Policy Transmittal
Aging and People with Disabilities

DHS | Oregon Department of Human Services

Mike McCormick
Authorized signature

Number: APD-PT-19-033
Issue date: 9/25/2019

Topic: Long Term Care

Due date:

Transmitting (*check the box that best applies*):

☒ New policy ☐ Policy change ☐ Policy clarification ☐ Executive letter
☐ Administrative Rule ☐ Manual update ☐ Other:

Applies to (*check all that apply*):

☐ All DHS employees
☒ Area Agencies on Aging: Type B
☒ Aging and People with Disabilities
☐ Self Sufficiency Programs
☐ County DD program managers
☐ Support Service Brokerage Directors
☐ ODDS Children's Residential Services
☐ Child Welfare Programs
☐ County Mental Health Directors
☐ Health Services
☐ Office of Developmental Disabilities Services (ODDS)
☐ ODDS Children's Intensive In Home Services
☐ Stabilization and Crisis Unit (SACU)
☐ Other (*please specify*):

Policy/rule title:	Client Contribution Informational Letters for PACE Cases		
Policy/rule number(s):		**Release number:**	
Effective date:	Immediately	**Expiration date:**	
References:			
Web address:			

Discussion/interpretation:

PACE participants who must contribute financially towards their services and pay room and board must be notified of the amount to pay, the options available to them to make the payment(s), and to whom and where the payments should be sent. The processes are different than non-PACE cases.

Attached below are standardized information letters that must be used to inform PACE participants and/or their authorized representative or guardian, the PACE organization, and the community-based care (CBC) provider of the amount the PACE participant must pay each month, the options available to make the payment, and to whom and

where the payment should be sent.

These letters are **informational only** and **DO NOT** replace any official notice (SPAN, 540, 540p, 541, etc.) sent to PACE participants regarding their financial obligations. Therefore, hearing rights will not be attached to the letter. These informational letters must be sent with the official notices when participants are notified about their financial obligations for receiving services.

A couple of things to keep in mind:

- The Liability Worksheet 450N form will calculate the pay-in amount for PACE In-Home (IH) and CBC cases. The Pay-In Calculation Worksheet may not function properly in Oregon ACCESS for IH cases. Therefore, use the 450N worksheet for both case types and attach it to the IH and CBC information letters and official notices (when appropriate).
- When PACE participants enter a nursing facility (NF) while receiving PACE services, they must continue to pay for services in the same manner they did before entering the NF. A Plan of Care (POC) and a liability line in MMIS should not be set up and the benefit and service plans in Oregon ACCESS do not change. Therefore, the 450N will not work for NF cases. The NF information letter has the calculation listed – to be filled in by the worker – since no calculation worksheet can be attached to the letter.

To avoid an over-collection of funds by the CBC provider when a participant enrolls into PACE, a copy of the information letter should be sent to the CBC provider.

Implementation/transition instructions:
The new informational pay-in/liability letters will be posted on the Case Management Tools page under the program heading Program of All-inclusive Care for the Elderly.

Training/communication plan: N/A

Local/branch action required:
Discontinue using other variations of these informational letters. The new letters were created to ensure consistency when informing PACE participants of their payment options and other information associated with service pay-in/liability responsibilities and room and board payments, if applicable.

Central office action required: Technical assistance as needed.

Field/stakeholder review: ☒ Yes ☐ No

If yes, reviewed by: APD policy review team

Filing instructions: N/A

If you have any questions about this policy, contact:

Contact(s): Lisa Bouchell PACE Policy Analyst	
Phone: 503-947-0192	Fax:
Email: lisa.bouchell@dhsoha.state.or.us	

DHS or AAA logo here

Click or tap to enter a date

Client name
c/o Authorized representative/Guardian
Mailing address
City State Zip code

RE: Monthly service payments

Dear Name of PACE participant:

You are required to "Pay-In" or contribute monthly towards the cost of your care because your income is over the Medicaid limit. The attached calculation worksheet shows you how the monthly contribution (pay-in) is calculated.

Effective Click or tap to enter a date you must pay:

$Insert dollar amount for the 1st month and

$Insert dollar amount for each month thereafter.

These amounts do not include your room & board and/or personal incidentals fund (PIF) amounts.

The monthly pay-in payment is due no later than the **10th of each month**. You will ***not*** receive a monthly bill. Payment should be for the current month only. Payments for future months will ***not*** be accepted.

- On-line payments can be made using a debit card, Visa, Mastercard, or Discover card by visiting https://apps.oregon.gov/ECommerce/DHSOHA/EPS/ then click on **'PACE Pay-In'.**
- Checks and money orders should be made payable to **'DHS-APD'.** In the memo area of the check or money order, please write '**PACE**'.
- A check or money order may be mailed to the address listed below: **DO NOT SEND CASH**

APD/AAA office name
Office mailing address
City State Zip code

You are also responsible for paying room and board to the community-based care (CBC) facility each month. Your room and board payments are due to the CBC provider or bookkeeper by the **5th of each month**.

Room & Board amount: **$**Enter current R&B amount

Remit payment to: Name/address of facility
Attn: Bookkeeper

Sincerely,
Case manager name
Phone number

[DHS or AAA logo here

Click or tap to enter a date

Client name
c/o Authorized representative/Guardian
Mailing address
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RE: Monthly service payments

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APD/AAA office name
Office mailing address
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Sincerely,
Case manager name
Phone number

DHS or AAA logo here

Click or tap to enter a date.

Client name
c/o Authorized representative/Guardian
Mailing address
City State Zip code

RE: Monthly service payments

Dear Name of PACE participant:

You are required to "Pay-In" or contribute monthly towards the cost of your care because your income is over the Medicaid limit. The calculation below shows you how the pay-in amount is calculated.

Your income:	**$**Insert dollar amount
Nursing facility standard:	-**$**Insert current NF standard
Other deductions:	-**$**Insert dollar amount; if none, enter 0 (zero)
Total monthly contribution:	**$**Insert dollar amount

Effective Enter effective date your monthly contribution (pay-in) amount is **$**Insert total monthly contribution from above.

The monthly pay-in payment is due no later than the **10th of each month**. You will ***not*** receive a monthly bill. Payment should be for the current month only. Payments for future months will ***not*** be accepted.

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Office mailing Address
City State Zip code

Sincerely,
Case Manager name
Phone number