INSTRUCTIONS FOR COMPLETING FORM AP-5615

THIS FORM IS TO BE COMPLETED FOR ALL MEDICAID APPLICANTS OR RECIPIENTS UPON ADMISSION, READMISSION, DISCHARGE OR TRANSFER. THIS FORM IS ALSO USED TO NOTIFY OF A CHANGE IN PATIENT PAYMENT. ONCE THE COUNTY HAS TAKEN ACTION, THE ORIGINAL SHALL BE RETURNED TO THE NURSING FACILITY AND A COPY IS TO BE RETAINED AT THE COUNTY DEPARTMENT.

Section I. CLIENT INFORMATION:

1. Appropriate box in upper right hand corner must be completed on each form submitted.

2. Line 1: Spelling of client name MUST be identical to that shown on the ULTC-100.2 and the Medicaid Authorization Card. Complete county identification and State ID number.

3. Line 2: Complete CBMS case ID number, date of birth, gender, date of Medicaid application, and patient level of care.

4. Line 3: Complete Social Security number, Social Security claim number with suffix, Railroad retirement claim number, and Veterans Administration claim number as applicable.

5. Line 4: The name, address and relationship of the patient's relative or responsible party MUST be indicated on each form submitted.

Section II. FACILITY INFORMATION:

1. Indicate the nursing facility's name, full address, provider number, and phone number.

2. Indicate the nursing facility's Medicaid Per Diem Rate effective at the time the form is initiated, for the period being reported.

Section III. FINANCIAL ARRANGEMENT:

1. A. Patient Income: Indicate the GROSS income from ALL sources at the time of admission, and on each occasion of a change in patient payment. Calculate the sum of ALL income listed and enter on the Total Income line.

2. B. Monthly Income Adjustments: Indicate ALL *verified* income adjustments for which the client *meets requirements* of: PERSONAL NEEDS; TRUSTEE/MAINTENANCE FEES; INCOME TAXES; COMMUNITY SPOUSES ALLOWANCE; DEPENDENT CARE ALLOWANCE; HOME MAINTENANCE ALLOWANCE; OTHER* (see note on form). Calculate the sum of ALL *approved* income adjustments and enter on the Total Deductions line. CAUTION: HOME MAINTENANCE ALLOWANCE may only be appropriate where *NO* COMMUNITY SPOUSES or DEPENDENT CARE ALLOWANCES are indicated.

3. C. Patient Payment Calculations: Enter Total Income and Total Deductions, as previously noted in A. and B.; if applicable, enter client's *verified* LTC Insurance Payment amount. Calculate the patient payment by adding and subtracting these items as appropriate, and enter total on line provided. If patient payment is -0-, indicate reason (e.g., paid to previous nursing facility or needed to reestablish in community). Enter appropriate patient payment for admit month (=first month

of Medicaid eligibility), 1st full month (=second month of Medicaid eligibility), 2nd full month (=third month of Medicaid eligibility).

4. D. Change in Patient Payment: Mostly used for on-going cases, when admission information is no longer appropriate. Indicate month/year of change and patient payment amount, as calculated in C. above.

Section IV. WE REQUEST MEDICAL AUTHORIZATION FOR MEDICAID NURSING FACILITY CARE FOR THE ABOVE PATIENT:

1. Information in this section should be completed by the nursing facility for initial admission of a Medicaid applicant/recipient, and at discharge, readmission, or death. Check the appropriate box, and always include the date (keeping in mind when you expect Medicaid to start or stop paying).

DO NOT COMPLETE THIS SECTION IN THE FOLLOWING CIRCUMSTANCES:

a. when submitting financial arrangements only; or

b. when submitting a county transfer.

2. Signature of Authorized NF Representative and date MUST be complete.

Section V. COUNTY TRANSFER (This section is always completed by a county department staff):

1. The County Department which *initiates transfer* of the case completes "Date Transferred out" and indicates the county to which the case was transferred.

2. The County Department which *accepts transfer* of the case completes "Date Transferred in" and indicates the county from which the case was transferred.

Section VI. COUNTY TRANSFER (This section is always completed by a county department staff):

1. The County Department indicates whether the information submitted has been approved, discontinued, or denied.

2. The County Department indicates the effective date of the action.

3. Enter comment as appropriate. (e.g., show calculation of lowered patient payment, communicate to nursing facility that they need to follow up with a new 5615 when client's current status has changed).

4. Signature of county staff completing form, phone number, and date of signature MUST be complete.