fees
Income Taxes
Community Spouses Allowance
Dependent Care Allowance
Home Maintenance Allowance
Other * (See Note Below)

RR
VA
Interest
Other
Total Income

Check
If Client has

* Note: Medicare Part B Premium deductible for the 1st and 2nd month, Medicare continuous, if applicable.

LTC Insurance payment $
Patient Payment $
* If patient payment is -0-, give reasons:

Admit Month $
First Full Month $
2nd Month $

D. Change in Patient Payment
Month $
Month $

IV. We Request Medical Authorization for Medicaid Nursing Facility Care for the Above Patient:

Original Admission Date to Nursing Facility
From: Home Medicare
Hospital Hosp Name
Medicaid 20
Medicare NF LOA YTD Tot
Hospital Name
Other Specify
Admitted to Medicare 20
From No. of Days

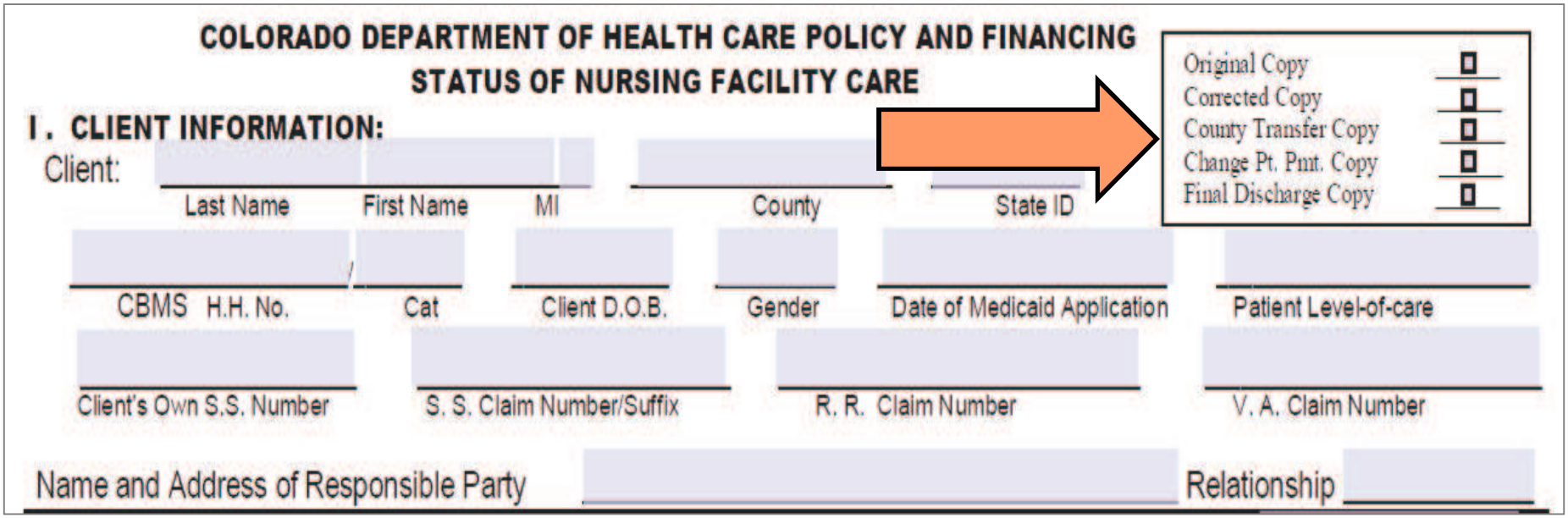
or original date hospitalized
Discharged 20
To: home Address
Days in hospital # Days in NF
Medicare NF LOA YTD Total
Other Specify
Died
Place of Death
Signature of Authorized NF Representative

Long Term Care Facilities

Eligibility Sites

- *Nursing Facilities*
- *Skilled Nursing*
- *Hospital Back Up*
- *ICF/IID*

Section I
Client Information



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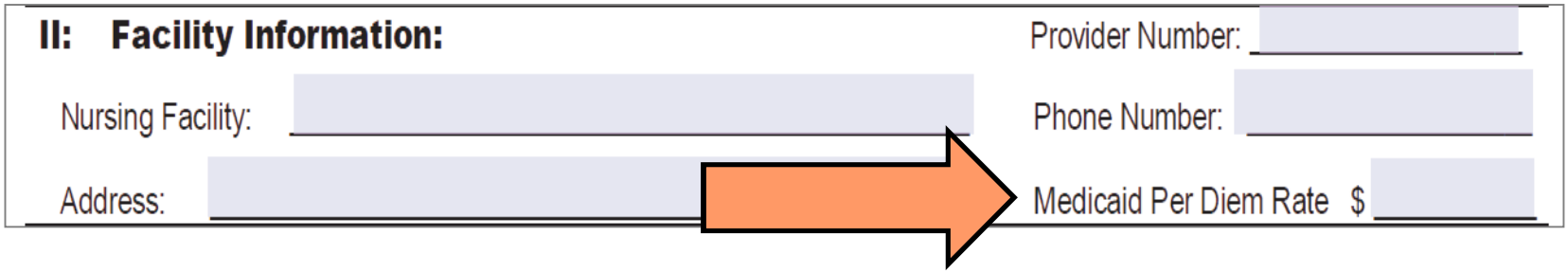
Name and Address of Responsible Party | Relationship

