Application for the Conversion of a Medicaid Facility
to a Medicare only Facility or a Medicare/Medicaid Facility

An application should include a **cover letter** and the following forms and/or documentation:

1. Form CMS-1561, Health Insurance Benefit Agreement (enclosed);
2. Documentation of compliance with Civil Rights should be filed online at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf per S&C 16-37
   - A copy of the online confirmation **from** OCR showing the provider has completed the civil rights submission online should be submitted to ISDH
5. A copy of the facility's Quality Assessment & Assurance Committee Policy
6. Facility Floor Plan representing the **current** bed configuration.
7. Facility Floor Plan representing the **proposed** bed configuration
8. Bed Inventory (State Form 4332) representing the **current** bed configuration; this form can be found at https://forms.in.gov/Download.aspx?id=4659 .
9. Bed Inventory (State Form 4332) representing the **proposed** bed configuration; this form can be found at https://forms.in.gov/Download.aspx?id=4659 .
10. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);

The following information will be reviewed by surveyors at the time of the initial health survey.

- Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid.

In addition, the facility must contact the Medicare Fiscal Intermediary (FI), Wisconsin Physician Service (WPS), or their CMS approved Fiscal Intermediary, for Form CMS-855A. The form can be downloaded at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf . The facility may reach Wisconsin Physician Service (WPS) at 608-221-4711. The completed Form CMS-855A should be forwarded directly to Wisconsin Physician Service (WPS) (or the appropriate FI) for review and recommendation for approval.

Once the Division of Long Term Care ("Division") has received and approved the completed application documents, and has received a copy of the approval of the Form CMS-855A *Medicare General Enrollment* application, the Division will process the application, along with a copy of the facility's most recent certification survey for Medicaid (if the survey is no more than six (6) months old) to the Centers for Medicare and Medicaid Services ("CMS") for approval. If CMS accepts this survey as demonstration of the facility's compliance with federal regulations, the effective participation will be the date that the CMS-855A application was approved. CMS may require another certification survey prior to admittance to the Medicare program. If that is the case, the program effective date would then be the exit date of the survey if no deficiencies were found at the time of the survey, or the date that an acceptable plan of correction was received if deficiencies were found at the time of the survey.

Please mail completed application packets to the following address:
Long Term Care – Provider Services
Indiana State Department of Health
2 N. Meridian St., Section 4-B
Indianapolis, IN 46204

If you have any questions regarding the application process please call Provider Services at 317-233-7794 or 317-233-7613 or by email at ltcproviderservices@isdh.IN.gov .

FORM APPROVED
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act,
as Amended and Title 42 Code of Federal Regulations (CFR)
Chapter IV, Part 489)

AGREEMENT

between
THE SECRETARY OF HEALTH AND HUMAN SERVICES
and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____
_____
D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE