Financial Answers About Long-Term Care

ROOSEVELT

HELPFUL Phone Numbers

Middlesex County Board of Social Services
(8:30 a.m. to 4:15 p.m. Monday to Friday)
732-745-3500

Social Security Administration
(7 a.m. to 7 p.m. Monday to Friday)
1-800-772-1213

Pharmaceutical Assistance to the Aged and Disabled
PAAD and Senior Gold
(8 a.m. to 5 p.m. Monday to Friday)
1-800-792-9745

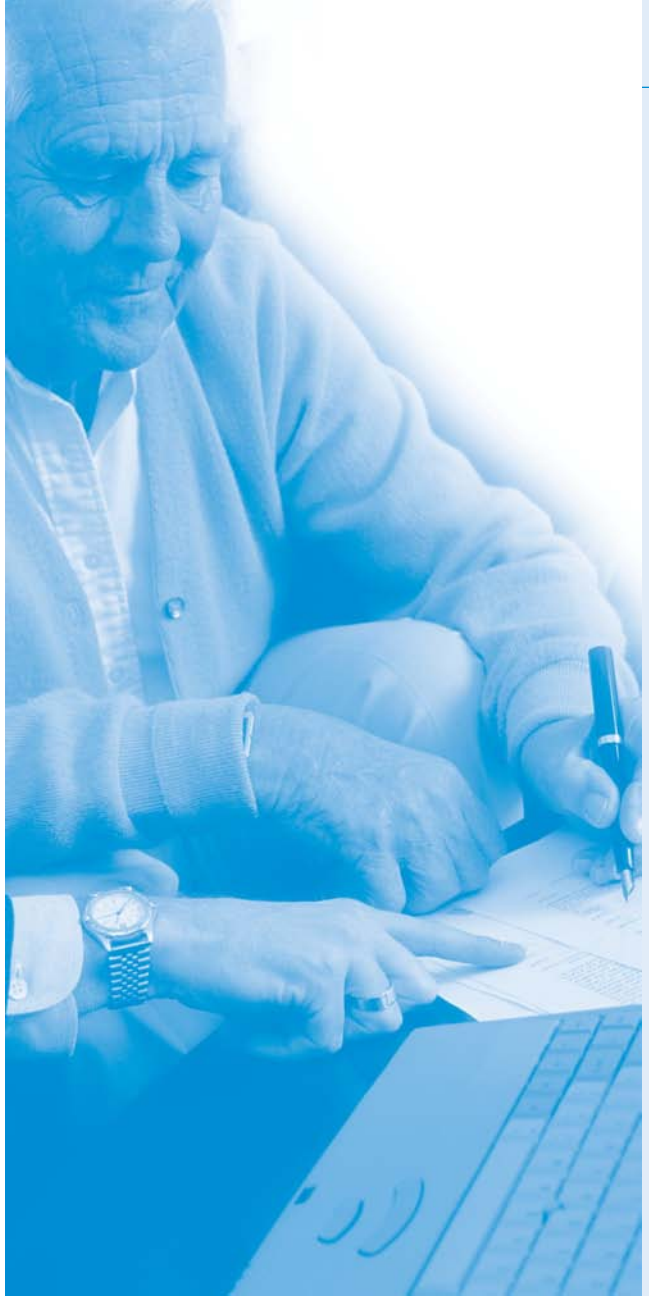
Medicare Part D Prescription Drug Coverage
1-800-MEDICARE

Roosevelt Care Center Business Office
(8:30 a.m. to 4 p.m. Monday to Friday)
732-321-6800 ext. 4013, 4012 or 4011
Fax: 732-767-4033

HELPFUL Websites

Social Security Administration
www.ssa.gov

New Jersey Department of Health and Senior Services
www.state.nj.us/health



The decision to have yourself or a loved one enter a long-term care facility such as Roosevelt Care Center is a difficult one to make and often made during a time of stress. No matter how prepared you feel you may be, questions may still be unanswered.

One of the more pressing issues you may be facing is how to pay for the stay and other associated expenses. How will it impact your finances and those of your loved ones? Will federal programs help pay? How do you apply? Will private insurance cover any of the cost?

Since funds may come from various sources, piecing together the financial puzzle of skilled care can be complicated. Be assured that we at Roosevelt Care Center are willing and able to discuss your payment options and help you through the process.

Whether you are a prospective resident or patient, a family member or a responsible party, use this brochure as a starting point, something to refer to while discussing payment with a social worker or business office counselor. While not a comprehensive reference, this booklet will answer some questions and also help you form others for our staff.

