INDIANA STATE DEPARTMENT OF HEALTH

APPLICATION FOR NEW FACILITY
TITLE 18 SNF OR TITLE 18 SNF/ TITLE 19 NF

This letter is to inform applicants of the required documentation for application for participation in the Medicare and Medicaid Programs. For additional information on the rules and regulations involving this action please refer to: http://www.in.gov/isdh/20511.htm

An application should include a cover letter (with contact information) and the following forms and/or documentation:

1. State Form 8200, Application for License to Operate a Health Facility, with required attachments. This form is available at https://forms.in.gov/Download.aspx?id=4691
2. State Form 19733, Implementing Indiana Code 16-28-2-6. This form is available at https://forms.in.gov/Download.aspx?id=9627
3. State Form 51996, Independent Verification of Assets and Liabilities, to include required attachments. This form is available at https://forms.in.gov/Download.aspx?id=6250
4. Documentation of the applicant entity's registration with the Indiana Secretary of State (with d/b/a if applicable);
5. Internal Revenue Services (IRS) documentation: SS-4 or comparable document **from the IRS** that reflects direct owner's corporation, limited liability company, partnership, etc name, d/b/a if applicable and EIN number. The document **must be from the IRS sent to the provider** not a form/document the provider completed and sent to the IRS.
6. Licensure Fee; $200 for the first 50 beds, $10 for each additional bed;
7. One (1) signed originals of the Form CMS-1561, Health Insurance Benefit Agreement (enclosed);
8. 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
9. Completed State Form 4332, Bed Inventory. This form is available at https://forms.in.gov/Download.aspx?id=4659
10. Facility floor plan on 8 ½" x 11" paper to show room numbers (must be legible) and number of beds per room, use multiple pages if needed, example attached;
11. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
12. A copy of the facility's Quality Assessment and Assurance Committee policy;
13. SF 55283 Contract and Service Agreement Checklist. This form is available at https://forms.in.gov/Download.aspx?id=11172
14. SF 55282 Proposed Staffing Structure. This form is available at https://forms.in.gov/Download.aspx?id=11170 and

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;
- A proposed two-week staffing schedule to demonstrate compliance with federal regulations (include all RN, LPN, CNA and QMA hours);
- Copies of all contracts or agreements for services to cover the full range of services to be offered to residents, to include copies of licenses/certification, if applicable, for individual professionals providing services; and
- Copy of the facility's disaster plan

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.

NOTE: The facility must contact HP, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to HP for processing.

The following is a general outline of the application process (in approximate chronological order):

1. Submit plans and specifications for new construction or an existing building to the Indiana State Department of Health, Health Care Engineering program for review and approval. The website is http://www.in.gov/isdh/24386.htm
2. Once plans and specifications have been approved, and new construction or remodeling of an existing building is substantially complete, please submit a copy of the architect's Statement of Substantial Completion Request for Inspection or a letter indicating that the construction is substantially complete, to the Program Director-Provider Services, Division of Long Term Care;
3. Submit the above completed application packet to the Division of Long Term Care;
4. Once the complete packet has been received and approved, a written request for the applicable fire safety inspections (Life Safety Code, Sanitarian and/or State Fire Code) may be submitted to the Program Director-Provider Services, Division of Long Term Care;
5. Once the applicable fire safety inspections have been conducted and released, the Division of Long Term Care will issue an Authorization to Occupy letter to the applicant (*residents may be admitted upon receipt of this authorization; however, please be advised that the facility will not be able to bill Medicare and/or Medicaid for services rendered prior to the initial certification survey and official program acceptance into these programs*);
6. Prior to the initial licensure and certification surveys, the following must occur:
   - The Division must approve all application documents submitted; and
   - The designated Fiscal Intermediary must approve the CMS-855A application;
7. Once these requirements are satisfied, and the facility has provided skilled care to at least two (2) comprehensive residents, the facility may submit a written request to the Program Director-Provider Services for the initial licensure and certification surveys (*every effort will be made to conduct these surveys within 21 days of the date you indicate your readiness for survey*);
8. Upon completion of the initial licensure and certification surveys, the Division of Long Term Care will forward the application to the Centers for Medicare and Medicaid Services ("CMS") and/or the State Medicaid Agency along with the initial certification survey results;
9. CMS and/or the State Medicaid Agency will notify the facility in writing of their final determination for acceptance or denial into their respective programs, with the effective participation dates.

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 contact Provider Services at 317-233-7794, 317-233-7613, or 317-234-3071 or by email at ltcproviderservices@isdh.IN.gov

Revised October 2016

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