Responsible Entity:

Eligibility Site **or** LTC Facility – whichever initiates form

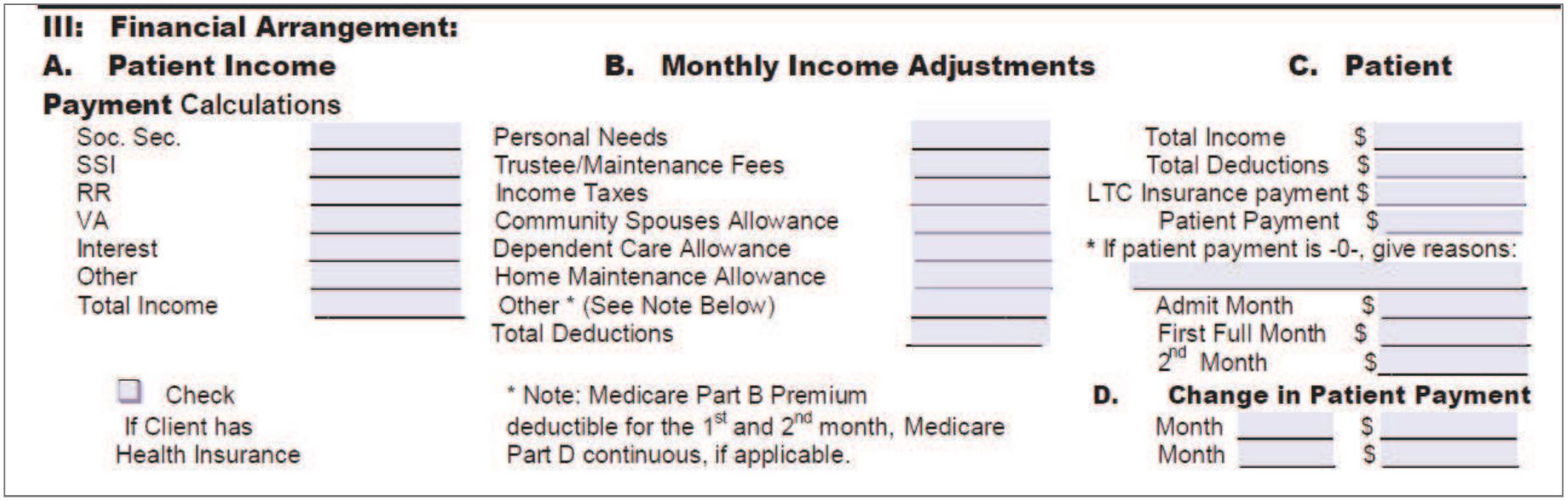
Section II
Facility Information



Responsible Entity:

Primary - LTC Facility

Section III
Patient Payment



III: Financial Arrangement:

A. Patient Income Payment Calculations

Soc. Sec.	
SSI	
RR	
VA	
Interest	
Other	
Total Income	

☐ Check If Client has Health Insurance

B. Monthly Income Adjustments

Personal Needs	
Trustee/Maintenance Fees	
Income Taxes	
Community Spouses Allowance	
Dependent Care Allowance	
Home Maintenance Allowance	
Other * (See Note Below)	
Total Deductions	

* Note: Medicare Part B Premium deductible for the 1st and 2nd month, Medicare Part D continuous, if applicable.

C. Patient

Total Income	$
Total Deductions	$
LTC Insurance payment	$
Patient Payment	$

* If patient payment is -0-, give reasons:

Admit Month	$
First Full Month	$
2nd Month	$

D. Change in Patient Payment

Month		$
Month		$

Responsible Entity:

Primary – Eligibility Site

Section III
Patient Income

- Patient Income
  - Use **gross** income totals
  - **All** income must be reported
  - **Always** report SSI income
  - Other Health Insurance

- If other total is used, causes
  - Client/LTC Facility recoveries
  - Less Personal Funds for client

III: Financial Arrangement:
A. Patient Income
Payment Calculations

Soc. Sec.	500
SSI	198
RR	
VA	
Interest	
Other	
Total Income	698

☐ Check
If Client has
Health Insurance

Section III
Monthly Income Adjustments

- **Personal Needs**
  - Non-Service related disability benefits
- **Don't** deduct Medicare Part B if client is on Medicare Buy-In
  - **Contact** Eligibility Site to notify and fix issue

