



RESIDENTIAL CARE ASSISTANCE PROGRAM (RCAP) RESIDENT STATUS CHANGE

State Form 55708 (R2 / 4-18)

- INSTRUCTIONS:**
1. Submit completed form to Indiana Division of Aging at rcap.provider@fssa.in.gov.
 2. Submit completed form and supporting documentation to Division of Family Resources for the following changes at FSSA.APPS4RCAP@fssa.in.gov.
 3. RCAP providers are required to submit any change of income for RCAP participants to the Division of Family Resources.

Type of change: <input type="checkbox"/> Name change <input type="checkbox"/> Income change <input type="checkbox"/> Transfer <input type="checkbox"/> Discharge from the RCAP program <input type="checkbox"/> Nursing facility level of care			
Name of RCAP facility		Address of facility (number and street, city, state, and ZIP code)	
Name of resident		Social Security number	Date of RCAP admission (month, day, year)

HOSPITAL / NURSING FACILITY STATUS			
<input type="checkbox"/> HOSPITAL	Name of hospital		Total hospital days used
	Address of hospital (number and street, city, state, and ZIP code)		
	Date of admission (month, day, year)	Admitted to: <input type="checkbox"/> Medical unit <input type="checkbox"/> Psychiatric unit	
	Date of discharge (month, day, year)	Discharged to: <input type="checkbox"/> RCAP facility <input type="checkbox"/> Nursing facility <input type="checkbox"/> Other: _____	
<input type="checkbox"/> NURSING FACILITY	Name of nursing facility		Total nursing facility days used
	Address of nursing facility (number and street, city, state, and ZIP code)		
	Date of admission (month, day, year)	Date of discharge (month, day, year)	Discharged to: <input type="checkbox"/> RCAP facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____

LEAVE OF ABSENCE DAYS (LOA)			
LOA days used	Date leave started (month, day, year)	Date returned to RCAP facility (month, day, year)	Remaining LOA days available

RESIDENT TRANSFER BETWEEN RCAP FACILITIES	
Name of facility transferred from	Date of discharge (month, day, year)
Address of facility transferred from (number and street, city, state, and ZIP code)	
Name of facility transferred to	Date of admission (month, day, year)
Address of facility transferred to (number and street, city, state, and ZIP code)	

RESIDENT DISCHARGE FROM RCAP PROGRAM	
Date of discharge (month, day, year)	Reason for discharge
Forwarding address of resident (number and street, city, state, and ZIP code)	

RCAP FACILITY REPRESENTATIVE		
Printed name of RCAP facility representative	Telephone number of RCAP facility representative ()	Date (month, day, year)

INTERNAL USE ONLY	
Date received by Division of Aging (month, day, year)	Date sent to Administrative Services (month, day, year)
Comments:	