PAYMENT Options

PRIVATE PAY & COMMERCIAL INSURANCE

If you are paying privately for room and board, that is, using your own funds, you will be billed in advance for the month. Payment is due by the 10th of the month, covering your stay through the end of the month. Any charges incurred in addition to room and board appear on your bill the next month, after the service was performed. We accept credit and debit card payments.

We also currently accept most commercial insurance plans and HMOs, such as Aetna and Horizon Blue Cross and Blue Shield, if they cover skilled nursing services. Each plan has different requirements, co-pays and deductibles. We will assist you in sorting out which services are covered and which you will be responsible for paying.

Any charges not covered by your commercial insurance will be billed to you each month and are due upon receipt of the bill. Please note that supplemental Medicare insurance is not considered commercial insurance.

MEDICARE

Medicare A and B may pay for some or all of your stay if certain criteria are met. The federal government has established a number of eligibility requirements for the programs. As part of your care plan, our staff will provide you with information, make determinations and assist you in meeting deadlines. You will not have to do this by yourself.

To be eligible to receive Medicare A benefits (benefits that cover room and board, medication, tests and other medical services), you must have been hospitalized for 3 midnights within 30 days of admission to our Center. Daily skilled nursing or rehabilitation services related to the hospital stay must be needed and you must be benefiting from the intervention. Medicare is considered your primary payer, only if no benefits are available from any other insurance plan.

Once you are eligible to receive Medicare A benefits, Medicare will pay for a maximum of 100 days for each benefit period. For the first 20 days, Medicare pays for skilled care in its entirety, with certain restrictions. For days 21 through 100, Medicare requires the resident to pay a per diem co-pay (a portion of the stay). Please check with the Business Office for the daily co-pay. That Co-pay may come directly from you or from any commercial insurance or other secondary insurance you may have, such as AARP and Blue Cross/Blue Shield Medigap insurance. It is important to note that not all secondary insurance covers skilled nursing care. Please check with your insurance carrier directly and make sure you refer to skilled-nursing care.

When you no longer need skilled care as defined by Medicare, Medicare will no longer pay for your stay, even if you have not used 100 days. You will be notified by telephone or in writing when it is determined that you are no longer eligible for Medicare benefits based on the Medicare guidelines. You will be notified why your benefits have been denied, and you can request that Medicare review our decision.

Once your 100 days of Medicare coverage have been used or you have been notified that you are no longer eligible for Medicare benefits based on the Medicare guidelines, you must pay with your own funds, use commercial insurance or Medicaid (see below), if you qualify.

Medicare B insurance covers certain services when you are not being covered under Medicare A. There is an annual deductible you must pay first, then Medicare B will pay 80 percent of the charges for those covered services. You will be responsible for the remaining 20 percent. If you have additional insurance that covers your deductible or 20-percent co-pay, we will bill that insurance plan for you. Covered services under Medicare B include rehabilitation therapies, certain equipment and certain medical supplies. Medicare B does not pay room and board.

MEDICAID

Medicaid, a federal-and-state-funded program for the needy, may pay for the cost of a stay if certain asset and income tests are met and if the resident is determined to meet the clinical eligibility requirements of Medicaid. The clinical requirements are determined by a nurse from the New Jersey Department of Health and Senior Services Long-Term Care Office or by your Medicaid HMO if you are enrolled in one. Rest assured, our staff will help you sift through the complicated rules and eligibility requirements.

There are time limits that must be met in order to receive Medicaid coverage in a nursing home. To ensure those deadlines are met, our staff will assess the daily life of the resident. Our staff will then determine the approximate amount and length of skilled-nursing care needed. It would be determined if a resident will be discharged home or to another community setting. If discharge is not possible, a long-term care plan must be in effect, and a resident's financial status will be reviewed in order to submit a timely Medicaid application. If a resident is not financially or clinically eligible for Medicaid, other payment options will be reviewed to pay for the long-term stay. Our staff will assist you in planning a course of action and meeting all deadlines.

Rules exist as to which assets you may own and which need to be liquidated to pay for a nursing-home stay prior to becoming eligible for Medicaid. Please note that if your spouse is still living in the community, allowances are made to ensure that he or she can continue living in the same manner to which he or she is accustomed. Your community spouse will not be displaced in order for you to be eligible for Medicaid. The rules to determine eligibility and payment are complicated and should be discussed with the appropriate state agency staff or an attorney specializing in elder law. We can refer you to the proper agency.

Due to the fact that many families choose to plan in advance, there is also an allowance for a burial account. Residents or their loved ones may purchase a pre-need, irrevocable burial contract. This contract then will not be counted in determining eligibility for Medicaid.

Our Business Office will assist you with the application if you wish, but the applicant or someone speaking on his or her behalf must act as the point of contact for the Middlesex County Board of Social Services.

A number of documents must be remitted to Medicaid, including, but not limited to: proof of birth date, Social Security card, Medicare card, proof of residency, a marriage certificate or divorce decree, spouse's death certificate, a Social Security check and information on all assets. A complete list of the required information is available in our Business Office.

At this time a resident may wish to execute a power of attorney naming an agent to conduct all financial affairs on his or her behalf. An advance directive for health care can also be considered that would allow a health care representative to be named by the resident to make any and all decisions

There are a number of elder law professionals in the community that can assist you in planning for long-term care issues.

Once an application has been approved, the state will determine what income you can keep and what must be paid to the Center. You must pay the Center the amount determined by the state each month as soon as you are eligible for Medicaid and immediately when you are no longer covered under another insurance plan or Medicare. Medicaid will pay our Center directly for its share of the bill.

DIRECT DEPOSIT OF FUNDS

Roosevelt Care Center allows direct deposit of any monthly funds that are received to pay for a stay here. You may choose to have your Social Security and pension checks or any other form of income sent to the Center. These funds will be allocated to room and board, coinsurance and a personal needs account as directed by Medicaid or, in the case of private funding, you. It also relieves families of having to track payments or continually write checks to the Center.

OTHER Costs

TRANSPORTATION

Most insurance plans, including Medicare, cover the cost of emergency transport to a hospital or other acute-care facility. However, transportation to and from doctors' appointments and other office visits is not covered. Many times family members bring residents to their appointments. If that is not feasible, transportation to and from the Center can be arranged at a cost to you.

Please note the Center does allow your doctors to visit you on-site, alleviating the need for transportation. The Center also contracts with specialists, such as dentists, ophthalmologists and podiatrists, to visit residents on-site. Please call your social worker for more information.

PRESCRIPTIONS

Changes in federal programs have resulted in the Medicare Part D Prescription Drug Program. The most significant change is that everyone that is Medicaid eligible must be enrolled in a Medicare Part D Plan. If you are applying for Medicaid, you must enroll in a Medicare Part D Plan by contacting 1-800-MEDICARE. While pending Medicaid approval, a resident can apply for the low-income subsidy for Part D coverage by contacting Social Security at 1-800-772-1213 to assist with premium payments or pharmaceutical assistance for the Aged & Disabled (PAAD) at 1-800-792-9745.

If a resident has coverage through an employer/union group, they may be advised not to enroll in Medicare Part D. If you are paying privately and you have Medicare, you can choose to participate in the Medicare Part D Prescription Drug Program. Enrollment takes place annually in December.

PERSONAL NEEDS ACCOUNT

Each resident of Roosevelt Care Center may set up a Personal Needs Account through the Business Office. Residents may use the account as a checking account of sorts, depositing to and withdrawing from it to pay for personal-care items, holiday and special occasion gifts or any other incidental expenses that may arise.

If you are eligible for Medicaid, you may designate the Center to receive your Social Security checks. The amount designated by Medicaid for your personal needs will be deposited into your Personal Needs Account.

Your family may contribute additional funds to a Personal Needs Account as needed. For your convenience, hairdresser fees are automatically deducted from the balance in your account. A statement of your balance is sent quarterly and is also available by contacting the Business Office.

DISCHARGE PLANS

Upon the conclusion of your stay, you will meet with several people — a discharge planner, a social worker and members of the Business Office. The Business Office will assist you in obtaining balances in your Personal Needs Account, and any balances due to the Center will be reviewed for final payment. Any balances due to you will be reconciled for reimbursement.

There are additional Medicaid programs available to you once you return to the community. More information on these programs may be obtained from your County Board of Social Services.

RESIDENT RESPONSIBILITIES

Though our staff will assist you with understanding rules, completing various forms and meeting deadlines, please remember that you are responsible for paying for your stay or the stay of a loved one. To that end, we will bill an insurance plan only if you authorize us to do so. You also must inform us immediately of any changes in insurance status because Medicare, Medicaid and commercial insurance (including HMOs) have different benefits and requirements in a skilled nursing facility. In all cases, the resident and any responsible party remain responsible for the cost of your stay if payment is not received from Medicare, Medicaid or any third-party payer.

A PLACE OF CARING

Our staff here at Roosevelt Care Center considers it a privilege to be caring for you or your loved one. Please reach out to us if you have any questions whatsoever. We'll do our best to provide you with the most accurate and timely information in a compassionate yet professional manner. Thank you for making us a part of your life.