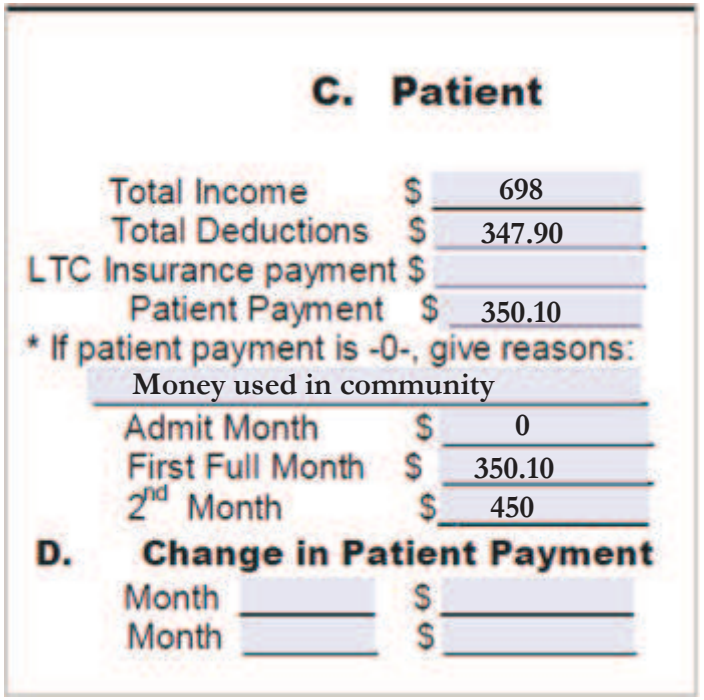
B. Monthly Income Adjustment

Personal Needs		50
Trustee/Maintenance Fees		
Income Taxes		
Community Spouses Allowance		
~~Dependent Care Allowance~~	Part B	99.90
Home Maintenance Allowance		
Other * (See Note Below)		198
Total Deductions		347.90

* Note: Medicare Part B Premium deductible for the 1st and 2nd month, Medicare Part D continuous, if applicable.

Section III
Patient Payment

- Calculating Patient Payment
  - Long-Term Care Insurance
  - Verify home expenses
  - If zero, give reasons
- Changes in Patient Payment
  - Use comment section
  - What did you change or expect to happen later



C. Patient

Total Income	$	698
Total Deductions	$	347.90
LTC Insurance payment	$	
Patient Payment	$	350.10

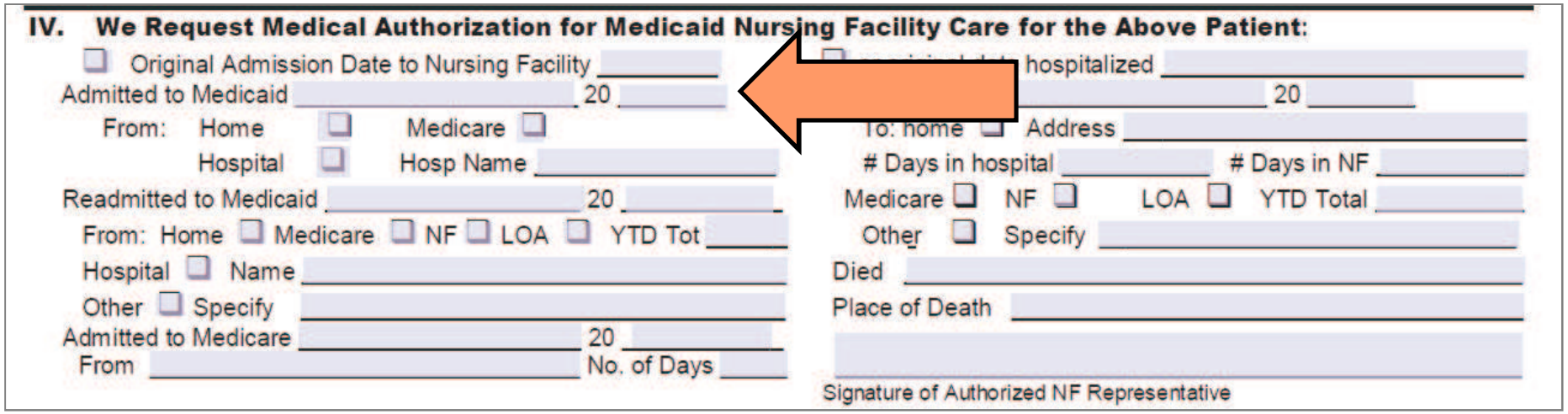
* If patient payment is -0-, give reasons:
Money used in community

