



APPLICATION FOR LONG-TERM CARE SERVICES

State Form 45943 (R10 / 4-02) / BAIS 0018

PLEASE COMPLETE BOTH SIDES OF THIS FORM

***THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-8-1. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.**

Application is for (check one): <input type="checkbox"/> Indiana's PreAdmission Screening (IPAS) / PreAdmission Screening and Resident Review (PASSRR) <input type="checkbox"/> In-Home Services		Initialed by:
If In-Home Services, check all that apply: <input type="checkbox"/> A & D Waiver <input type="checkbox"/> C.H.O.I.C.E. <input type="checkbox"/> Autism Waiver <input type="checkbox"/> S.S.B.G. <input type="checkbox"/> MFC Waiver <input type="checkbox"/> Title III In-Home Services <input type="checkbox"/> TBI Waiver <input type="checkbox"/> AL Waiver <input type="checkbox"/> DD Waiver <input type="checkbox"/> AFC Waiver <input type="checkbox"/> Support Svcs Waiver		

SECTION I - To be completed by the applicant, guardian, or responsible person.

Name of applicant		Telephone number ()	*Social Security number
Home address (number and street, apartment number, R.R. number, city, state and ZIP code)			
State of residence prior to NF placement: <input type="checkbox"/> INDIANA <input type="checkbox"/> OTHER _____		Reason why out-of-state resident is requesting admission to an Indiana nursing facility: <input type="checkbox"/> No bed available in home state <input type="checkbox"/> Family is moving to or resides in Indiana, etc. <input type="checkbox"/> Other _____	
Date of birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Medicaid status (check all that apply) State: _____		Applicant's location at time of application:	
<input type="checkbox"/> a. Medicaid applicant county number: _____ <input type="checkbox"/> b. Medicaid recipient number: _____ <input type="checkbox"/> c. Will apply for Medicaid <input type="checkbox"/> At admission or within <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 days <input type="checkbox"/> d. Non-Medicaid / Private-pay for at least 6 months after admission <input type="checkbox"/> e. Medicaid Waiver Services recipient <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> f. Medicaid MCO Enrollee <input type="checkbox"/> Medicaid effective date: _____		<input type="checkbox"/> a. Home <input type="checkbox"/> b. Hospital <input type="checkbox"/> c. CMHC <input type="checkbox"/> d. Nursing Facility <input type="checkbox"/> In-state <input type="checkbox"/> Out-of-state <input type="checkbox"/> e. Other _____ Address: _____	
Name of relative or contact person / address		Telephone number ()	
Name of physician / address		Telephone number ()	

PREADMISSION SCREENING NOTIFICATION

Every person applying for admission to a nursing facility in Indiana must be assessed by the PreAdmission Screening Program (PAS) to determine the person's need for care in a nursing facility. Failure to participate in the PreAdmission Screening Program will result in the applicant's ineligibility for Medicaid reimbursement in any nursing facility for up to one (1) year from date of admission. **NOTE: See IPAS Information Sheet for program details.**

I AGREE to participate in the PreAdmission Screening Program to determine my need for care in a nursing facility and / or home and community-based services.

I AUTHORIZE THE RELEASE OF INFORMATION to and among state agencies and their agents on my medical condition and other relevant information necessary to determine appropriate long-term care services and / or In-Home Services, by my physician, hospital, nursing facility, Community Mental Health Center, Division of Mental Health, Office of Family and Children, other social service or health services providers, and family members. I understand I may revoke this release of information in writing at any time.

I DO NOT AGREE to participate in the PreAdmission Screening Program and I understand that I will not be eligible for Medicaid reimbursement in any nursing facility for up to one (1) year from date of admission.

Signature of applicant or responsible person	Date	Time
If signature is by a responsible person, what is the relationship to the applicant?		
Signature of witness (Required if the signature is by an "X")	Date	

SECTION II - Temporary Admission Authorization - To be completed by PAS agency designee or discharge planner designee.

I authorize temporary admission to the nursing facility named on this application for a period of time from the date of admission to the nursing facility, as designated below. **NOTE - This authorization does not apply to PASRR Level II cases; see PASRR forms (State Form 45932 and 45277).**

Type of admission: Direct from hospital (M.D. ETR + 25 up to 120) Emergency/APS (25 days) 30 Day Short Term (30 days) Continuing care retirement community (30 days - extend 25 up to 55)

PASRR (State Form 45932 or Level I required)

Hospital Discharge Planner Designee: Medicaid MCO Enrollee and NF placement for: Short-Term Long-Term
(Check all that apply.)

I certify that this patient is a nonresident admitted to acute hospital care after treatment in the emergency room.
 I certify that the applicant has been given a list of long term care options that may be available to the applicant, are located within the hospital's service area, and are known to the hospital. (IC 10-12-10-28.5)

Period of care authorized: Start date: _____ Stop date: _____

Signature of (Circle one) IPAS agency or Discharge Planner Designee: (For: Direct from in state acute care only)	Date	
Affiliation:	Telephone number:	FAX Number:
Name of nursing facility / address (number and street, city, state, ZIP code)		

Forms Distribution: Original - IPAS Agency Applicant Nursing Facility File CMHC BDDS OMPP State PASRR unit

This document contains Protected Health Information which is governed by the Health Insurance Portability and Accountability Act (HIPAA) and may only be disseminated to authorized individuals!

SECTION III - Estimated Nursing Facility Cost - To be completed by the nursing facility.

Name of nursing facility / address (number and street, city, state, ZIP code)

Name of applicant

Per 460 IAC 1-1-8(e), the nursing facility must provide to the IPAS agency an estimate of the cost of all services that the applicant is anticipated to require.

State level of NF services needed:

Estimated NF cost for NF services at the rate charged to private payers:

\$

Information provided by:

Telephone number:

Fax number: