



INDIANA MEDICAID UPDATE

November 16, 1998

**TO: All Indiana Medicaid-Enrolled Nursing Facilities
Hospital Discharge Planners
Area Agencies on Aging/IPAS Contact Persons**

SUBJECT: Current Form 450B Nursing Facility Level of Service Procedures

The purpose of this bulletin is to provide updated information regarding Form 450B and level of service procedures in effect as of October 1, 1998, for Indiana Medicaid-certified nursing facilities. As you are aware, rule 405 IAC 1-14.6, establishing a case mix system of reimbursement, became effective October 1, 1998, for Medicaid recipients in Medicaid-certified and dually-licensed nursing facilities. **The case mix system establishes a Medicaid reimbursement rate for each facility, but does not determine individual recipient eligibility for nursing facility care.** Authorization for Medicaid reimbursement for residents in nursing facilities who are not subject to the federal Preadmission Screening and Resident Review (PASRR) requirements continue to be determined and data entered into the IndianaAIM system by the Office of Medicaid Policy and Planning (OMPP). Nursing facility determinations for residents who are subject to PASRR requirements are rendered by the Bureau of Aging and In-Home Services or its authorized designee.

This bulletin is not intended to cover HIV facilities reimbursed under rule 405 1-14.5. There are no changes in Form 450B procedures for HIV facilities. These facilities continue to be subject to intermediate and skilled level of care determinations for all Medicaid reimbursements.

Criteria for Nursing Facility Level of Services

The case mix system of reimbursement eliminates the distinction between intermediate and skilled level of care for Medicaid reimbursement purposes. The case mix system is not, however, designed to determine an individual resident's eligibility for nursing facility care, as neither the MDS nor the case mix system is an eligibility tool. Each resident must continue to show a documented need for nursing facility care as required under state and federal laws. Therefore, certain medical reviews will continue to be conducted to ensure that individuals applying for admission to and residing in nursing facilities require the array of health related level of services that nursing facilities provide above the level of room and board and below the level of hospital acute care. The "skilled and intermediate" **criteria found at 405 IAC 1-3-1 and 1-3-2 continue to define the threshold of nursing facility care needs** required for residents in a Medicaid-certified nursing facility and will continue to be used by OMPP, the Indiana Pre-Admission Screening (IPAS) agencies, and the EDS review teams.

Please note, for individuals who are not infants or young children and are not mentally retarded/developmentally disabled (subject to federal Preadmission Screening and Resident Review requirements - "PASRR"), the criteria set forth in 405 IAC 1-3-2 (intermediate criteria) define the minimum requirements for admission to and continued stay in a nursing facility. Since the care that parents routinely provide to infants and young children is equivalent to the criteria at 405 IAC 1-3-2, infants and children must meet the criteria at 405 IAC 1-3-1 (skilled criteria) in order to require pediatric nursing facility services. Likewise, intermediate care facilities for the mentally retarded (ICFs/MR) are required to provide the intermediate level of nursing care at 405 IAC 1-3-2, therefore, individuals who are mentally retarded/developmentally disabled generally must also meet the criteria at 405 IAC 1-3-1 for admission to and continued stay in a nursing facility. This determination will continue to be made through the PASRR assessment process. Note that in order for an individual to be determined as developmentally disabled, the condition must have occurred prior to the person reaching age 22. Therefore, this does not apply to individuals who have had a stroke, traumatic brain injury, have Alzheimer's disease or any other condition that occurred on or after the age of 22.

Federal Preadmission Screening and Resident Review (PASRR)

The federal requirements for PASRR screening and assessments of individuals applying for nursing facility admission and residing in a nursing facility, who may be mentally ill and/or mentally retarded, continue unchanged as of October 1, 1998. All individuals applying for admission to nursing facilities, regardless of source of payment, must continue to be pre-screened through the PASRR Level I process to identify those individuals who may be mentally ill and/or mentally retarded. Those individuals who have been identified as possibly being mentally ill and/or mentally retarded are subject to the PASRR Level II assessment. They must be prior authorized for admission to a Medicaid-certified nursing facility, either by completing the Level II process or by being temporarily exempted from the completion of the Level II process under Form 450B Section V, Parts A or B: (1) "Exempted Hospital Discharge" (for nursing facility care of less than 30 days following a hospitalization); (2) "Respite Short-term (30-day)" (for

respite care in a nursing facility of 30 days or less for individuals from a non-institutional setting); or (3) "Adult Protective Services (7-day)" (for emergency placements in a nursing facility of endangered adults referred by Adult Protective Services). Questions regarding PASRR program requirements should be referred to the local Indiana Pre-Admission Screening (IPAS) Agency of the local Area Agency on Aging.

Indiana Pre-Admission Screening (IPAS) Procedures

The IPAS procedures and requirements remain unchanged as of October 1, 1998. All Medicaid and non-Medicaid applicants to Medicaid-certified nursing facilities must be referred to the local IPAS agency to initiate the IPAS process. The OMPP will continue to render medical decisions regarding the need for nursing facility care under the criteria at 405 IAC 1-3-1 and 1-3-2 for nursing facility applicants (non-PASRR) who are on Medicaid or are pending Medicaid eligibility. Nursing facility admission determinations for private pay, non-Medicaid applicants will continue to be rendered by the local IPAS agency.

Once all required information is submitted, OMPP renders final decisions on IPAS cases within three working days of receipt pursuant to 460 IAC 1-1-12. In order to expedite this IPAS determination process, it is critical that the Form 450B Section I "Recipient Identification" and Section II "Physician Certification for Long-Term Care Services" are both fully completed. All appropriate information needs to be addressed in the Form 450B. In order for the Form 450B to be processed, the "primary diagnosis" must be completed with the diagnosis and must not be marked as "see attached". Once the physician has completed and signed Section II of the Form 450B, no one else should make any changes or additions to Section II. All updated or additional information should be provided as an attachment with an explanation of the new or changed information being provided and a signature or notation of the name of the individual providing the additional information. Attachments should support, or more fully explain the information documented on the Form 450B. Under the case mix system of reimbursement, the physician merely needs to certify the need for nursing facility care, rather than a specific level of care, on the Form 450B.

Admissions of out-of-state residents need to be carefully screened prior to admission into an Indiana nursing facility to ensure that each individual meets Indiana's criteria prior to moving to Indiana. Since each state establishes its own criteria for admission to a nursing facility, an applicant's ability to meet another state's nursing facility criteria does not establish eligibility for admission to an Indiana nursing facility. Please be aware that regardless of whether a non-resident is being admitted to an Indiana nursing facility from an out-of-state nursing facility, or is being admitted directly from an Indiana acute care hospital under a designee authorization pursuant to IC 12-10-12-27.1, or is being admitted from any other setting, OMPP can not authorize any Medicaid reimbursement until OMPP has determined that the individual meets Indiana's criteria for admission to an Indiana nursing facility. In order to ensure that the IPAS case will be processed within the three-business day turn-around period, the case must include sufficient information to substantiate the need for medical care. If OMPP cannot

establish an individual's eligibility for admission and ongoing nursing facility care, OMPP must either deny the application or request additional information, which will delay the IPAS processing.

Unless an out-of-state resident is very obviously appropriate for nursing facility care, such as someone who is comatose, in addition to the Form 450B, OMPP requires documentation of medical needs that include the following:

From out-of state hospital: (1) Last 7 days of nurses' notes or equivalent documentation, **and**
(2) Most recent physician progress notes and social service progress notes

From out-of-state nursing facility: Past 30 days of nurses' notes, social service progress notes and physician's orders and progress notes

Readmission to Nursing Facility from Hospital

Refer to page two of the Case Mix Reimbursement Provider Bulletin E98-26 of August 14, 1998 that references the submission of a "450B Data Entry/Authorization Sheet" for readmissions from hospitals. Under the case mix system of reimbursement, the Form 450B is no longer required for any readmission (on or after October 1, 1998) following a hospitalization exceeding the bed-hold policy, as long as the resident was approved for nursing facility care preceding the hospitalization. This applies to readmissions of both Medicaid and dually eligible Medicaid/Medicare residents. This also applies to residents (approved for nursing facility care) who change nursing facilities immediately following the hospitalization, rather than return to the original nursing facility, regardless of the length of the intervening hospitalization.