FREQUENTLY ASKED **Questions**

Below you will find answers to several questions residents and their loved ones have raised in the past.

Q. How do I know what my commercial insurance will pay?

A. Each insurance company is different in terms of levels and limits of coverage. We will review, on an individual basis, what is and is not covered by your insurance carrier.

Q. What happens if an insurance company denies my claim?

A. The insurance companies have stated that all claims are subject to review prior to authorization for payment. If your claim is denied, you will be responsible for payment. However, there are appeal procedures that each insurance company has if you are not satisfied with the decision. We do follow up with insurance companies on your behalf and resubmit claims. We will communicate with you throughout this process.

Q. Don't I automatically get 100 days of Medicare coverage if I have been in the hospital?

A. No. If you have had a 3-day qualifying hospital stay, are admitted to a skilled-nursing facility within 30 days of discharge from the hospital and you have days remaining, then you will receive coverage only for the period of time that you are receiving skilled care related to your hospitalization. Skilled care is a service that can only be provided by a skilled nurse or therapist, such as dressing changes for a healing wound, intravenous therapy, tube feedings, a physical, occupational or speech therapy. Medicare stops coverage when you reach a plateau in your recovery or require only custodial care such as assistance with dressing, bathing, toileting and eating.

Q. Will Medicare Part B cover any of my stay once I go off Medicare A?

A. Part B will cover certain services if they fall within the Medicare guidelines for coverage given your health status. The guidelines are complex; therefore, we would discuss coverage based on your specific situation. With this in mind, generally speaking, Part B will cover:

- Therapy services (physical, occupational and speech therapies)
- Medical supplies that replace a function of the body, such as urological supplies (catheters), enteral supplies and nutrition (feeding tubes), some wound supplies, ostomy supplies (colostomies and tracheotomies)

You must meet an annual deductible and pay 20 percent of the charge for the services. There also is an annual cap on the amount of therapy services Medicare will pay for. Part B does not pay room and board.

Q. How does the facility determine if my Medicare benefits should stop?

A. The facility has a Utilization Review Committee that meets regularly to review those patients covered under Medicare A. The committee is made up of nurses, therapists, social workers and physicians. The committee reviews each patient's health status, the services the patient is receiving and the patient's progress. A determination for continued coverage is then made based on the Medicare guidelines.

Q. Do I need to be discharged once Medicare benefits no longer pay?

A. No. The decision to be discharged is based on your health status, level of independence and your home situation. If you are not ready to be discharged when Medicare will no longer pay, then you can pay privately or if you are eligible and require continued skilled care, Medicaid will pay for your stay.

Q. How do I apply for Medicare Part D Prescription Drug coverage?

A. Call 1-800-MEDICARE and have a list of the current drugs you are taking available when you call. If you are on Medicaid, there is annual list of Medicaid-approved $0 premium plans. A copy can be obtained from the business office.

Q. Can I get assistance with Medicare D premiums?

A. You may qualify for a low-income subsidy through Social Security or you can apply for PAAD.

Q. My husband/wife has been admitted to Roosevelt Care Center and we are eligible for Medicaid. Will Medicaid take all of our assets?

A. Medicaid will perform a spousal-allowance calculation, which determines how much the community spouse is entitled to keep. The remainder of the assets will need to be "spent down" by paying for things such as our bill, personal items for the resident, prepaid burials, etc.

Q. I have a dependent child and am eligible for Medicaid. Will Medicaid provide an allowance for him or her?

A. If you receive Social Security benefits or other income, Medicaid will consider if there is a dependent child in the community and determine if a monetary allowance can be made for the care of that child.

Q. Will Medicaid take my home?

A. If there is a spouse in the community, Medicaid may not touch the home where the couple had been living together (joint tenancy). There are also allowances for caregivers and dependent children who have been living in the home. The allowances will be determined by the Middlesex County Board of Social Services.

Roosevelt Care Center Social Worker

Name: _____

Direct-Dial: _____

Beeper: _____

Fax: _____

Other Numbers: _____

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Roosevelt

Roosevelt Care Center at Edison
118 Parsonage Road, Edison, NJ 08837
Phone: 732-321-6800 | Fax: (732) 321-1452 | Web: www.rooseveltcarecenter.com

Roosevelt Care Center at Old Bridge
1133 Marlboro Road, Old Bridge, NJ 08857
Phone: 732-360-9830 | Fax: (732) 360-9897 | Web: www.rooseveltcarecenter.com

Operated by the Middlesex County Improvement Authority