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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

Helping people. It's who we are and what we do.

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PATIENT REPESENTATIVE & 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, MER.

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 MER via email at mer@dhcfp.nv.gov or by U.S. mail to Medicaid Estate Recovery, 1100 E William Street Suite 101, Carson City, NV 89701.

Any questions about this process, the forms or the Medicaid Estate Recovery program may be directed to MER at (775) 687-8416 or (800) 992-0900 and select option 6 and then enter extension 78416 to be transferred to the Medicaid Estate Recovery unit or by visiting Nevada Medicaid's website at http://dhcfp.nv.gov/; select "Providers" and then "Medicaid Estate Recovery."

NAME OF THE PATIENT: _______________________________________ DATE OF BIRTH: ___________________________

SOCIAL SECURITY NUMBER: ____________________________________ DATE OF DEATH: ___________________________

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:

   ____

   ____

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

   Name: ____ Relationship: ______________________

   Address: ____

   Phone Number: _______________________________

   Please provide any other helpful information:

   ____

   ____

NAME OF THE PATIENT: _________________________________ DATE OF BIRTH: _____________________

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 account 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 MER Date: ___________________ or Amount Enclosed ___________________________
   Disbursed to: ____ Date: _______________________
   Relationship to patient: ____
   Address: ____Phone: ____________________

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

NAME OF THE PATIENT: ________________________________ DATE OF BIRTH: _________________________

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 MER Date: __________________ or Amount Enclosed

   Disbursed to: _______________________________ Date: ____________________

   Relationship to patient: ____

   Address: ___________________________________ Phone: __________________

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