Indiana State Department of Health
An Equal Opportunity Employer

APPLICATION FOR NEW FACILITY
TITLE 18 SNF OR TITLE 18 SNF/ TITLE 19 NF

TO: Applicant

FROM: Program Director-Provider Services Division of Long Term Care

This letter is to inform applicants of the required documentation for application for participation in the Medicare and Medicaid Programs. For additional information on the rules and regulations involving this action please refer to: http://www.in.gov/isdh/20511.htm

An application should include the following forms and/or documentation:

1. State Form 8200, Application for License to Operate a Health Facility, including required attachments(enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State, with d/b/a if applicable;
4. Internal Revenue Services (IRS) documentation: SS-4 or comparable document from the IRS that reflects direct owner's corporation, limited liability company, partnership, etc name, d/b/a if applicable and EIN number. The document **must be from the IRS sent to the provider** not a form/document the provider completed and sent to the IRS.
5. State Form 51996, Independent Verification of Assets and Liabilities, including required attachments (enclosed);
6. Licensure Fee; $200 for the first 50 beds, $10 for each additional bed;
7. Three (3) signed originals of the Form HHS-690, Assurance of Compliance (enclosed);
8. Three (3) signed originals of the Form CMS-1561, Health Insurance Benefit Agreement (enclosed);
9. Documentation of compliance with Civil Rights requirements (forms and instructions enclosed);
10. State Form 4332, Bed Inventory (enclosed);
11. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
12. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
13. A copy of the facility's Quality Assessment and Assurance Committee policy;
14. State Form 55282 Proposed Staffing Structure (enclosed);
15. State Form 55283 Contract and Service Agreement Checklist (enclosed); and

The following items will be reviewed and/or collected by surveyor(s) at the time of the initial health survey.

- Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed);
- A proposed two-week staffing schedule to demonstrate compliance with federal regulations (include all RN, LPN, CNA and QMA hours);
- All contracts and services agreements; and
- The facility's disaster plan.

In addition, the applicant must contact the Medicare Fiscal Intermediary, Wisconsin Physician Services (WPS) (or the facility's CMS approved Fiscal Intermediary), for Form CMS-855A. The facility may reach Wisconsin Physician Services (WPS) at 608-221-4711. The completed Form CMS-855A should be forwarded directly to National Government Services for review and recommendation for approval. Form CMS-855A or the form can be downloaded at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf

NOTE: The facility must contact HP, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to HP for processing.

The following is a general outline of the application process (in approximate chronological order):

1. Submit plans and specifications for new construction or an existing building to the Indiana State Department of Health, Division of Sanitary Engineering for review and approval;
2. Once plans and specifications have been approved, and new construction or remodeling of an existing building is substantially complete, please submit a copy a letter indicating that the construction is substantially complete, to the Program Director-Provider Services, Division of Long Term Care;
3. Submit the following documents in order for the Division of Long Term Care to grant authorization to occupy the facility:
    (1) Completed State Form 8200, Application For License To Operate A Health Facility, to include all required attachments;
    (2) Licensure Fee; $200 for the first 50 beds, $10 for each additional bed;
    (3) Documentation of the applicant entity's registration with the Indiana Secretary of State, with d/b/a if applicable;
    (4) Internal Revenue Services (IRS) documentation: SS-4 or comparable document from the IRS that reflects direct owner's corporation, limited liability company, partnership, etc name, d/b/a if applicable and EIN number. The document **must be from the IRS sent to the provider** not a form/document the provider completed and sent to the IRS;
    (5) State Form 19733, Implementing Indiana Code 16-28-2-6;
    (6) Completed State Form 51996, Independent Verification Of Assets And Liabilities, to include required attachments;
    (7) State Form 4332, Bed Inventory;
    (8) Facility floor plan on 8 ½" X 11" paper to show room numbers and numbers of beds per room;
    (9) Written request for the applicable fire safety inspections (Life Safety Code, Sanitarian and/or State Fire Code) to the Program Director-Provider Services, Division of Long Term Care;
4. Once the applicable fire safety inspections have been conducted and released, the Division of Long Term Care will issue an Authorization to Occupy letter to the applicant (*residents may be admitted upon receipt of this authorization; however, please be advised that the facility will not be able to bill Medicare and/or Medicaid for services rendered prior to the initial certification survey and official program acceptance into these programs*);
5. Prior to the initial licensure and certification surveys, the following must occur:
    (1) All remaining application documents must be submitted and approved by the Division; and
    (2) The designated Fiscal Intermediary must approve the CMS-855A application;
6. Once these requirements are satisfied, and the facility has provided skilled care to at least two (2) comprehensive residents, the facility may submit a written request to the Program Director-Provider Services for the initial licensure and certification surveys (*every effort will be made to conduct these*

surveys within 21 days of the date you indicate your readiness for survey);

7. Upon completion of the initial licensure and certification surveys, the Division of Long Term Care will forward the application to the Centers for Medicare and Medicaid Services ("CMS") and/or the State Medicaid Agency along with the initial certification survey results;
8. CMS and/or the State Medicaid Agency will notify the facility in writing of their final determination for acceptance or denial into their respective programs, with the effective participation dates.

Should you have questions regarding the application process please call Provider Services at 317/233-7794 or 317/233-7613.

