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

Initialed by:

If In-Home Services, check all that apply: ☐ C.H.O.I.C.E. ☐ S.S.B.G. ☐ Title III In-Home Services ☐ AL Waiver ☐ AFC Waiver
☐ A & D Waiver ☐ Autism Waiver ☐ MFC Waiver ☐ TBI Waiver ☐ DD Waiver ☐ Support Srvs 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 _____

Date of birth: | ☐ Male ☐ Female | Age:

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 _____

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 ☐ In-state ☐ Out-of-state ☐ c. CMHC ☐ d. Nursing Facility
☐ 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: *(Check box)*
☐ 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: (Check all that apply.)
☐ Medicaid MCO Enrollee and NF placement for: ☐ Short-Term ☐ Long-Term
☐ 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 availabe 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

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