



A Program of the American Osteopathic Association

Application / Reapplication for Accreditation For Ambulatory Care Centers/Office Based Surgery

Healthcare facilities seeking accreditation from the Healthcare Facilities Accreditation Program (HFAP) must comply with all the requirements listed in the latest edition of *Accreditation Requirements for Ambulatory Care Centers/Office Based Surgery*.

All applications must be accompanied by the appropriate fees. Contact the HFAP office for specifics regarding your facility.

This application is a **sample only**. All facilities applying for re/accreditation must complete an application online at www.hfap.org. For questions regarding this process, please contact our offices at info@hfap.org or 312-202-8258.

Documents to be submitted with completed application:

1. *Governing Body Bylaws*
2. *Medical Staff Bylaws*
3. *List of Program Sites*
4. *Facility Maps by Floor*
5. *Restraint Policy and Procedure*
6. *Patient Rights Documents*
7. *Quality Assessment and Improvement Plan*
8. *A Copy of your Facility's most Current Annual Report*
9. *Organizational Chart with Names and Titles*
10. *Copy of State License*
11. *Map of the area, hotel & airport information*

Use current or most recent edition of all documents. These will be used by the surveyors to score your standards compliance

FACILITY INFORMATION

Facility Name (as it should appear on accreditation certificate): _____

Street Address _____

City/State/Zip _____

Facility Main Telephone Number _____

Web Site Address _____

Hours of Operation _____

Medicare Provider Number: _____

Medicaid Provider Number: _____

Indicate services for which the facility/program is licensed by the state:

Organization Date: _____ Incorporation Date: _____ In State Of: _____

Date of Tax/Exemption: _____

Date of First Admission: _____

Type of Ownership: _____

Date of Last State License/Registration Certificate: _____

Does your facility have Wi-Fi capabilities in all areas of the building? _____

Is your Facility Currently Accredited: _____ Yes _____ No _____

If yes, indicate accrediting organization and attach evidence of current accreditation, if other than HFAP

_____ HFAP _____ JCAHO _____ CARF _____ State _____ AAAHC

Is this Institution Part of a Multi-Hospital Group? _____ Yes _____ NO

If yes, Name of Group: _____

Are there Satellite Facilities Associated with this Facility: _____ Yes _____ No

If yes, distance from main site _____

Do you have radiology and laboratory services in the facility? _____ Yes _____ No

Do you have a transfer agreement with a hospital in an emergency? _____ Yes _____ No

PROFESSIONAL MEDICAL STAFF DATA
 (note: Statistical data is for the last calendar year)

	Licensed by State	Certified by state	Certified by Other	Non-Licensed Non-Certified
Physician DOs/MDs				
Certified Social Worker				
Physician Assistant				
Nurse Practitioner, RN, MSN				
Registered Nurse				
Registered Nurse, BSN				
Licensed Practical Nurse, LPN				
Other				

PATIENT DATA

<p><u>Outpatient Data:</u></p> <p>Total Outpatient Visits for Year _____</p> <p>Total Consultations _____</p>
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REQUEST FOR SURVEY BLACK OUT DATES:

It is preferred that facilities submit application for survey **at least six (6) months prior to the facility's accreditation expiration date.** Whereas accreditation surveys are unannounced, HFAP allows facilities to request "black-out" dates. In this manner, facilities have a degree of control for planning retreats, conferences and other activities. Your survey will not be scheduled during those requested "black-out" dates. No more than three (3) black-out dates (days) will be permitted.

Requests for survey "black out" dates must be made at the time of application. Due to scheduling issues we are unable to honor requests after the application has been received.

Blackout Dates: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

CONTACT INFORMATION

Chief Executive Officer:

Name

Preferred Title

Telephone

Fax

Email

Chief Operating Officer:

Name

Preferred Title

Telephone

Fax

Email

Medical Director:

Name

Preferred Title

Telephone

Fax

Email

Chief Nursing Officer:

Name

Preferred Title

Telephone

Fax

Email

Accreditation Coordinator / Contact Person:

Name

Preferred Title

Telephone

Fax

Email

INSTITUTIONAL PLANNING DATA

1) Does the facility, under direction of the Governing Body, prepare an overall plan and budget which provides for an annual operating budget and capital expenditure plan? YES NO

2) Does the annual operating budget include all anticipated income and expenses related to items which would under generally accepted accounting principles to be considered income and expense items? YES NO

3) Is there a capital expenditure plan for at least a 3-year period which includes and identified in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of \$100,000? YES NO

4) Is the overall plan and budget prepared under the direction of the governing body of the facility by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff of the facility? YES NO

(a) Governing Body (b) Administrative Staff (c) Medical Staff

COMPOSITION OF COMMITTEE

NAME	TITLE

If 4 is yes, is the overall plan and budget reviewed and updated at least annually by the committee referred to in (4) under the direction of the governing body of the facility? YES NO

LABORATORY

All areas within a health care facility that provide moderate or high complexity testing for patients must be surveyed under the Clinical Laboratory Improvement Amendments (CLIA) which can be accomplished through an accrediting agency deemed by the Centers for Medicare and Medicaid (CMS) or by the State. CLIA mandates that all moderate/high complexity laboratories and/or testing areas shall be inspected on a two-year cycle.