Note: "approved for nursing facility care" means that there must be a valid Form 450B (or new Form 450B SA/DE as described below) signed by the State that has been data entered into IndianaAIM authorizing the nursing facility stay and Medicaid reimbursement for the period immediately preceding the hospitalization. The Medicaid reimbursement date is documented by OMPP on the Form 450B in the "Effective Medicaid Reimbursement Date" block in the State Authorization section. If the IndianaAIM system does not show that the resident was authorized for Medicaid reimbursement immediately preceding the hospitalization, OMPP will not be able to authorize the readmission to the nursing facility. In this situation, the nursing facility must submit a fully completed Form 450B (and proof of IPAS if the resident has been in the nursing facility for less than one year prior to the requested start date for Medicaid reimbursement) for all nursing facility care that is to be reimbursed by Medicaid. If an IPAS case is pending for the preceding nursing facility care, the IPAS case must be fully processed by OMPP prior to the submission of any further paperwork to OMPP by the nursing facility.

A streamlined state authorization and data entry form to replace the Form 450B is currently being printed. A copy of the new form, Form 450B SA/DE, is attached for your use until the finalized form is available for distribution. This form must be fully completed, including applicable “Medicare from/through dates” **for the period under review**. Please note the new form (Form 450B SA/DE) is officially titled “Nursing Facility Level of Service - State Authorization and Data Entry”. Please refer to the last section of this bulletin for information on ordering this form. Until this new form is available, nursing facilities may continue to use the current Form 450B for readmissions. Only Section I “Recipient Identification” needs to be completed, along with documentation of the dates of the hospitalization. The entire Section II “Physician’s Medical Evaluation” and the “Level of Care Physician Certification” should be left blank. (A physician’s order for nursing facility care must be on file in the resident’s records.)

Admissions from Other Nursing Facilities

All admissions of Medicaid recipients directly from other nursing facilities continue to require the submission of a fully completed Form 450B (or optional Form 450B SA/DE as described in the following note) to OMPP to show the continuing need for nursing facility care. Documentation that the resident is not subject to IPAS and the one-year non-Medicaid payment penalty, such as a copy of the PAS 4B for the previous nursing facility, needs to be attached to the Form 450B. Dates of primary Medicare coverage also need to be documented on the Form 450B, as applicable.

As long as the resident was initially authorized to enter a nursing facility and has received ongoing medical care in a nursing facility or hospital, another IPAS application should not be initiated for transfers between nursing facilities.

NOTE: Nursing facilities now have another option for submitting a fully completed Form 450B for admissions from other nursing facilities on or after October 1, 1998. The admitting facility may submit a hard copy of the fully completed minimum data set (MDS) (Version 2.0 or subsequent version as approved by the Health Care Financing Administration) **for the period under review** along with a fully completed new Form 450B SA/DE “Nursing Facility Level of Service - State Authorization and Data Entry” described in the last section of this bulletin. If the A3a date [last day of the MDS observation period] on the complete MDS is within ninety (90) days of the Medicaid effective/requested reimbursement start date, OMPP will consider the MDS as current “for the period under review”.

Resident Change from Private Pay (non-Medicaid) to Medicaid Recipient

The OMPP will continue to require the submission of a fully completed Form 450B (or Form 450B SA/DE as described in the following note) to authorize Medicaid reimbursement when a resident’s payment status changes from non-Medicaid to Medicaid. This includes residents who are changing eligibility status from Medicare only (non-Medicaid) to dually eligible Medicaid/Medicare. Documentation that the

resident's admission was originally approved through the IPAS/PASRR assessment process, such as a copy of the PAS 4B, must be submitted with the Form 450B.

If the date of the physician's signature on the original Form 450B that was completed and approved through the IPAS/PASRR Program is within ninety (90) days of the Medicaid effective/requested start date, the facility may resubmit the original Form 450B to OMPP for data entry of the start date for Medicaid reimbursement. For example:

An individual entered a nursing facility on July 1, 1998 and immediately applied for IPAS and Medicaid. The Form 450B was completed July 25, 1998 and the IPAS admission was approved September 15, 1998. Medicaid was approved on October 10, 1998 retroactive back to September 1, 1998. The nursing facility may resubmit the original Form 450B to OMPP for Medicaid reimbursement because the Form 450B is dated within the 90-day time period of the effective start date of the Medicaid reimbursement to the nursing facility of September 1, 1998. However, if the individual had excess resources to spend down and did not become eligible for Medicaid until November 1, 1998, the facility would have to submit a new Form 450B, because the original form was over 90 days old and would no longer be current for an effective Medicaid reimbursement start date of November 1, 1998.