Admit Month	$	0
First Full Month	$	350.10
2nd Month	$	450

D. Change in Patient Payment

Month	_____	$ _____
Month	_____	$ _____

Section IV
Medical Authorization



IV. We Request Medical Authorization for Medicaid Nursing Facility Care for the Above Patient:

- ☐ Original Admission Date to Nursing Facility _____
- Admitted to Medicaid _____ 20 _____
- From: Home ☐ Medicare ☐
- Hospital ☐ Hosp Name _____
- Readmitted to Medicaid _____ 20 _____
- From: Home ☐ Medicare ☐ NF ☐ LOA ☐ YTD Tot _____
- Hospital ☐ Name _____
- Other ☐ Specify _____
- Admitted to Medicare _____ 20 _____
- From _____ No. of Days _____

- ☐ _____ hospitalized _____
- _____ 20 _____
- To: home ☐ Address _____
- # Days in hospital _____ # Days in NF _____
- Medicare ☐ NF ☐ LOA ☐ YTD Total _____
- Other ☐ Specify _____
- Died _____
- Place of Death _____

Signature of Authorized NF Representative

Responsible Entity:

Primary – LTC Facility

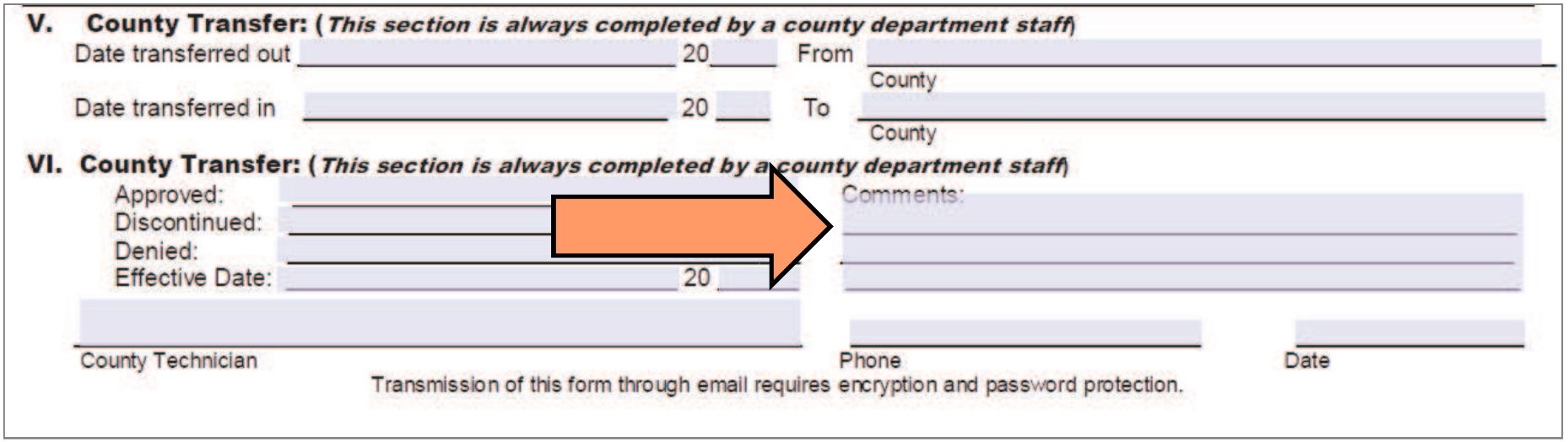
Section IV
Medical Authorization

- Admitted to Medicaid Date
  - Date LTC Facility expects Medicaid to begin paying
  - If blank, Counties must contact LTC Facility
- Admitted to Medicare Date
  - Date LTC Facility expects Medicare to begin paying
- Why do we need to do this?
  - Avoids duplicate billing
  - Avoids audit recoveries

Section IV
Medical Authorization

- Report Discharge/Death
  - Notify County upon discharge or death of a client
  - Avoids unnecessary billing
  - Avoids audit recoveries
- Authorized Signature
  - Should be a handwritten signature, not typed

Section V & VI
County Transfer/Approval



V. County Transfer: (*This section is always completed by a county department staff*)

Date transferred out _____ 20____ From _____
County

Date transferred in _____ 20____ To _____
County

VI. County Transfer: (*This section is always completed by a county department staff*)

Approved:
Discontinued:
Denied:
Effective Date: _____ 20____

Comments:

County Technician | Phone | Date

Transmission of this form through email requires encryption and password protection.

Responsible Entity:

Primary – Eligibility Site

Best Practices

- Importance of Admitted to Medicaid Date
- Contact Eligibility Site for help with Medicare Buy-In
- Review comments section and checkbox
  - Review for any additional information
  - Use checkbox to help with paper trail
- Encrypt when emailing 5615
  - If you don't have the ability to encrypt emails, must fax or mail

Training Contact

Jennifer Larsen

Case Manager Trainer

Long Term Services and Supports

jennifer.larsen@state.co.us