<p>Laboratory Data:</p> <p>Legal Name of Institution/Laboratory: _____</p> <p>Street Address: _____</p> <p>City: _____ State: _____ Zip +4: _____</p> <p>CLIA Number: _____ Complexity Level: ___ Moderate ___ High</p> <p>Laboratory Director: _____ Telephone: _____</p> <p>Email _____</p> <p>Additional Information:</p> <p>Contact: _____ Title: _____</p> <p>Telephone: _____ Fax: _____</p> <p>E-Mail Address: _____</p> <p>Who should receive a copy of HFAP Laboratory News? _____ <i>(Note: Include title if different than above)</i></p>	<p><u>Accreditation Status</u></p> <p>The main laboratory is accredited by the following agency(ies):</p> <p>_____ AOA</p> <p>_____ CAP</p> <p>_____ JCAHO</p> <p>_____ State</p> <p>_____ AABB</p> <p>Proficiency Testing</p> <p>Services Used</p> <p>_____ CAP</p> <p>_____ AAB</p> <p>_____ API</p> <p>_____ State: _____</p> <p>_____ Other, List</p>
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It is the responsibility of the health care facility to notify the HFAP and HHS, in writing, within 30 days of changes in the laboratory's ownership, name, location, or director.

I certify that the application submitted is truthful and accurate, and no material fact has been omitted.

The health care facility is required to notify HFAP, in writing, of any changes in the accreditation status of the laboratory, as it becomes known.

I verify that the aforementioned information about the laboratory and other testing areas is correct and understand the responsibility of the health care facility to notify the HFAP of any changes as stated above.

_____/_____/_____
 (Signature of Laboratory Director) (Print/type Name) (Date)

_____/_____/_____
 (Signature of Laboratory Director) (Print/type Name) (Date)

APPLICATION FOR ACCREDITATION SURVEY AGREEMENT

Obtaining accreditation is one of several steps in the process of becoming eligible for reimbursement for care provided to Medicare and Medicaid patients. The process of accreditation is separate and distinct from the process of reimbursement. The Centers for Medicare and Medicaid Services retains sole and final authority on decisions of eligibility for Medicare and Medicaid reimbursement. Accordingly, any questions related to reimbursement issues and the process for becoming eligible for reimbursement should be referred to the facility's Regional Office (RO) of the Centers for Medicare and Medicaid Services.

The undersigned makes application to the Healthcare Facilities Accreditation Program (HFAP) for an accreditation survey of this facility (Name of Facility) and its components. As the administrative representative of this facility, I certify that the facility meets all eligibility requirements for accreditation by the Healthcare Facilities Accreditation Program (HFAP), and grant permission to the state licensing agency or any other licensing/accreditation group to release facility records to HFAP for any review deemed necessary as part of the accreditation process.

The Healthcare Facilities Accreditation Program (HFAP) will ensure that all information received in the course of facility application, survey, and accreditation review, will be confidential and used for the sole purpose of reaching an accreditation decision except as otherwise required by law.

I certify that the information contained in this application for accreditation is accurate and true. I understand that providing falsified documents of information may be grounds for denial or revocation of facility accreditation.

By signing this application for accreditation, I understand that the facility is responsible for timely payment of all applicable accreditation fees including those costs associated with the triennial survey as well as any directed or mid-cycle surveys. Non-payment is grounds for revocation of accreditation.

In the event that this facility has any disagreement with HFAP regarding any aspect of accreditation procedures or decisions, I understand that the facility has the right to appeal such decision in accordance with the HFAP appeal procedures in place at the time of appeal. Final decision rests with the Board of Trustees of the American Osteopathic Association (AOA). The facility shall not be entitled to compensatory damages of any type from HFAP or any of its representatives resulting from any controversy related to accreditation. HFAP's aggregate liability shall not exceed the sum of (a) the fees paid to HFAP pursuant to this Agreement.

Chief Executive Officer (Please PRINT)

Title

Signature of Chief Executive Officer

Date

Name of Organization (Please PRINT)