Regardless of whether the nursing facility resubmits the original Form 450B or submits an updated Form 450B, the facility must complete the Medicaid (RID) number in Section I and check the Medicaid status as "Medicaid Recipient" in the top right hand box of the Form 450B.

NOTE: Nursing facilities now have another option for submitting a fully completed Form 450B for resident changes from private pay to Medicaid reimbursement on or after October 1, 1998. The admitting facility may submit a hard copy of the fully completed MDS (Version 2.0 or subsequent version as approved by the Health Care Financing Administration **for the period under review** along with a fully completed new Form 450B SA/DE "Nursing Facility Level of Service - State Authorization and Data Entry" described in the last section of this bulletin. If the A3a date [last day of the MDS observation period] on the complete MDS is within ninety (90) days of the Medicaid effective/requested reimbursement start date, OMPP will consider the MDS as current "for the period under review".

Resident Change from Medicare Primary Payer to Medicaid as Primary Payer

A dually eligible resident whose primary payer is Medicare does not require an approved Form 450B for facility reimbursement purposes. The Medicare claim automatically crosses over from the Medicare reimbursement system to the IndianaAIM system for Medicaid reimbursement of the co-insurance and deductible for dually-eligible residents in nursing facilities. When the Medicare coverage period is over, the facility should submit a Form 450B reflecting the resident's current medical condition(s)

and need(s) at the time of the onset of full Medicaid coverage. To expedite the processing of these Form 450Bs, the effective dates of the Medicare coverage should also be noted at the top of the Form 450B.

The following applies to dates of service on or after October 1, 1998:

- (1) If the resident does not have an approved Form 450B (or Form 450B SA/DE) for Medicaid reimbursement for the current institutionalization, the facility has the option of submitting an MDS and the new Form 450B SA/DE as described above in the section "Resident Change from Private Pay (non-Medicaid) to Medicaid Recipient".
- (2) If the resident has an approved Form 450B (or Form 450B SA/DE) for Medicaid reimbursement for the current institutionalization, only the Form 450B SA/DE (no MDS) should be submitted to OMPP for data entry of the Medicare dates of service and the onset of Medicaid as the primary payer.

Resident Change from Medicaid Managed Care to Regular Medicaid Reimbursement

A resident who is admitted short-term to a nursing facility while enrolled in a Medicaid managed care organization (MCO) under the Hoosier Healthwise Program is not eligible for reimbursement of per diem under regular Medicaid. (Medicaid status should be verified by calling AVR.) Subsequent to the institutionalization it may be determined that the resident will require extended nursing facility care. However, prior to the start of regular Medicaid reimbursement, the resident must be disenrolled from the MCO. Additionally, the nursing facility must submit a Form 450B (or Form 450B SA/DE and MDS) to OMPP for authorization of the start of regular Medicaid reimbursement. Please refer to the procedure described previously in the section "Resident Change from Private pay (non-Medicaid) to Medicaid." Questions about Hoosier Healthwise and Hoosier Healthwise disenrollments should be directed to the Hoosier Healthwise Helpline at 1-800-889-9949.

Changes in Level of Care Within a Nursing Facility

With the implementation of the case mix system effective October 1, 1998, there are no longer skilled and intermediate levels of Medicaid reimbursement. For dates of service on or after October 1, 1998, nursing facilities should no longer submit a Form 450B for level of care changes. The facility's quarterly case mix reimbursement rate will be automatically updated to reflect the resident's current condition (including significant changes in condition) that are identified on the MDS forms transmitted to Myers and Stauffer.

Changes in level of care for dates of service prior to October 1, 1998, will continue to require the submission of a fully completed Form 450B to OMPP.

Duplicate Form 450Bs

OMPP continues to receive duplicate Form 450Bs. In general, the submission of duplicate Form 450Bs unnecessarily adds to the paperwork to be processed by both the nursing facility and OMPP. Further, duplicate forms delay the review process for the initial Form 450Bs. To streamline the process of determining if a Form 450B needs to be resubmitted, OMPP requests that the provider contact the OMPP receptionist at (317) 233-3558 to verify the dates of the Form 450Bs that have been processed by OMPP. If the original Form 450B in question was not mailed by the facility prior to the date of the forms currently being processed by OMPP, the facility is not to submit a duplicate Form 450B. (E.g., if the original Form 450B was mailed by the facility on 09/17/98; however, OMPP is currently reviewing forms received the week of 09/12/98, the facility should not resubmit a duplicate Form 450B.)

