



APPLICATION FOR LONG-TERM CARE SERVICES

State Form 45943 (R8 / 4-02) / BAIS 0018

PLEASE COMPLETE BOTH SIDES OF THIS FORM

***THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-3-1. 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):

Indiana's PreAdmission Screening (IPAS) / PreAdmission Screening and Resident Review (PASSRR) In-Home Services

Initialed by: _____

If In-Home Services, check all that apply:

A & D Waiver C.H.O.I.C.E. Autism Waiver S.S.B.G. MFC Waiver Title III In-Home Services TBI Waiver AL Waiver DD Waiver AFC Waiver 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:

INDIANA OTHER _____

Reason why out-of-state resident is requesting admission to an Indiana nursing facility:

No bed available in home state
 Family is moving to or resides in Indiana, etc.
 Other _____

Date of birth: _____

Male Female

Age: _____

Medicaid status (check all that apply) State: _____

a. Medicaid applicant county number: _____
 b. Medicaid recipient number: _____
 c. Will apply for Medicaid At admission or within 30 60 90 120 days
 d. Non-Medicaid / Private-pay for at least 6 months after admission
 e. Medicaid Waiver Services recipient Yes No
 f. Medicaid MCO Enrollee Medicaid effective date: _____

Marital status:

Married Single Divorced Separated Widowed

Applicant's location at time of application:

a. Home b. Hospital c. CMHC d. Nursing Facility
 In-state Out-of-state
 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

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: