



# NURSING FACILITY LEVEL OF SERVICE STATE AUTHORIZATION AND DATA ENTRY

State Form 49120 (11-98) / OMPP 450B SA/DE  
Indiana Family and Social Services Administration (FSSA)

**CONFIDENTIAL**

MEDICAID STATUS	
<input type="checkbox"/>	Medicaid Pending
<input type="checkbox"/>	Medicaid Recipient
<input type="checkbox"/>	Non-Medicaid

Disclosure of information requested is MANDATORY and CONFIDENTIAL pursuant to IC 12-15-2, IC 12-21 and 470 IAC 1-3-1.

### INSTRUCTIONS:

NOTE: This form may be utilized in place of the Form 450B "Physician Certification for Long Term Care Services" for persons already in a nursing facility (NF) and only in the following situations:

1. PAS/PASRR, onset of NEW MEDICAID (*private pay to Medicaid recipient*), and NURSING FACILITY to NURSING FACILITY TRANSFERS when a fully completed MDS (*Initial, Quarterly, or Significant Change for the period under review*) is available. A copy of the applicable MDS must be submitted with this form in place of the Form 450B. NOTE: The Physician Orders for the NF care must be in the resident's records and available for audit.
2. READMISSION to any NF after the 15-day bed-hold from a hospital stay, to reinstate Medicaid reimbursement for persons who have a State authorization for Medicaid reimbursement for NF care prior to the hospitalization (**No MDS is required**). Please specify the "from and through" dates of the hospitalization in Section I below.

Evidence of PAS (4B) must be attached if the request for Medicaid reimbursement is for a time period less than one year from the initial admission.

PASRR: Note, there are no changes in the PASRR program requirements or procedures other than the State allowing the MDS to be used in place of the Form 450B for individuals who are already in the NF. The Form 450B may continue to be used.

A fully completed Form 450B, including the physician's signature, must continue to be submitted in any situation where the NF does not have a completed MDS for the resident or chooses not to submit the MDS in place of a Form 450B. Submit either a complete, physician signed Form 450B or this form with a copy of the applicable complete MDS. **PLEASE DO NOT SUBMIT BOTH Form 450B and the MDS.**

SECTION I - RECIPIENT IDENTIFICATION									
Name of applicant ( <i>last, first, middle</i> )				Date of birth ( <i>month, day, year</i> )		Sex	Name of county		
Name of NF ( <i>stamp or label accepted</i> )				NF admission date ( <i>mo., day, yr.</i> )		Medicaid number (RID)			
Address of NF ( <i>number and street</i> )				Re-admission date from hospital		Social Security number			
City, state, ZIP code				Discharge date ( <i>if applicable</i> )		New Medicaid eligibility date			
Resident admitted from:						Request length of care			
<input type="checkbox"/> a. Home		<input type="checkbox"/> d. Acute Care Hospital - From _____ Through _____				<input type="checkbox"/> Short-term		<input type="checkbox"/> Long-term	
<input type="checkbox"/> b. ICF/MR		<input type="checkbox"/> e. NF Facility _____		<input type="checkbox"/> g. Out-of-State _____		NF provider number			
<input type="checkbox"/> c. Psychiatric Bed		<input type="checkbox"/> f. ARCH / RBA / Residential		<input type="checkbox"/> h. Other _____		Medicare from/through dates			
SECTION II - STATE AUTHORIZATION									
This certification is for:				Date data entered		Comments:			
<input type="checkbox"/> Admission		<input type="checkbox"/> Readmission		<input type="checkbox"/> Continued Care					
<input type="checkbox"/> Approved		<input type="checkbox"/> Disapproved		Effective Medicaid reimbursement date					
Authorized signature:						Date signed ( <i>month, day, year</i> )			
<input type="checkbox"/> IFSSA		<input type="checkbox"/> Area PAS agency							
MEDICAID only:	Rwvr ID	LOC code	Start Rsn	Start date	Stop Rsn	Stop date	Prior Res	Empty Bed	

RESIDENT COPY		Resident Appeal Rights / How to Request an Appeal	
<p>If you are not satisfied with this decision, you may request an appeal within 30 days of the date of receipt of this decision. Sign and return this form or send a letter with your signature to: MS04, Indiana Family and Social Services Administration, Hearings and Appeals, 402 W. Washington St., Rm. W392, Indianapolis, Indiana 46204. (IC 12-15-28 and 405 IAC 1.1-1) Be sure that the letter contains your address and a telephone number where you can be reached. It is also helpful if you describe the nature of the action you are appealing, if you are not using this form to request the appeal. If you are unable to write this letter yourself, you may have someone assist you in requesting this appeal.</p> <p>You will be notified in writing by IFSSA Hearings and Appeals of the date, time and place for the hearing. Prior to, or at the hearing, you will have the right to examine the entire contents of your case record. You may represent yourself at the hearing or authorize a representative such as an attorney or other spokesperson to do so. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question or refute any testimony or evidence presented.</p>			
<input type="checkbox"/> I wish to appeal the above decision.		Signature of resident / guardian	