Admissions of Patients with Confirmed or Suspected Tuberculosis

Health Facilities Rules (410 IAC 16.2-3.1-18-D) require that each resident, prior to admission, shall be required to have a statement to show no evidence of TB in an infectious stage, as verified on admission and yearly thereafter. This specific waiver program will allow the admission of patients with confirmed or suspected tuberculosis (TB) or patients under treatment for tuberculosis to licensed long-term facilities which meet the specific criteria detailed in the Guidelines for Preventing the Transmission of Tuberculosis in Health Care Settings, 2005 (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm).

No waiver will be considered by the Indiana State Department of Health ("Department") unless there is prior written assurance by the Administrator and Medical Director of the long-term care facility that these guidelines have been met. Further, the facility must have a room or rooms equipped as detailed in Guidelines for Preventing the Transmission of Tuberculosis in Health Care Settings, 2005. These assurances should be provided to the Department and will be kept on file, prior to the admission of any patient under the waiver program.

Each waiver will be specific for only one person, only for facilities which have proper assurance on file with the Department, and for a period not to exceed one year. Additional waivers will be considered or renewed as requested. The facility must demonstrate that it can meet and/or exceed the current medical guidelines as cited above. Past survey findings will be reviewed to assess the status of infection control within the facility during the past year. Upon request for admission or later verification of a communicable disease incident within a facility, an on-site visit may be made by one or more representatives of the Communicable Disease Division/Tuberculosis Control Program and/or Division of Long Term Care to verify compliance with appropriate infection control procedures. A waiver may be rescinded if at any time the Department determines that the Guidelines are not met or that proper assurances have not been given.

The request for a waiver should be directed to the Indiana State Department of Health, Division Long Term Care to the attention of the Program Director-Provider Services. The initial request for a waiver may be verbal, and permission to admit may be given verbally by the Director or his/her designee. Written confirmation must be expeditiously initiated by the facility administrator on the **"Tuberculosis Waiver Request."** This form must be signed by the administrator, medical director and attending physician. A copy of the form will be returned to the facility and the original will be retained by the Division in a confidential file.

The Director of the Division of Long Term Care will provide a written final notice of approval or disapproval to the facility for each request for waiver to admit a resident with confirmed or suspected Tuberculosis.

Program Director-Provider Services
Indiana State Department of Health
Division of Long Term Care, Section 4-B
2 N Meridian St
Indianapolis, IN 46204

Telephone Number: 317-233-7794
Fax: 317-233-7322

TUBERCULOSIS WAIVER REQUEST
State Form 46595 (R2/3-02)
Indiana State Department of Health-Division of Long Term Care

CONFIDENTIAL: This document contains patient information of a confidential nature.

SECTION I: TO BE COMPLETED BY REQUESTOR

_____
Name of Facility

_____
Street Address

_____ _____ _____
City Zip Code Telephone Number

I hearby request that _____ be admitted to the above name facility. This patient suffers from confirmed or suspected ***Tuberculosis***, a communicable disease. As Administrator of the facility, I certify that the facility is capable of providing proper care for this patient, according to the current guidelines published by the Centers for Disease Control.

_____ _____
Date Signature of Administrator

I, _____, M.D. the Medical Director of the above named facility, request that the patient, who has confirmed or suspected ***Tuberculosis***, be admitted to the facility.

_____ _____
Date Signature of Medical Director

I, _____, M.D. the attending physician for the above named facility, request that the patient, who has confirmed or suspected ***Tuberculosis***, be admitted to the facility.

_____ _____
Date Signature of Attending Physician

SECTION II: TO BE COMPLETED BY DIVISION OF LONG TERM CARE

Based upon the requests made on this form, and with the facility's and medical director's assurance that appropriate precautions to deal with the confirmed or suspected ***Tuberculosis*** has been taken, I hereby grant a waiver to the facility and give them permission for this patient to be admitted.

_____ _____
Date Director, Division of Long Term Care
Indiana State Department of Health