A Gainwell Technologies Company

PATIENT REPRESENTATIVE & FAMILY CONTACT INFORMATION FORM (FORM A), PATIENT TRUST FUND INFORMATION FORM (FORM B) AND PATIENT LIABILITY FUND INFORMATION FORM (FORM C) FOR USE BY LONG-TERM CARE FACILITIES AND/OR INSTITUTIONS FOR DECEASED MEDICAID PATIENTS

Per Federal and State law, Medicaid must recover from the estates of deceased Medicaid recipients. 42 USC § 1396p; NRS 422.29302. Nevada law gives Medicaid the authority to subpoena information from facilities and other institutions to assist with recovery efforts. NRS 422.2366.

The following forms are for use by Long-Term Care Facilities and/or Institutions to provide information to the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy's Medicaid Estate Recovery program through its vendor, HMS.

Form A, Form B and Form C must be filled out by the Long-Term Care Facility and/or Institution upon the death of any inpatient who received medical services paid for by the Nevada Medicaid program.

In addition to Forms A, B and C, Nevada Medicaid requires each facility or institution to provide an accounting of the Patient Trust Fund, if applicable, and/or the Patient Liability Fund, if applicable. In addition, it is upon each facility to provide Nevada Medicaid with any other helpful information that would assist Nevada Medicaid in its mandated recovery efforts.

Nevada Medicaid requests that upon the death of a Medicaid patient, each facility or institution complete these forms within thirty (30) days to ensure timely collection of the Medicaid debt. Forms may be returned to HMS via email at nvestaterecovery@hms.com or by U.S. mail to HMS, P.O. Box 12610, Reno, NV 89510.

Any questions about this process, the forms or the Medicaid Estate Recovery program may be directed to HMS at (800) 293-3973 or (303) 837-8293 or by visiting Nevada Medicaid's website at http://dhcfp.nv.gov/; select "Providers" and then "Medicaid Estate Recovery."

HMS LETTERHEAD

LTC Name
LTC Address
LTC City, NV Zip Code

Re: _____
Date of Death:_____

To Administration/Business Office Manager,

HMS, an agent of Nevada's Medicaid Estate Recovery program ("MER"), was recently informed of the death of _____, an inpatient in your facility. This patient received medical services paid for by the Nevada Medicaid program. Per Federal and State law, Medicaid must recover from the estates of deceased Medicaid recipients. 42 USC § 1396p; NRS 422.29302. Nevada law gives Medicaid the authority to subpoena information from facilities and other institutions to assist with recovery efforts. NRS 422.2366.

Your facility must provide HMS with an accounting of the Patient Trust Fund, if applicable, an accounting of the Patient Liability Fund as well as information regarding any person who may have received money from those accounts.

Please complete the enclosed Form A, Form B and Form C and return the forms to HMS **within 30 days** to ensure timely collection of this debt. Forms may be returned to HMS via email at nvestaterecovery@hms.com or by U.S. mail to HMS, P.O. Box 12610, Reno, NV 89510.

If you have any questions about this process or the MER program, please contact me directly or visit Nevada's website at http://dhcfp.nv.gov/; select "Providers" and then "Medicaid Estate Recovery."

Please note that failure to return the requested forms in a timely manner may result in a legal subpoena to your facility. Thank you in advance for your cooperation.

Sincerely,

_____
Name
HMS

FORM A—PATIENT REPRESENTATIVE & FAMILY CONTACT INFORMATION

1. Please provide the name, title, and phone number of the person completing this form and the date of completion:

   Name: _____ Title: _____

   Phone Number: _____ Date: _____

2. Please provide the following information regarding the surviving spouse, next of kin and/or person handling the affairs of the patient and/or the estate:

   Name:_____

   Relationship:_____

   Address:_____

   Phone Number: (___)_____

   Please provide any other helpful information:

   _____

   _____

2. Please provide the following information regarding additional known persons, including next of kin, family members and/or persons handling the affairs of the patient and/or the estate, if applicable:

   Name:_____

   Relationship:_____

   Address:_____

   Phone Number: (___)_____

   Please provide any other helpful information:

   _____

   _____

FORM B – PATIENT TRUST FUND INFORMATION

A Patient Trust Fund ("PTF") is a financial account set up for a patient's personal needs and cannot be used for any other purpose. A facility may not hold these funds when a patient is discharged to another living arrangement or when a patient passes away. A facility may not use these funds to pay a past due balance for a patient liability account. Upon a patient's discharge or death, each facility must convey a patient's trust fund money and a final accounting of that money to the patient, the legal representative of the patient and/or the estate, or, the MER program, if applicable.

1. Please provide the name, title, and phone number of the person completing this form and the date of completion:

   Name: _____ Title: _____

   Phone Number: _____ Date: _____

2. Does this patient have a PTF account with your facility?

   ☐ No. If you have any information relating to the patient's personal trust fund account or persons who may have knowledge regarding that account, please provide that information.
   _____
   _____

   ☐ Yes, please proceed to numbers 3 and 4.

3. Please provide the following information regarding the disbursement of the PTF.

   Amount in the PTF as of the patient's date of death: $_____

   ☐ Disbursement Still Pending. Reason: _____

   Expected Release Date: _____

   ☐ Disbursed to HMS Date: _____ or ☐ Amount Enclosed

   ☐ Disbursed to: _____ Date: _____

   Relationship to patient: _____

   Address:_____ Phone Number: _____

4. Please provide a copy of the PTF ledger with this response.

FORM C – PATIENT LIABILITY FUND INFORMATION

Patient Liability is the cost assessed for patient care and cannot be used for any other purpose. Patient Liability cannot be held by a facility when a patient is discharged to another living arrangement or passes away. Each facility must refund any remaining patient liability money to the patient, the legal representative of the patient and/or the estate, or, the MER program, if applicable.

1. Please provide the name, title, and phone number of the person completing this form and the date of completion:

   Name: _____ Title: _____

   Phone Number: _____ Date: _____

2. Does the patient's Patient Liability account receive payments from the Social Security Administration?

   ☐ No, please continue to number 3.

   ☐ Yes, please review the enclosed Social Security Manual information regarding Social Security overpayments. If you determine that a Social Security overpayment was made to the patient, please indicate the amount of the overpayment: $_____.

   Please indicate whether the overpayment has been returned to Social Security, the date of the return and the amount remaining in the PL:

   ☐ Yes Date of Return: _____

   Amount remaining in PL: _____

   ☐ No Anticipated Social Security return date: _____

   Anticipated Amount remaining in PL: _____

3. The Patient Liability for this patient at the time of death has been calculated by the Nevada Welfare Division to be: $_____

   Amount in patient's PL account at your facility as of the patient's date of death (please do not include the amount of any Social Security overpayment, if applicable): $_____

   If the amount of PL at your facility does not equal the amount calculated by the Nevada Welfare Division, please indicate the reason for the discrepancy.

   _____

   _____

4. Please provide the following information regarding the disbursement of the PL.

☐ Disbursement still Pending. Reason: _____

Expected Release Date: _____

☐ Disbursed to HMS Date: _____ or ☐ Amount Enclosed

☐ Disbursed to: _____ Date: _____

Relationship to patient: _____

Address:_____ Phone Number: _____

5. Please provide a copy of the PL ledger with this response.