Enclosures

APPLICATION FOR LICENSE TO OPERATE A HEALTH FACLITY

(Pursuant to IC 16-28 and 410 IAC 16.2)
State Form 8200 (R3/08-00)
Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received_____
Date Approved_____
Approved by_____

Please Print or Type

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Other**_____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility			
Street Address			P.O. Box:
City		County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd):*	To *(mm/dd):*

B. Licensee/Ownership Information

Licensee *(Operator(s) of the facility)* The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address			P.O. Box
City		State	Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

C. Building Information

1. Status of building to be used *(check appropriate item)*

☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other_____

2. Type of Construction (materials) *(if new, as certified by architect or engineer registered in the state of Indiana)*

_____ _____ _____ _____

D. Type of Services to be Provided

1. **Level of Care**	Number of Beds in Each Category (to be licensed)	2. **Certification Designation**	Number of Beds in Each Category (to be licensed)
☐ Residential	_____	☐ SNF (Title 18 – Medicare)	_____
☐ Comprehensive (Certified)	_____	☐ SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
☐ Comprehensive (Non-certified)	_____	☐ NF (Title 19 – Medicaid)	_____
☐ Children's Facility	_____	☐ ICF/MR	_____
☐ Developmentally Disabled	_____		
Total Number of Licensed Beds	_____	**Total Certified Beds**	_____

SECTION III – STAFFING

A. Administrator

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of Birth	Date employed in this position

1. List post secondary education and health related experience

   _____

   _____

   _____

2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.

3. Has the administrator ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

4. Has the administrator's license ever lapsed, been suspended or revoked? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility?
   ☐ Yes ☐ No *(If no, explain on a separate sheet)*

B. Director of Nursing

Name *(enter full name)*

Indiana License Number *(please include a copy of license with application)*	Date of birth	Date employed in this position

Education *(Name of School of Nursing)*

School Degree	Year Graduated

Other College Education

Qualifications or Experience

1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)
2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? ☐ Yes ☐ No
   (If yes, state on a separate sheet the facts of each case completely and concisely)

SECTON IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT

(In compliance with the Indiana Health Facilities Rules (410 IAC 16.2)

A. Applicant Entity

Name of Applicant Entity *(operator(s) of the facility)*

D/B/A *(Name of Facility)*

B. Ownership Information

List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. *(use additional sheet if necessary)*

Name	Business Address	EIN Number

C. Type of Change of Ownership

☐ Assignment of Interest ☐ Lease ☐ Merger ☐ New Partnership
☐ Sale ☐ Sublease ☐ Termination of Lease ☐ Other_____

D. Type of Entity

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ * Partnership	☐ Individual	☐ County
☐ ** Corporation	☐ * Partnership	☐ City
☐ *** Limited Liability Company	☐ ** Corporation	☐ City/County
☐ Other *(specify)* _____	☐ *** Limited Liability Company	☐ Hospital District
_____	☐ Other *(specify)* _____	☐ Federal
_____	_____	☐ Other *(specify)* _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. **List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company.** ***(use additional sheet if necessary)***

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? ☐ Yes ☐ No

If "yes," list names and addresses of facilities owned by each individual. (use *additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? ☐ Yes ☐ No

If yes, explain_____

_____

Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? ☐ Yes ☐ No
(If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)
☐ Yes ☐ No *(If "Yes", provide name of facility, state, date(s), restrictions and type)*

2. Had a facility's license revoked, suspended or denied. ☐ Yes ☐ No *(If "Yes", provide name of facility, state, type of actions and date(s))*

3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.
☐ Yes ☐ No *(If "Yes", provide name of facility, state, date, type of action, results of action)*

4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy ☐ Yes ☐ No *(If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)*

5. Filed for bankruptcy, reorganization or receivership. ☐ Yes ☐ *No (If "Yes", include all relevant documentation and provide a detailed summary of the events and circumstances. Include state, dates and names of facilities)*

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color. creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative *(Typed)*	Title
Signature	Date

STATE OF _____ COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____County, State of_____,

this _____day of _____20_____

(SEAL) (Signature)_____

_____, Notary Public
(Type or Print Name)

My Commission expires_____

IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)
Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility		
Street Address		
City	State	Zip+4

SECTION A

This health facility ☐ does ☐ does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility ☐ does ☐ does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? ☐ yes ☐ no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

_____

_____

_____

_____

_____

_____

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.

2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

_____

_____

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILTIY HAS ADMISSION CHARGES OTHER THAN DAILY OR MONTLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

_____
Board Chairman or Owner

_____
Print Name of Signer

STATE OF _____)

COUNTY OF_____)

Subscribed and sworn to before me, this_____day of _____,20_____

_____
Notary Public

(Seal)

_____
County of Residence

My commission expires_____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204

INDEPENDENT VERIFICATION OF ASSETS AND LIABILITIES
State Form 51996 (R2 / 5-13)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, 410 IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

Please Type or Print Legibly.

SECTION I – INSTRUCTIONS

Licensee:

1. Complete sections II, III, and F & G in section IV.
2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process.
3. All financial information listed on this form should be for the applicant entity listed on SF 8200 Application for Licensure to Operate a Health Care Facility and Section III of this form, it should not be the parent company's financial information.
4. Forward the completed materials to an Independent Certified Public Accountant.
5. Upon receipt from the CPA, sign and date the certification statement in section V (Name of Authorized Person).

CPA:

1. Complete Section IV on the reverse side of this form using the applicant entity's current balance sheet and a projection of revenue and operating expenses. Attach additional schedules or information as necessary for the documentation requested.
2. Sign and date the certification statement in Section V.
3. This form must be returned with the application materials, including the balance sheet and projection of revenue and operating expenses for the applicant entity, in order to complete the application process.
4. All financial information listed on this form should be for the applicant entity listed on State Form 8200, Application for Licensure to Operate a Health Care Facility, and Section III of this form, it should not be the parent company's financial information.

