Reset Form

CONTRACT AND SERVICE AGREEMENT CHECKLIST

State Form 55283 (R2 / 7-21)
Indiana Department of Health-Division of Long Term Care
(Pursuant to IC16-28, 410 IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

Facility Number		**Provider Number**	
Facility Name		**City**	

Please mark whether or not the facility has a contract or service agreement for the services listed below. If this is a new facility, have a copy available for the surveyor(s) to review at the time of the initial health survey. For a change of ownership please include copies of any new contracts.

COMPREHENSIVE CARE

Contract/Service Agreement	Yes	No
Audiology	☐	☐
Beauty and/or Barber Services	☐	☐
Dentistry Services	☐	☐
Dialysis Services **	☐	☐
Dietician	☐	☐
Emergency Shelter	☐	☐
Emergency Water Supply	☐	☐
Hospice Services **	☐	☐
Hospital Transfer Agreement(s)	☐	☐
IV Therapy **	☐	☐
Laboratory Services	☐	☐
Laundry and/or Housekeeping Services **	☐	☐
Medical Director	☐	☐
Mental Health Services	☐	☐
Nursing Pool Services **	☐	☐
Occupational Therapy	☐	☐
Optometry	☐	☐
Oxygen Services **	☐	☐
Pharmacy Services	☐	☐
Physical Therapy	☐	☐
Podiatry Services	☐	☐
Respiratory Therapy	☐	☐
Speech Therapy	☐	☐
X-ray Services	☐	☐
Other *(Please specify.)***	☐	☐
	☐	☐

** If applicable

RESIDENTIAL CARE

Contract/Service Agreement	Yes	No
Dialysis Services **	☐	☐
Dietician	☐	☐
Emergency Shelter	☐	☐
Emergency Water Supply	☐	☐
Pharmacy Services	☐	☐
Other *(Please specify.)* **	☐	☐
	☐	☐
	☐	☐
	☐	☐