YOU AND YOUR MEDICARE BENEFIT

What you and your family need to know.

To be eligible for a Medicare paid stay at Knute Nelson, you must meet the following criteria:

- ☐ You have Medicare Part A Hospital Insurance.
- ☐ You have had a qualifying hospital stay of three (3) or more consecutive nights as an acute inpatient.
- ☐ You are transferred to Knute Nelson as you require skilled nursing and/or rehabilitation therapy related to the condition for which you were hospitalized.
- ☐ You are admitted to the facility within thirty (30) days of leaving the hospital.
- ☐ A doctor certifies that you need, and you receive, skilled nursing or rehabilitation services on a daily basis.

Following a hospital stay and admission that meets the above criteria, you are eligible for a benefit of up to 100 days*. It is especially important to remember the requirement that you must need and receive skilled nursing care or rehabilitation services on a daily basis.

**Not every resident will qualify for the entire 100 days of coverage. Determination is made on an individual basis and according to Medicare guidelines.*

Beginning with the twenty-first (21) day, a daily co-insurance or co-payment is due to the skilled nursing facility by the resident. This dollar amount is determined by Medicare and is subject to an annual increase. In some cases an insurance policy might pay the co-payment. Otherwise, this is the financial responsibility of the resident. If the resident is enrolled in the Minnesota Medical Assistance Program, this will pay the co-payment.

When Medicare is paying for your stay at Knute Nelson, you and the facility need to work closely together to coordinate your care. Family and friends may want to visit you while you are in the facility. This type of support is an important part of your recovery, but you will need time for meals, rest, bathing, nursing and therapy to make your recovery as swift and complete as possible.

Your participation in the nursing care and therapy programs is the primary factor in your recovery. You need to know that your lack of participation or refusal to participate in physician ordered therapy may impact your Medicare payment.

When the decision is made that your level of care does not meet Medicare guidelines, you will be informed and given a "Notice of Denial." This form will end your benefit period. If you choose to discharge from the facility, your nurse, social worker and therapist will help you plan for discharge and offer you community resources. Therapy can complete a home visit to determine any factors that may influence your decision and ability to return home.

You are able to stay in the facility after receiving a "Notice of Denial." These days would not be covered by Medicare and would be the financial responsibility of the resident or another payer source.

If you have questions at any time, please feel free to ask any staff member.