SECTION II - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership (*Anticipated date of Sale/Purchase/Lease (mm/dd/yy)*):**____ ☐ **New Facility** ☐ **Other:** ____

SECTION III - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility			
Street Address *(number and street)*			
City		County	ZIP Code +4
Telephone Number ( )	Fax Number ( )	Facility's Cost Reporting Year From *(mm/dd)*:	To *(mm/dd)*:

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) *Same as Licensee on State Form 8200, Application for License to Operate a Health Facility, Section B.*		
Street Address *(number and street)*		P.O. Box
City	State	ZIP Code + 4

SECTION IV – SELECTED BALANCE SHEET ITEMS AS OF_____

(mm/dd/yy)

A. Current Assets:		**B. Current Liabilities:**	
Asset	**Amount** ***(rounded to nearest dollar)***	**Liability**	**Amount** ***(rounded to nearest dollar)***
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		**Total Current Liabilities**	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			

C. Working Capital: ***(Total Current Assets minus Total Current Liabilities)*** **$**_____

D. Total Liabilities: $_____ **E. Total Owner's Equity or Fund Balance: $** _____

F. Lines of Credit *(List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary.)***:**

Name of Institution or Lender	**Amount of Credit Available**
1.	$
2.	$
3.	$
4.	$

G. Number of Facility Beds: _____

Projected Monthly Revenue: **$**_____

Projected Monthly Operating Expenses: **$**_____

SECTION V – CERTIFICATION STATEMENTS

This is to certify that the foregoing information, including any attached exhibits, schedules, and explanations, is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.

Name of Authorized Person (*Typed*)	**Title/Position**
Signature of Authorized Person	**Date** ***(mm/dd/yy)***

In my opinion, the information reported above presents fairly, in all material respects, the current assets, current liabilities, working capital, the total liabilities and total owner's equity or fund balance as well as lines of credit available as of the date identified above. Additionally, we have reviewed management's underlying assumptions and believe that they provide a reasonable basis for the projected monthly revenue and operating expense.

Name of Independent Certified Public Accountant (*Typed*)	**Title/Position**	
Signature of Independent Certified Public Accountant	**License/Certification Number**	**Date** ***(mm/dd/yy)***

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

_____
Date

_____
Signature and Title of Authorized Official

_____
Name of Applicant or Recipient

_____
Street

_____
City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

FORM APPROVED
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act, as Amended and Title 42 Code of Federal Regulations (CFR) Chapter IV, Part 489)

AGREEMENT

between
THE SECRETARY OF HEALTH AND HUMAN SERVICES
and

_____

doing business as (D/B/A) _____

In order to receive payment under title XVIII of the Social Security Act,_____
_____
D/B/A _____ as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Name _____ Title _____

Date _____

ACCEPTED FOR THE PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES BY:

NAME *(signature)*

TITLE	DATE

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

NAME *(signature)*

TITLE	DATE

Form Approved
OMB No. 0990-0243
Exp. Date 03/31/2014

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office for Civil Rights (OCR)

Civil Rights Information Request For Medicare Certification

Instructions: Healthcare providers applying for participation in the Medicare Part A program must receive a civil rights clearance from OCR. Complete all fields and return this form, with the required polices and procedures, to your State Health Department, along with your other Medicare application materials.

I. Healthcare Provider Information

CMS Medicare Provider Number:

Name of Facility:

Address: _____
Street Number and Name

_____ - _____
City or Town *State or Province* *Zip Code*

Administrator's Name: _____ Contact Person: _____

Telephone: ( ) - _____ TDD: ( ) - _____

FAX: ( ) - _____ E-mail: _____

Type of Facility: _____ Number of employees: _____

Corporate Affiliation: _____ Reason for Application: Circle One
Initial Medicare Certification or Change of Ownership

II. Documents Required for Submission

Additional guidance is available at:(http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html)

1.	**Assurance of Compliance form, HHS 690 completed, signed and dated**
2.	**Nondiscrimination Policy that provides for admission and services without regard to race, color, national origin, disability, or age, as required by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (see sample policy).** **Learn more about regulatory requirements**
3.	**Description of methods used to disseminate your nondiscrimination policies/notices:** **a) Describe where you post your Nondiscrimination Policy;** **b) Include brochures, websites, pamphlets, postings, or ads with general information about your services.**
4.	**Facility admissions policy that describes eligibility requirements for your services.**
5.	**A description/explanation of any policies or practices restricting or limiting your facility's admissions or services on the basis of age. In certain narrowly defined circumstances, age restrictions are permitted. Learn more about regulatory requirements**
6	**For healthcare providers with 15 or more employees: copy of your procedures used for handling disability discrimination grievances along with the name/title and telephone number of the Section 504 coordinator (see sample policy). Learn more about regulatory requirements.**

7.	**Procedures to effectively communicate with persons who are limited English proficient (LEP), including:** **a) Process for how you identify individuals who need language assistance;** **b) Procedures to provide services (interpreters, written translations, bilingual staff, etc.). Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);** **c) Methods to inform LEP persons that language assistance services are available at no cost to the person being served;** **d) Appropriate restrictions on the use of family and friends as LEP interpreters;** **e) A list of all written materials in other languages, if applicable. Examples may include consent and complaint forms, intake forms, written notices of eligibility criteria, nondiscrimination notices, etc (see sample policy). Learn more about regulatory requirements**
8.	**Procedures used to communicate effectively with individuals who are deaf, hard of hearing, blind, have low vision, or who have other impaired sensory, manual or speaking skills, including:** **a) Process to identify individuals who need sign language interpreters or other assistive services;** **b) Procedures to provide interpreters and other auxiliary aids and services. Include the name(s) and telephone number(s) of your interpreter(s) and/or interpreter service(s);** **c) Procedures used to communicate with deaf or hard of hearing persons over the telephone, including the telephone number of your TTY/TDD or State Relay System;** **d) A list of available auxiliary aids and services;** **e) Methods to inform persons that interpreter or other assistive services are available at no cost to the person being served;** **f) Appropriate restrictions on the use of family and friends as sign language interpreters (see sample policy). Learn more about regulatory requirements.**
9.	**Notice of Program Accessibility and methods used to disseminate information to patients/clients about the existence and location of services and facilities that are accessible to persons with disabilities (see sample policy). Learn more about regulatory requirements.**

III. Certification

I certify that the information provided to the Office for Civil Rights is true, complete, and correct to the best of my knowledge.

