



A Program of the American Osteopathic Association

Application / Reapplication for Accreditation For Ambulatory Surgical Centers

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 Surgical Centers*.

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. Quality Assessment and Improvement Plan
6. Restraint Policy and Procedure
7. Patient Rights Documents
8. A Copy of your Facilities most Current Annual Report
9. Organizational Chart with Names and Titles
10. Copy of State License
11. Completed 855 Form (New Facilities)
12. Map of the area, local hotels, local airport

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 _____

Specific Surgery Days _____

Medicare Provider Number: _____

Medicaid Provider Number: _____

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

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

_____ Outpatient Surgery

_____ Research

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

Institution is: _____ For-Profit _____ Not-For-Profit, _____ Date of Tax/Exemption

Date of First Admission: _____

Type of Ownership _____

Date of Last State License/Registration Certificate: _____

Is your Facility Currently Accredited: _____ Yes _____ No _____

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

_____ AOA _____ JCAHO _____ CARF _____ State _____ AAAHC

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				
Certified Nurse Anesthetist (CRNA)				
Name of all Management and Staff				

PATIENT DATA

Outpatient Date:

Total Outpatient for Year _____

Total Outpatient Visits for the Most Recent 12 Months _____

Total Number Emergency Care _____

Total Surgical Cases _____

Total Surgical Cases _____

Total Consultations _____

REQUEST FOR SURVEY BLACKOUT 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. ___/___/___

SAMPLE

CONTACT INFORMATION

<u>Chief Executive Officer:</u>	
_____ Name	_____ Preferred Title
_____ Telephone	_____ Fax
_____ Email	
<u>Chief Operating Officer:</u>	
_____ Name	_____ Preferred Title
_____ Telephone	_____ Fax
_____ Email	
<u>Medical Director:</u>	
_____ Name	_____ Preferred Title
_____ Telephone	_____ Fax
_____ Email	
<u>Chief Nursing Officer:</u>	
_____ Name	_____ Preferred Title
_____ Telephone	_____ Fax
_____ Email	
<u>Accreditation Coordinator / Contact Person:</u>	
_____ 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

ACCREDITATION EFFECTIVE DATES

Medicare policy states that: “Failure to substantially meet one or more Conditions is a cause for termination of participation. ‘Substantially,’ for purposes of this section, is defined as meeting the applicable Conditions for Participation (CoPs) or Conditions for Coverage (CfCs). Any provider/supplier that does not substantially meet the Conditions is considered to be limited in its capacity to furnish services at an adequate level or quality. Compliance with Conditions; i.e., condition level deficiencies can never be certified based on a PoC or acceptable progress since the law specifically requires that all CoPs or CfCs must be met.”

1. For providers or suppliers seeking HFAP accreditation for an initial provider agreements:

If a provider or supplier is found to be in substantial compliance with all Medicare Conditions on the initial survey then the date of accreditation will be the last day of the survey.

If a provider or supplier is seeking an initial provider agreement is found to be out of substantial compliance with one or more Medicare Conditions on the initial survey then the date of accreditation will be either:

- **The date in which the provider or supplier meets all requirements.**
- **The date on which a provider or supplier is found to meet all conditions of participation or coverage, but has lower level deficiencies, and CMS or the state survey agency receives an acceptable plan of correction for the lower level deficiencies.**

The provider or supplier must complete all corrective actions within 60 days and have a monitoring system in place to determine whether or not the corrective is effective. Under Federal guidelines, verification of the provider or supplier being in compliance with any Medicare Condition will require a full resurvey of the entire facility.

2. For providers or suppliers seeking HFAP re-accreditation for continuation of an existing provider agreement:

If a provider or supplier that is seeking re-accreditation is found to be in substantial compliance with all Medicare Conditions on the initial survey then the date of accreditation will be the last day of the survey.

If the provider or supplier is found to be out of substantial compliance with one or more Medicare Conditions during its survey then the date of the accreditation will be either:

- **The date in which the provider or supplier meets all requirements.**
- **The date on which a provider or supplier is found to meet all conditions of participation or coverage, but has lower level deficiencies, and CMS or the state survey agency receives an acceptable plan of correction for the lower level deficiencies.**

The provider or supplier must complete all corrective actions within 60 days and have a monitoring system in place to determine whether or not the corrective is effective. Under Federal guidelines, verification of the provider or supplier being in compliance with any Medicare Condition will require a focused resurvey of the facility.

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*)

SAMPLE