

**LTC SURVEY PACKET COVER**

State Form 47849 (R3 / 3-16)

Indiana State Department of Health-Division of Long Term Care

EVENT ID \_\_\_\_\_

PKT \_\_\_\_\_ OF \_\_\_\_\_

**SURVEY DATES**

From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

**EXT/PART EXT SURVEY DATES**

From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Facility Name	Facility Number
Facility Address ( <i>number and street</i> )	Provider/CCN Number
City	Area Supervisor

**Select applicable survey type.**

- ☐ I Recertification
- ☐ E Initial Certification
- ☐ A Complaint Investigation
- ☐ H Life Safety Code
- ☐ G FSES (Validation-Sanitararians)
- ☐ M Pre-Occupancy (Other)
- ☐ K State Licensure
- ☐ M Other \_\_\_\_\_
- ☐ K-R Residential Licensure

**FOLLOW-UP VISITS**

- ☐ DI PSR/PCR to Recertification
- ☐ DH PSR to Life Safety Code
- ☐ DA PSR to Complaint
- ☐ DIA PSR/PCR to Recert / Complaint
- ☐ D\* PSR/PCR to Immediate Jeopardy
- ☐ D-R PSC to Residential Licensure/Complaint

- ☐ Immediate Jeopardy
- ☐ SSQC
- ☐ Conditions of Participation
- ☐ SF 47860 Long Term Care Referral enclosed

STAGGERED SURVEY? Yes ☐ No ☐

If yes, day of week: \_\_\_\_\_

If yes, time: \_\_\_\_\_ AM ☐ PM ☐

**NOTE:** If you are conducting multiple surveys (e.g., recertification and a complaint investigation) at a single visit, you must submit survey packets separated by Event IDs and a Cover Sheet per Event ID.

☐ Refer to Event ID(s) \_\_\_\_\_ for some surveyor notes.

**NOTE:** A separate 670 must be entered in the computer for each survey prior to submission of CMS-2567 to ACO, with the number of hours allotted for each surveyor and team leader identified.

**SURVEY TEAM MEMBERS (\*Please list Team Leader first.)****Federal ID  
Number**

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