Name and Title of Authorized Official	Signature	Date

Office for Civil Rights

Civil Rights Information Request
For
Medicare Certification

Technical Assistance

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Go to (http://www.hhs.gov/ocr/civilrights/resources/providers/medicare_providers/index.html) for more information, including links to the full regulations.

Nondiscrimination Policies and Notices

The regulations implementing Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 require health and human service providers that receive Federal financial assistance from the Department of Health and Human Services to provide notice to patients/residents, employees, and others of the availability of programs and services to all persons without regard to race, color, national origin, disability, or age.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.6(d) Information to beneficiaries and participants. Each recipient shall make available to participants, beneficiaries, and other interested persons such information regarding the provisions of this regulation and its applicability to the program for which the recipient receives Federal financial assistance, and make such information available to them in such manner, as the responsible Department official finds necessary to apprise such persons of the protections against discrimination assured them by the Act and this regulation.

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§ 84.8 Notice. (a) A recipient that employs fifteen or more persons shall take appropriate initial and continuing steps to notify participants, beneficiaries, applicants, and employees, including those with impaired vision or hearing, and unions or professional organizations holding collective bargaining or professional agreements with the recipient that it does not discriminate on the basis of handicap in violation of section 504 and this part. The notification shall state, where appropriate, that the recipient does not discriminate in admission or access to, or treatment or employment in, its programs and activities. The notification shall also include an identification of the responsible employee designated pursuant to **§**84.7(a). A recipient shall make the initial notification required by this paragraph within 90 days of the effective date of this part. Methods of initial and continuing notification may include the posting of notices, publication in newspapers and magazines, placement of notices in recipients' publication, and distribution of memoranda or other written communications.

(b) If a recipient publishes or uses recruitment materials or publications containing general information that it makes available to participants, beneficiaries, applicants, or employees, it shall include in those materials or publications a statement of the policy described in paragraph (a) of this section. A recipient may meet the requirement of this paragraph either by including appropriate inserts in existing materials and publications or by revising and reprinting the materials and publications.

Age Discrimination Act: 45 CFR Part 91

§ 91.32 Notice to subrecipients and beneficiaries. (b) Each recipient shall make necessary information about the Act and these regulations available to its program beneficiaries in order to inform them about the protections against discrimination provided by the Act and these regulations.

See Policy Example Section for examples of Nondiscrimination Policies.

Communication with Persons Who Are Limited English Proficient

In certain circumstances, the failure to ensure that Limited English Proficient (LEP) persons can effectively participate in, or benefit from, federally-assisted programs and activities may violate the prohibition under Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, and the Title VI regulations against national origin discrimination. Specifically, the failure of a recipient of Federal financial assistance from HHS to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI and HHS's implementing regulations. It is therefore important for recipients of Federal financial assistance, including Part A Medicare providers, to understand and be familiar with the requirements.

Applicable Regulatory Citations:

Title VI of the Civil Rights Act of 1964: 45 CFR Part 80

§80.3 Discrimination prohibited.

(a) General. No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program to which this part applies.
(b) Specific discriminatory actions prohibited. (1) A recipient under any program to which this part applies may not, directly or through contractual or other arrangements, on ground of race, color, or national origin:

(i) Deny an individual any service, financial aid, or other benefit under the program;
(ii) Provide any service, financial aid, or other benefit to an individual which is different, or is provided in a different manner, from that provided to others under the program;
(iii) Subject an individual to segregation or separate treatment in any matter related to his receipt of any service, financial aid, or other benefit under the program;
(iv) Restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under the program;
(v) Treat an individual differently from others in determining whether he satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet in order to be provided any service, financial aid, or other benefit provided under the program;
(vi) Deny an individual an opportunity to participate in the program through the provision of services or otherwise or afford him an opportunity to do so which is different from that afforded others under the program (including the opportunity to participate in the program as an employee but only to the extent set forth in paragraph (c) of this section).
(vii) Deny a person the opportunity to participate as a member of a planning or advisory body which is an integral part of the program.

(2) A recipient, in determining the types of services, financial aid, or other benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.

Resources

For further guidance on the obligation to take reasonable steps to provide meaningful access to LEP persons, see HHS' "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at

http://www.hhs.gov/ocr/lep/. This guidance is also available at http://www.lep.gov/, along with other helpful information pertaining to language services for LEP persons.

Technical Assistance for Medicare and Medicare+Choice organizations from the Centers for Medicare and Medicaid for Designing, Conducting, and Implementing the 2003 National Quality Assessment and Performance Improvement (QAPI) Program Project on Clinical Health Care Disparities or Culturally and Linguistically Appropriate Services- http://www.cms.hhs.gov/healthplans/quality/project03.asp

Examples of Vital Written Materials

Vital written materials could include, for example:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient's program or activity or to receive recipient benefits or services.

Nonvital written materials could include:

- Hospital menus.
- Third party documents, forms, or pamphlets distributed by a recipient as a public service.
- For a non-governmental recipient, government documents and forms.
- Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated).
- General information about the program intended for informational purposes only.

