



# Indiana State Department of Health

## Application for Conversion from Residential Care to Non-Certified Comprehensive Care Facility

Enclosed are the application forms and required documentation for application for conversion from residential level care to non-certified comprehensive level care. For additional information on the rules and regulations involving this action please refer to: <http://www.in.gov/isdh/20511.htm>. Please submit the following forms and documentation:

1. State Form 4332, Bed Inventory (enclosed) to reflect the configuration before **and** after the conversion
2. Copy of the facility's floor plan on 8 1/2" x 11" paper, to include room numbers and number of beds per room, to reflect the configuration after the conversion
3. Proposed staffing plan based upon 20%, 50% and 100% occupancy for the number of beds to be converted (to include all RN, LPN, QMA and CNA hours)
4. List of Key Personnel, to include name and position title or function
5. Proposed nurse staffing schedule (by position) for a two (2) week period, indicating nursing hours per resident per day
6. Copy of all Patient Transfer Agreements with hospitals
7. Copies of all contracts/service agreements between the facility and third parties for services provided to residents

### **Prior to the Division of Long Term Care granting authorization for the facility to admit comprehensive care residents, the following must occur:**

1. The Indiana State Department of Health, Division of Sanitary Engineering must approve the plans and specifications for the facility to ensure that the physical structure meets the requirements for comprehensive beds (please contact Dennis Ehlers at 317/233-7588 for instructions). See attached State Form 49453 Application for Construction Permit for Long Term Care Facilities.
2. If any modifications to the building are to be made, the project architect must submit to the Division of Long Term Care a Certificate of Substantial Completion to verify that any and all modifications are complete
3. Once the Division of Sanitary Engineering has approved the plans and specifications for the physical plant, the facility may submit a written request for the Life Safety Code and Sanitarian inspections. When these inspections have been completed and released, the Division of Long Term Care forward to the facility an authorization to admit comprehensive care residents. The facility must pass Life Safety Code and Sanitarian inspections.
4. Once the facility has received this, and is ready for the survey for comprehensive level care, the facility may submit a written request for initial licensure survey, noting that at least two (2) residents are receiving comprehensive level care. Every effort will be made to schedule the survey to occur no later than twenty-one (21) calendar days after the date specified in the letter indicating that the facility will be ready for survey.

If you have any questions regarding this process please contact Provider Services at 317/233-7794 or 317/233-7613.



# BED INVENTORY

State Form 4332 (R3/1-02)  
Indiana State Department of Health-Division of Long Term Care

Name of Facility											
Street Address											
City				County				Zip+4			
<b>PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:</b> Each room should be listed only once and listed in numerical order under each classification column.										Room No.	No. Beds
Title 18 SNF = Medicare ONLY beds Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) Title 19 NF = Medicaid NCC = Non-Certified Comprehensive Residential Level of Care										8	2
										9	2
										10	2
										11	3
										12	2
20										2	
<b>All licensed beds must be listed.</b>											
Title 18 SNF		Title 18/19 SNF/NF		Title 19 NF				NCC		Residential	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF		Total 19 NF				Total NCC		Total Residential	
Current SNF Census _____				Current SNF/NF Census _____				<b>NOTE</b> <i>Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed and certified for.</i>			
Current NF Census _____				Current NCC Census _____							
Current Residential Census _____				TOTAL CURRENT CENSUS _____							
TOTAL LICENSED CAPACITY _____											
Completed by						Position			Date		



**APPLICATION FOR CONSTRUCTION PERMIT  
FOR LONG-TERM CARE FACILITIES**

State Form 49453 (R2 / 8-06)

INDIANA STATE DEPARTMENT OF HEALTH / SANITARY ENGINEERING  
Approved by State Board of Accounts, 2006

DATE RECEIVED \_\_\_\_\_

RECEIPT NUMBER \_\_\_\_\_

PROJECT NUMBER \_\_\_\_\_

- INSTRUCTIONS: 1. Send check or money order along with plans to:  
Indiana State Department of Health  
Attention: Cashier's Office  
P O Box 7236  
Indianapolis, IN 46207-7236  
2. Direct questions to 317/233-7177

**FAXED COPIES OF APPLICATIONS  
WILL NOT BE ACCEPTED**

<p>1. OWNER _____ Name _____ Address _____ _____ Phone No. _____</p>	<p>5. The Following Documents are Attached: (CHECK WHERE APPLICABLE) A. Water Supply: <input type="checkbox"/> Public <input type="checkbox"/> Existing <input type="checkbox"/> Private <input type="checkbox"/> New B. Plot Plan with Site Utilities: <input type="checkbox"/> C. Sewage Disposal: <input type="checkbox"/> Public <input type="checkbox"/> Existing <input type="checkbox"/> Private <input type="checkbox"/> New D. Plans and Specifications certified by Architect or Engineer: <input type="checkbox"/> E. Number of Licensed Beds _____ (1) Comprehensive Care <input type="checkbox"/> (2) Residential Care <input type="checkbox"/> F. Fees Required by 410 IAC 6-12-17. <input type="checkbox"/> (see other side)</p>
<p>2. OWNER'S DESIGNATED AGENT Name _____ Title _____ Address _____ _____ Phone No. _____</p>	<p>6. SIGNATURE Application is hereby made for a Permit to authorize the activities described herein. I certify that I am familiar with the information contained in this application, and to the best of my knowledge and belief such information is true, complete, and accurate.  _____ Printed Name of Person Signing  _____ Title  _____ Signature of Owner or Designated Agent  _____ Date Application Signed (month, day, year)</p>
<p>3. FACILITY (TYPE OF PROJECT) _____ Name _____ Address _____ _____ City _____ County _____ Zip _____</p>	
<p>4. ENGINEER/ARCHITECT Name _____ _____ Address _____ _____ _____ Phone No. _____ License # _____</p>	

**INSTRUCTIONS FOR COMPLETION OF CONSTRUCTION PERMIT FOR  
LONG-TERM CARE FACILITIES**

1. Owner Name and address of person, company, firm, municipality, authority, etc.,
2. Authorized Agent Name, title, address, and phone number of person who is designated to act for owner and who is familiar with the project and can furnish additional information as required.
3. Name of Facility or Project State its name, location, and nearest possible address.
4. Name of Engineer/Architect Name, title, company, address and phone number of engineer or architect registered in the State of Indiana who certified and sealed the construction plans and specifications.
5. Check the squares indicating name of documents attached to Application. All documents are required except where inapplicable.
  - A. Specify the type of water supply serving the subject facility, and whether new or existing.
  - B. Plot plan or plans to scale showing property lines, structures, roads, and site utilities.
  - C. Specify the type of sewage disposal serving the subject facility, and whether new or existing.
  - D. Plans, drawn to scale, shall be prepared, by an individual qualified under applicable laws of the State of Indiana. (See No. 4 above, if applicable).
  - E. Specify the number of licensed beds and indicate the level of licensure below.
    - (1) Comprehensive Care
    - (2) Residential Care
  - F. **Fees Required** by Rule 410 IAC 6-12-17.

<b>Health Facility</b>	<b>\$150</b>
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6. SIGNATURE  
An application submitted by a corporation must be signed by a principal executive officer of at least vice president level or his duly authorized representative, if such a representative is responsible for the overall operation at the facility from which the construction described in the form will originate. In the case of a partnership or a sole proprietorship, the application must be signed by a general partner or the proprietor, respectively.