STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Bureau for Medical Services
Commissioner's Office
350 Capitol Street – Room 251
Charleston, West Virginia 25301-3706
Telephone: (304) 558-1700 Fax: (304) 558-1451

Karen L. Bowling
Cabinet Secretary

MEMORANDUM

TO: West Virginia Long Term Care Providers (ICF/IID and Nursing Facilities)

FROM: Bureau for Medical Services

DATE: July 30, 2014

SUBJECT: Contribution Notices or DFA-NH-3's

This memo is to inform Long Term Care providers of a change for the August 2014 contribution notices or "NH3's". Enclosed is a desk reference for the local Economic Service Workers in each county regarding when manual NH3's are to be completed. In addition, enclosed you will find copies of the NH3's.

The important information for the Long Term Care providers is that system generated letters will replace most notifications; however, a hand written DFA-NH-3 may still be sent regarding the following changes:

- when the resident resides in more than one facility in the same month;
- when the resident leaves the facility; and,
- when the resident receives an undue hardship waiver.

All other contribution letters and notices will be system generated to the facilities, members, and/or responsible parties. While the format is different than what you are used to seeing, all of the same information is still present on the system generated notice.

This change in the notices will hopefully provide a more accurate account of the contribution due to the facility. If you have any questions, please feel free to contact your local Department of Health and Human Resources Office or Kelley Johnson, Nursing Facilities Program Manager, at Kelley.S.Johnson@wv.gov or 304-558-1700.

Enclosures: Notice of Client's Contribution toward His Cost of Care
DFA-NH-3 Notice of Contribution to the Cost of Care
System Generated Contribution Notice

NOTICE OF CONTRIBUTION TO THE COST OF CARE

TO:

CLIENT ______________________
CASE NAME ______________________
MEDICAID BILLING NUMBER ______________________
FACILITY NAME ______________________

☐ INITIAL ☐ ACTIVE CASE

- Beginning date of eligibility for payment: ______________ mm/dd/yy
- Beginning ______/______/_________, the client's contribution toward his/her cost of care is: ______________
- Contribution toward cost of care changed: From: ______________ To: ______________ Effective: ______________ mm/yy
- Medical Eligibility Date: ______________
- Date of most recent admission to the facility: ______________
- Effective ______/_____/_____, the Medicaid billing number changed from ____________________ to ____________________
- Client became financially ineligible for services effective: ______________ mm/yy
- Date of Discharge ______________
- Date of Death ______________

For the month of ____________________, the client's contribution is split as follows:

Facility: ____________________ Client Pays: ____________________
Dates covered: From ___________ to ______________

Facility: ____________________ Client Pays: ____________________
Dates covered: From ___________ to ______________

Client resources must be paid for in facility days and bed hold days.

Additional Comment: ____
____
____

☐ Facility Administrator ☐ Client or Representative ☐ LTC Unit

______________________________ ______________
WORKER'S SIGNATURE DATE

DFA-NH-3
Rev. 8/14

COPY

DHHR BERKELEY COUNTY
433 MID-ATLANTIC PK
PO BOX 1247
MARTINSBURG WV 25402

Mailing Date: 09/26/13

1234 NURSING HOME WAY BR
CHARLESTON WV 25301

West Virginia
Department of Health
& Human Resources

Case Name:
Case Number:
Worker Name:
Telephone: (304)

Dear BETTY JONES,
This notice informs you of your eligibility for all assistance programs which may be available to you and your family. It gives reasons if you are not eligible for a benefit(s). The notice has three (3) sections:

Section 1: Notice Eligibility Summary: This section is an eligibility summary for each individual in the household.
Section 2: Detailed Notices: This section is a detailed explanation of the benefits evaluated and benefit amounts.
Section 3: Other Applicable Information: This section includes benefit calculations and other applicable information, if any.

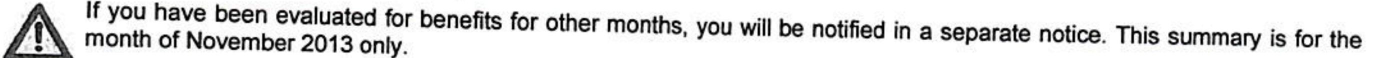
Fair Hearing: If you do not agree with any decision, you may request a Fair Hearing and/or Pre-Hearing Conference within 90 days of the effective date of the action. If you wish to request continued benefits, you must ask for a Fair Hearing or Conference within 13 days of the date of this notice. Continued benefits only apply to closures and decreases in benefits. The form to request a Fair Hearing and/or Pre-Hearing Conference is enclosed, but you may request it by phone or in person. The following organization provides free legal services to eligible persons:
LEGAL AID OF WEST VIRGINIA, 525 WINCHESTER AVE., MARTINSBURG, WV, 25401, 304-263-8871/866-255-4370

Note: If you currently receive Medical Assistance, the summary information could include eligibility for another Medical Assistance coverage group which is not addressed in the Detailed Notices in Section 2.