Auxiliary Aids and Services for Persons with Disabilities

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973: 45 CFR Part 84

§84.3 Definitions

(h) Federal financial assistance – means any grant, loan … or any other arrangement by which [DHHS] makes available … funds; services …

(j) Handicapped person – means any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.

(k) Qualified handicapped person means - (4) With respect to other services, a handicapped person who meets the essential eligibility requirements for the receipt of such services.

§84.4 Discrimination prohibited

(1) General. No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance.

Discriminatory actions prohibited –

(1) A recipient, in providing any aid, benefits, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded other;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the recipients program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service.

Subpart F – Health, Welfare and Social Services

§84.51 Application of this subpart

Subpart F applies to health, welfare, or other social service programs and activities that receive or benefit from Federal financial assistance …

§84.52 Health, welfare, and other social services.

(a) *General.* In providing health, welfare, or other social services or benefits, a recipient may not, on the basis of handicap:

(1) Deny a qualified handicapped person these benefits or services;

(2) Afford a qualified handicapped person an opportunity to receive benefits or services that is not equal to that offered non-handicapped persons;

(3) Provide a qualified handicapped person with benefits or services that are not as effective (as defined in **§** 84.4(b)) as the benefits or services provided to others;

(4) Provide benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons; or

(5) Provide different or separate benefits or services to handicapped persons except where necessary to provide qualified handicapped persons with benefits and services that are as effective as those provided to others.

(b) Notice. A recipient that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified handicapped persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their handicap.

(c) ***Auxiliary aids.*** (1) A recipient with fifteen or more employees "shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such person an equal opportunity to benefit from the service in question." (2) Pursuant to the Department's discretion, recipients with fewer than fifteen employees may be required "to provide auxiliary aids where the provision of aids would not significantly impair the ability of the recipient to provide its benefits or services." (3) "Auxiliary aids may include brailed and taped material, interpreters, and other aids for persons with impaired hearing or vision."

504 Notice

The regulation implementing Section 504 requires that an agency/facility "that provides notice concerning benefits or services or written material concerning waivers of rights or consent to treatment shall take such steps as are necessary to ensure that qualified disabled persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their disability." **(45 CFR §84.52(b))**

Note that it is necessary to note each area of the consent, such as:

1. Medical Consent
2. Authorization to Disclose Medical Information
3. Personal Valuables
4. Financial Agreement
5. Assignment of Insurance Benefits
6. Medicare Patient Certification and Payment Request

Resources:

U.S. Department of Justice at www.ada.gov

ADA Business Brief: Communicating with People Who are Deaf or Hard of Hearing in Hospital Settings at http://www.ada.gov/business.htm

A new on-line library of ADA documents is now available on the Internet. Developed by Meeting the Challenge, Inc., of Colorado Springs with funding from the National Institute on Disability and

Rehabilitation Research, this website makes available more than 3,400 documents related to the ADA, including those issued by Federal agencies with responsibilities under the law. It also offers extensive document collections on other disability rights laws and issues. By clicking on one of the general categories in the left column, for example, you will go to a catalogue of documents that are specific to the topic. http://www.dbtac.vcu.edu/adaportal//

Requirements for Facilities with 15 or More Employees

Applicable Regulatory Citations:

Section 504 of the Rehabilitation Act of 1973:

45 CFR Part 84§84.7 Designation of responsible employee and adoption of grievance procedures.

(a) *Designation of responsible employee.* A recipient that employs fifteen or more persons shall designate at least one person to coordinate its efforts to comply with this part.

(b) *Adoption of grievance procedures.* A recipient that employs fifteen or more persons shall adopt grievance procedures that incorporate appropriate due process standards and that provide for the prompt and equitable resolution of complaints alleging any action prohibited by this part. Such procedures need not be established with respect to complaints from applicants for employment or from applicants for admission to postsecondary educational institutions.

Age Discrimination Act Requirements

The Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) has the responsibility for the Age Discrimination Act as it applies to Federally funded health and human services programs. The general regulation implementing the Age Discrimination Act requires that age discrimination complaints be referred to a mediation agency to attempt a voluntary settlement within sixty **(60)** days. If mediation is not successful, the complaint is returned to the responsible Federal agency, in this case the Office for Civil Rights, for action. OCR next attempts to resolve the complaint through informal procedures. If these fail, a formal investigation is conducted. When a violation is found and OCR cannot negotiate voluntary compliance, enforcement action may be taken against the recipient institution or agency that violated the law.

The Age Discrimination Act permits certain exceptions to the prohibition against discrimination based on age. These exceptions recognize that some age distinctions in programs may be necessary to the normal operation of a program or activity or to the achievement of any statutory objective expressly stated in a Federal, State, or local statute adopted by an elected legislative body.

Applicable Regulatory Citations:

45 CFR Part 91: Nondiscrimination on the Basis of Age in Programs or Activities Receiving Federal Financial Assistance From HHS

§ 91.3 To what programs do these regulations apply?

(a) The Act and these regulations apply to each HHS recipient and to each program or activity operated by the recipient which receives or benefits from Federal financial assistance provided by HHS.
(b) The Act and these regulations do not apply to:
(1) An age distinction contained in that part of a Federal, State, or local statute or ordinance adopted by an elected, general purpose legislative body which:
(i) Provides any benefits or assistance to persons based on age; or
(ii) Establishes criteria for participation in age-related terms; or
(iii) Describes intended beneficiaries or target groups in age-related terms.

Subpart B-Standards for Determining Age Discrimination

§ 91.11 Rule against age discrimination.

The rules stated in this section are limited by the exceptions contained in §§91.13 and 91.14 of these regulations.