New Form 450B SA/DE “Nursing Facility Level of Service - State Authorization and Data Entry”

Please refer to the attached copy of the new Form 450B SA/DE “Nursing Facility Level of Service - State Authorization and Data Entry”, State Form 49120 (11/98). Nursing facilities may copy and utilize the attached form as described above for:

- (1) readmissions to nursing facilities from hospitals;
- (2) admission from other nursing facilities (not subject to IPAS or PASRR); and,
- (3) resident changes from private pay to Medicaid recipient, including changes from Medicare primary payer to Medicaid primary payer.

A complete MDS is also required with the Form 450B SA/DE addressed in item number 2 and 3 above, as described in this bulletin.

The instructions on Form 450B SA/DE note that it can also be utilized for IPAS and PASRR. However, implementation of the use of this new Form 450B SA/DE for IPAS and PASRR programs will not become effective until the State has completed MDS training for the local Area Agencies on Aging and other entities who will need to become familiar with the MDS for processing IPAS/PASRR cases. Further notification will be provided at the time that the Form 450B SA/DE can be implemented (for those cases where a current MDS is available) for IPAS and PASRR assessment cases.

The new form, Form 450B SA/DE, is currently being printed and is anticipated to be ready for distribution by December 1, 1998. The forms are being padded in 100 forms per pad, so your order should reflect this packaging. It is requested that facilities not order more than one pad of 100 forms on their initial order. Orders should be submitted on facility letterhead. Please specify the State form number and full name of the new form [SF 49120 (11/98) Form 450B SA/DE Nursing Facility Level of Service - State Authorization and Data Entry] and submit the order to:

Department of Administration
Forms Distribution Center
6400 E. 30th Street
Indianapolis, Indiana 46219

If you have any questions regarding the information contained in this bulletin, please contact the EDS Provider Assistance Unit at 1-800-577-1278, or for local providers at (317) 655-3240.

**Use of Forms 450B and 450B SA/DE
Requirements for Dates of Service on or after October 1, 1998****

<u>Scenario</u>	<u>Qualifier</u>	<u>Form Required</u>	<u>Accompanying Information</u>
Initial Admission to NF (IPAS and PASRR)	All IPAS/PASRR cases	Entire 450B (Section I & II) completed	Complete IPAS/PASRR packet - (no change)
NF to Hosp & Return Same NF (with State approved level of care)	Not Exceeding Bed Hold Policy	None	None
NF to Hosp and Return Same NF (with State approved level of care)	Exceeding Bed Hold Policy	450B (Section I only) <i>OR</i> 450B SA/DE	None
NF to Hosp and Return to Another NF (with State approved level of care)	Following any length of hospitalization	450B (Section I only) <i>OR</i> 450B SA/DE	None
Transfer from NF to NF(no intervening hospitalization)		Entire 450 B (Section I & II) completed <i>OR</i> 450B SA/DE with fully completed MDS*	Copy of PAS 4B from previous NF
Resident Change from Private Pay (non-Medicaid) to Medicaid Recipient	Including changes in elig status from Medicaid MCO to regular Medicaid	Entire 450B(Section I & II) completed <i>OR</i> 450B SA/DE with fully completed MDS*	Copy of PAS 4B
Change from Medicare Primary Payer to Medicaid Primary Payer (without State approved level of care)	When Medicare Coverage Ends	Entire 450B(Section I & II) completed <i>OR</i> 450B SA/DE with fully completed MDS*	Copy of PAS 4B
Change from Medicare Primary Payer to Medicaid Primary Payer (with State approved level of care)	When Medicare Coverage Ends	450B(Section I only) or 450B SA/DE	None

* The fully completed MDS for the period under review should be submitted with the Form 450B SA/DE only. (A3a date [last day of the MDS observation period] must be within 90 days of Medicaid effective/requested start date.)

** For all Dates of Service prior to October 1, 1998 - Providers are required to submit a fully completed Form 450B for the Level of Care (skilled or intermediate) being requested.



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:

- 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.
- 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 _____			
<input type="checkbox"/> c. Psychiatric Bed		<input type="checkbox"/> f. ARCH / RBA / Residential				<input type="checkbox"/> h. Other _____			
						NF provider number			
						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	