Section 1: Notice Eligibility Summary

If you have been evaluated for benefits for other months, you will be notified in a separate notice. This summary is for the month of November 2013 only.

Medical Assistance



Name	Begin Date	End Date	Status	Medicaid ID No.
	2013-11-01		Eligible	

Please see the attached detailed notices for additional information.

Section 2: Detailed Notices

EDR2

Valley Haven Geriatric Center, Inc.

Amount:	Reason:
Your patient responsibility amount payable to ;ncrease from $ 0.00 to $ 5950.00, effective 11/01/13.	You are required to contribute more money to the cost of your care because your income has increased. Your income has increased.

Continued on back

The following is the list of individuals who are eligible for this benefit. If an individual has been added to the Assistance Group, their name will appear here. If an individual income has increased, this will be stated by the amount it increased by.

REASON	AMOUNT
Your income has increased.	6000.00

Policy: West Virginia Income Maintenance Manual Section(s):
17.9.C

Notes:

If you receive Medicaid only as a Qualified Medicare Beneficiary, DHHR will pay your Medicare premium and you will receive a monthly Medicaid card that only pays for the co-payment and deductible expenses related to Medicare. All other persons who are eligible for Medicaid will receive a Medicaid card each month. The card lists the people who are covered and it must be shown to the health care provider each time you request medical service. Examples of health care providers are: hospitals, doctors and pharmacists.

If you are interested in applying for the Tel-Assistance/Lifeline Program to help you save money on your phone bill, an application is available for you at your local Department of Health and Human Resources Office or you can download an application using your My inROADS account on inROADS at www.wvinroads.org.

Section 3: Other Applicable Information

Medicaid and/or WV CHIP

The budget below was used to determine eligibility for

Vehicle Assets	0.00		
Liquid Assets	0.00		
Real Property Assets	0.00		
Personal Property Assets	0.00		
Life Insurance Assets	0.00		
Lump Sum Assets	0.00		
Burial Assets	0.00		
Deemed Assets	0.00		
Your Countable Assets	0.00	MA Asset Limit	2000.00

Shelter Cost		0.00
Standard Utility Allowance	+	0.00
30% of Min Comm Sps Allowance	-	0.00
Minimum Comm Spouse Allowance	+	0.00
Comm Spouse Gross Income	-	0.00
Adjusted Comm Spouse Maint Allowance		0.00
Maximum Comm Spouse Maint Allowance	-	0.00
Comm Spouse Maint Allowance (Lesser of Adjusted/ Maximum)		0.00

Gross Earned Income		0.00
Gross Unearned Income	+	6000.00
Gross Income	=	6000.00
Personal Allowance	-	50.00
Outside Living Expense	-	0.00
Community Spouse Maint Allowance	-	0.00
Family Maintenance Allowance	-	0.00
Spenddown	-	0.00

Continued on next sheet

Medicare Premium	-	0.00
Health Insurance Premium	-	0.00
Remedial Medical Expenses	-	0.00
$65 Disregard	-	0.00
Resource Amount		5950.00
Penalty Remainder	+	0.00
Spenddown	+	0.00
Total Contribution (Amount *you* must pay)		5950.00

Continued on back

Notice of Client's Contribution Toward His Cost of Care

IMM Section 17.6, B

Effective August 1, 2014

<table>
<tr>
<th>System Generated Notice (eRAPIDS)
(DFA-NL-A, DFA-NL-B, DFA-NL-C, EDI2, EDR2)</th>
<th>DFA-NH-3 (manual completion by Worker)</th>
</tr>
<tr>
<td>Notifies the client, or his representative, and the nursing facility when:

• The client first enters the facility, or becomes eligible for payment*

• When there is a change in the contribution to care</td>
<td rowspan="3">Notifies the client, or his representative, the nursing facility, and the BMS LTC Unit when:

• The client resides in more than one facility in the same month - notify each facility

• When the client leaves the facility

• For payment of services due to an Undue Hardship Waiver request</td>
</tr>
<tr>
<td>System Generated Report (eRAPIDS)</td>
</tr>
<tr>
<td>Notifies the BMS LTC Unit when:

• The client first enters the facility, or becomes eligible for payment*

• When there is a change in the contribution to care

*Prorated contributions must be calculated manually offline by the Worker and entered into the data system, see IMM Section 17.9.

This is completed in RAPIDS by selecting the benefit on the confirmation screen; "click" over-ride eligibility results; then type the pro-rated amount in the over-ride contribution amount field.</td>
</tr>
</table>

The Income Maintenance Manual is the source authority for the eligibility policy of the Division of Family Assistance in the Bureau for Children and Families of the WV Department of Health and Human Resources (DHHR). This transmission is a clarification of the official policy, but it not a substitute for it. Therefore, this transmission may not be used as evidence during a DHHR Fair Hearing and may not be viewed by, or distributed to, any individual, group, business, government agency, or other entity not employed by DHHR, unless approved by the Assistant Attorney General assigned to the Bureau for Children and Families. This and any documents accompanying this transmission contain confidential information that is legally privileged. The information contained herein is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.