(a) General rule: No person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.
(b) Specific rules: A recipient may not, in any program or activity receiving Federal financial assistance, directly or through contractual licensing, or other arrangements, use age distinctions or take any other actions which have the effect, on the basis of age, of:
(1) Excluding individuals from, denying them the benefits of, or subjecting them to discrimination under, a program or activity receiving Federal financial assistance.

(2) Denying or limiting individuals in their opportunity to participate in any program or activity receiving Federal financial assistance.
(c) The specific forms of age discrimination listed in paragraph (b) of this section do not necessarily constitute a complete list.

§ 91.13 Exceptions to the rules against age discrimination: Normal operation or statutory objective of any program or activity.

A recipient is permitted to take an action, otherwise prohibited by § 91.11, if the action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity. An action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of a program or activity, if:

(a) Age is used as a measure or approximation of one or more other characteristics; and
(b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and
(c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and
(d) The other characteristic(s) are impractical to measure directly on an individual basis.

§ 91.14 Exceptions to the rules against age discrimination: Reasonable factors other than age.

A recipient is permitted to take an action otherwise prohibited by § 91.11 which is based on a factor other than age, even though that action may have a disproportionate effect on persons of different ages. An action may be based on a factor other than age only if the factor bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.

§ 91.15 Burden of proof.

The burden of proving that an age distinction or other action falls within the exceptions outlined in §§ 91.13 and 91.14 is on the recipient of Federal financial assistance.

Sample Policies

The next few pages contain samples of policies that you could use as guidance in developing civil rights policies and procedures for your facility. You may modify them to best reflect your procedures and methods.

Examples of Nondiscrimination Policies

Example One (for posting in the facility and inserting in advertising or admissions packages):

NONDISCRIMINATION POLICY

As a recipient of Federal financial assistance, (insert name of provider) does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by (insert name of provider) directly or through a contractor or any other entity with which (insert name of provider) arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

In case of questions, please contact:

Provider Name:

Contact Person/Section 504 Coordinator:

Telephone number:

TDD or State Relay number:

Example Two (for use in brochures, pamphlets, publications, etc.):

(Insert name of provider) does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: (insert name of Section 504 Coordinator, phone number, TDD/State Relay).

Example of a Policy and Procedure for Providing Meaningful Communication with Persons with Limited English Proficiency

POLICY AND PROCEDURES FOR COMMUNICATION WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY

POLICY:

(Insert name of your facility) will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of (***Insert name of your facility)*** is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. ***(include those documents applicable to your facility)***. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in effective communication techniques, including the effective use of an interpreter.

(Insert name of your facility) will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

PROCEDURES:

1. IDENTIFYING LEP PERSONS AND THEIR LANGUAGE

(Insert name of your facility) will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or "I speak cards," available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

2. OBTAINING A QUALIFIED INTEPRETER

(Identify responsible staff person(s), and phone number(s)) is/are responsible for:

(For a, b, c below, choose only what is applicable to your facility)

(a) Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff ***(provide the list);***

(b) Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret;

(c) Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language.
(*Identify the agency(s) name(s) with whom you have contracted or made arrangements)* have/has agreed to provide qualified interpreter services. The agency's (or agencies') telephone number(s) is/are **(*insert number (s)),*** and the hours of availability are (***insert hours)***.

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person.

Children and other clients/patients/residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

3. PROVIDING WRITTEN TRANSLATIONS

(a) When translation of vital documents is needed, each unit in ***(insert name of your facility)*** will submit documents for translation into frequently-encountered languages to ***(identify responsible staff person).*** Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.

(b) Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

(c) ***(Insert name of your facility)*** will set benchmarks for translation of vital documents into additional languages over time.

4. PROVIDING NOTICE TO LEP PERSONS

(Insert name of your facility) will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to the emergency room, outpatient areas, etc. ***(include those areas applicable to***

your facility). Notification will also be provided through one or more of the following: outreach documents, telephone voice mail menus, local newspapers, radio and television stations, and/or community-based organizations ***(include those areas applicable to your facility)***.

5. MONITORING LANGUAGE NEEDS AND IMPLEMENTATION

On an ongoing basis, ***(insert name of your facility)*** will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, ***(insert name of your facility)*** will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations, etc. ***(include those areas applicable to your facility)***.

Bilingual Individuals
(center location here)
(As of *(month and year submitting information)*

Staff Members:
We currently have:

☐ no staff members available who are qualified to speak and/or interpret a language other than English.

☐ the following staff member(s) who are qualified to speak and/or interpret a language other than English:

Name:	
Title:	
Phone Number:	
Language(s) spoken:	
Hours of Availability:	

Name:	
Title:	
Phone Number:	
Language(s) spoken:	
Hours of Availability:	

Contractors:

The Director of Clinical Services, *(First Name, Last Name – phone number),* is responsible for maintaining a list of local bilingual interpreters/translators.

The Director of Clinical Services has chosen the following interpreter/translator to ensure that qualified persons with Limited English Proficiency (LEP) can adequately communicate with Hospice staff members.

Company/Organization:	
Contact Person:	
Address:	
Address:	
City/State/Zip:	
Voicemail:	
Fax:	
Email:	

Example of a Policy and Procedure for Providing Auxiliary Aids for Persons with Disabilities

AUXILIARY AIDS AND SERVICES FOR PERSONS WITH DISABILITIES

POLICY:

(Insert name of your facility) will take appropriate steps to ensure that persons with disabilities, including persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures outlined below are intended to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. The procedures also apply to, among other types of communication, communication of information contained in important documents, including waivers of rights, consent to treatment forms, financial and insurance benefits forms, etc. (***include those documents applicable to your facility)***. All necessary auxiliary aids and services shall be provided without cost to the person being served.

