



Our Mission: Working together to provide services that help people maintain their independence

**Nursing Facility Extension Request**

Check extension type and provide the additional information listed underneath authorization type that is "checked". Submit as soon as the need is identified to assure processing prior to expiration of temporary authorization. Submit via fax 812-432-6222 or email: pas@lifetime-resources.org. Thank you.

Date: \_\_\_\_\_ Nursing Facility: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Authorization Expiration Date: \_\_\_\_\_

Signature of Person Requesting Extension: \_\_\_\_\_

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**\_\_\_\_ Short-Term 30 Day Temporary Authorization**

Explanation of Changes in the Client's Condition that Requires a Longer Stay:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What Type of Care is now needed: \_\_\_\_Additional Short-Term \_\_\_\_Long-Term

If Short-Term Stay, Number of Days Requested (up to 25 allowed) \_\_\_\_\_

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**\_\_\_\_ Level II Exempted Hospital Discharge**

Why is a Longer Stay required and/or Why did the Client not Convalesce within the Expected Time Frame:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What Type of Care is now needed: \_\_\_\_Additional Short-Term \_\_\_\_Long-Term

If Short-Term Stay, Number of Days Requested (up to 10 allowed) \_\_\_\_\_