All staff will be provided written notice of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques, including the effective use of interpreters.

PROCEDURES:

1. Identification and assessment of need:

(Name of facility) provides notice of the availability of and procedure for requesting auxiliary aids and services through notices in our ***(brochures, handbooks, letters, print/radio /televison advertisements, etc.)*** and through notices posted ***(in waiting rooms, lobbies, etc****.)*. When an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

2. Provision of Auxiliary Aids and Services:

(Insert name of your facility) shall provide the following services or aids to achieve effective communication with persons with disabilities:

A. For Persons Who Are Deaf or Hard of Hearing

(i) For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the ***(identify responsible staff person or position with a telephone number*)** is responsible for providing effective interpretation or arranging for a qualified interpreter when needed.

In the event that an interpreter is needed, the ***(identify responsible staff person)*** is responsible for:

(For a, b, c below, choose only what is applicable to your facility)

(a) Maintaining a list of qualified interpreters on staff showing their names, phone numbers, qualifications and hours of availability ***(provide the list)*;**

(b) Contacting the appropriate interpreter on staff to interpret, if one is available and qualified to interpret; or

(c) Obtaining an outside interpreter if a qualified interpreter on staff is not available. **(Identify the agency(s) name with whom you have contracted or made arrangements)** has agreed to provide interpreter services. The agency's/agencies' telephone number(s) is/are **(insert number(s) and the hours of availability).[Note: If video interpreter services are provided via computer, the procedures for accessing the service must be included.]**

(ii) Communicating by Telephone with Persons Who Are Deaf or Hard of Hearing

[Listed below are three methods for communicating over the telephone with persons who are deaf/hard of hearing. Select the method(s) to incorporate in your policy that best applies/apply to your facility.]

(*Insert name of facility)* utilizes a Telecommunication Device for the Deaf (TDD) for external communication. The telephone number for the TDD is ***(insert number*)**. The TDD and instructions on how to operate it are located ***(insert location*)** in the facility; OR

(Insert name of provider) has made arrangements to share a TDD. When it is
determined by staff that a TDD is needed, we contact ***(identify the entity e.g., library, school or university, provide address and telephone numbers*)**; OR

(Insert name of facility) utilizes relay services for external telephone with TTY users. We accept and make calls through a relay service. The state relay service number is ***(insert telephone for your State Relay)***.

(iii) For the following auxiliary aids and services, staff will contact ***(responsible staff person or position and telephone number)***, who is responsible to provide the aids and services in a timely manner: Note-takers; computer-aided transcription services; telephone handset amplifiers; written copies of oral announcements; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning; telecommunications devices for deaf persons (TDDs); videotext displays; or other effective methods that help make aurally delivered materials available to individuals who are deaf or hard of hearing.

(iv) Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and ***after*** an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.
NOTE: Children and other residents will *not* be used to interpret, in order to ensure confidentiality of information and accurate communication.

B. For Persons Who are Blind or Who Have Low Vision

(i) Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision **[in addition to reading, this section should tell what other aids are available, where they are located, and how they are used]**.

The following types of large print, taped, Brailled, and electronically formatted materials are available: **(d*escription of the materials available)***. These materials may be obtained by calling **(*name or position and telephone number*)**.

(ii) For the following auxiliary aids and services, staff will contact ***(responsible staff person or position and telephone number),*** who is responsible to provide the aids and services in a timely manner:
Qualified readers; reformatting into large print; taping or recording of print materials not available in alternate format; or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff are available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

C. For Persons With Speech Impairments

To ensure effective communication with persons with speech impairments, staff will contact ***(responsible staff person or position and telephone number),*** who is responsible to provide the aids and services in a timely manner:
Writing materials; typewriters; TDDs; computers; flashcards; alphabet boards; communication boards; ***(include those aids applicable to your facility)*** and other communication aids.

D. For Persons With Manual Impairments

Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following:
note-takers; computer-aided transcription services; speaker phones; or other effective methods that help to ensure effective communication by individuals with manual impairments. For these and other auxiliary aids and services, staff will contact ***(responsible staff person or position and telephone number)*** who is responsible to provide the aids and services in a timely manner.

Sign Language Interpreters

(center location here)

(As of *(month and year submitting information)*

Staff Members:

We currently have:

☐ no staff members available who are qualified to interpret American Sign Language.

☐ the following staff member(s) who are qualified to interpret American Sign Language:

Name:	
Title:	
Phone Number:	
Hours of Availability:	

Name:	
Title:	
Phone Number:	
Hours of Availability:	

Contractors:

The Director of Clinical Services, *(First Name, Last Name – phone number),* is responsible for obtaining an outside interpreter when required.

The Director of Clinical Services has chosen the following interpreter referral agency to ensure that qualified persons with disabilities, including those with impaired hearing, can adequately communicate with Hospice staff members:

Company/Organization:	
Contact Person:	
Address:	
Address:	
City/State/Zip:	
Voicemail:	
TTY:	
Email:	

Example of a Notice of Program Accessibility for Describing that your Program is Accessible to Persons with Disabilities

Section 504 Notice of Program Accessibility

The regulation implementing Section 504 requires that an agency/facility "*…adopt and implement procedures to ensure that interested persons, including persons with impaired vision or hearing, can obtain information as to the existence and location of services, activities, and facilities that are accessible to and usable by disabled persons.*" **(45 C.F.R. §84.22(f))**

(Insert name of facility) and all of its programs and activities are accessible to and useable by disabled persons, including persons who are deaf, hard of hearing, or blind, or who have other sensory impairments. Access features include:

- Convenient off-street parking designated specifically for disabled persons.
- Curb cuts and ramps between parking areas and buildings.
- Level access into first floor level with elevator access to all other floors.
- Fully accessible offices, meeting rooms, bathrooms, public waiting areas, cafeteria, patient treatment areas, including examining rooms and patient wards.
- A full range of assistive and communication aids provided to persons who are deaf, hard of hearing, or blind, or with other sensory impairments. There is no additional charge for such aids. Some of these aids include:
    - Qualified sign language interpreters for persons who are deaf or hard of hearing.
    - A twenty-four hour (24) telecommunication device (TTY/TDD) which can connect the caller to all extensions within the facility and/or portable (TTY/TDD) units, for use by persons who are deaf, hard of hearing, or speech impaired.
    - Readers and taped material for the blind and large print materials for the visually impaired.
    - Flash Cards, Alphabet boards and other communication boards.
    - Assistive devices for persons with impaired manual skills.

If you require any of the aids listed above, please let the receptionist or your nurse know.

Example of a Section 504 Grievance Procedure that Incorporates Due Process Standards

Section 504 GRIEVANCE PROCEDURE

It is the policy of ***(insert name of facility/agency)*** not to discriminate on the basis of disability. **(*Insert name of facility/agency*)** has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from Federal financial assistance." The Law and Regulations may be examined in the office of ***(insert name, title, tel. no. of Section 504 Coordinator)***, who has been designated to coordinate the efforts of ***(insert name of facility/agency)*** to comply with Section 504***.***

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for ***(insert name of facility/agency)*** to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

Grievances must be submitted to the Section 504 Coordinator within (insert timeframe) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of ***(insert name of facility/agency)*** relating to such grievances.
The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.
The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the ***(Administrator/Chief Executive Officer/Board of Directors/etc.)*** within 15 days of receiving the Section 504 Coordinator's decision.
The ***(Administrator/Chief Executive Officer/Board of Directors/etc.)*** shall issue a written decision in response to the appeal no later than 30 days after its filing.
The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

*(**Insert name of facility/agency**)* will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped

cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

BED INVENTORY

State Form 4332 (R9 / 9-08)
INDIANA STATE DEPARTMENT OF HEALTH-DIVISION OF LONG TERM CARE

Name of Facility		
Street Address		
City	County	ZIP+4

PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS:
Each room should be listed only once and listed in numerical order under each classification column.

Title 18 SNF = Medicare ONLY beds
Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified)
Title 19 NF = Medicaid
NCC = Non-Certified Comprehensive Residential Level of Care

All licensed beds must be listed.

Room No.	No. Beds
8	2
9	2
10	2
11	3
12	2
20	2

Title 18 SNF		Title 18/19 SNF/NF		Title 19 NF				NCC		Residential	
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds
Total 18 SNF		Total 18/19 SNF/NF				Total 19 NF		Total NCC		Total Residential	

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds classifications and numbers currently licensed and certified for.

Completed by	Position	Date

PROPOSED STAFFING STRUCTURE
State Form 55282 (5-13)
Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, 410 IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

Please complete the below form with the number of employees and education level for each position.

Position	Number of Employees	Education Level
Administrator		
Director of Nursing		
Registered Nurse (RN)		
Licensed Practical Nurse (LPN)		
Certified Nursing Assistant (CNA)		
Registered Dietitian		
Therapy Staff		
Social Services		
Food Services		
Building Services		
Housekeeping		
Other		

CONTRACT AND SERVICE AGREEMENT CHECKLIST

State Form 55283 (5-13)
Indiana State 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		
Hospital Transfer Agreement(s)		
Pharmacy Services		
Other *(Please specify.)* **		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey

From: F1 ☐☐ ☐☐ ☐☐ To: F2 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Extended Survey

From: F3 ☐☐ ☐☐ ☐☐ To: F4 ☐☐ ☐☐ ☐☐
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5 ☐☐ ☐☐ ☐☐ MM DD YY

Street Address	City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☐	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☐
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31_____
MM DD YY

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

		A			B					C					D				
	Tag Number	Services Provided			Full-Time Staff (hours)					Part-Time Staff (hours)					Contract (hours)				
		1	2	3															
Administration	F33																		
Physician Services	F34																		
Medical Director	F35																		
Other Physician	F36																		
Physician Extender	F37																		
Nursing Services	F38																		
RN Director of Nurses	F39																		
Nurses with Admin. Duties	F40																		
Registered Nurses	F41																		
Licensed Practical/ Licensed Vocational Nurses	F42																		
Certified Nurse Aides	F43																		
Nurse Aides in Training	F44																		
Medication Aides/Technicians	F45																		
Pharmacists	F46																		
Dietary Services	F47																		
Dietitian	F48																		
Food Service Workers	F49																		
Therapeutic Services	F50																		
Occupational Therapists	F51																		
Occupational Therapy Assistants	F52																		
Occupational Therapy Aides	F53																		
Physical Therapists	F54																		
Physical Therapists Assistants	F55																		
Physical Therapy Aides	F56																		
Speech/Language Pathologist	F57																		
Therapeutic Recreation Specialist	F58																		
Qualified Activities Professional	F59																		
Other Activities Staff	F60																		
Qualified Social Workers	F61																		
Other Social Services	F62																		
Dentists	F63																		
Podiatrists	F64																		
Mental Health Services	F65																		
Vocational Services	F66																		
Clinical Laboratory Services	F67																		
Diagnostic X-ray Services	F68																		
Administration & Storage of Blood	F69																		
Housekeeping Services	F70																		
Other	F71																		

Name of Person Completing Form	Time
Signature	Date

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete
Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).