



A Program of the American Osteopathic Association

Application / Reapplication for Accreditation For Mental Health/Substance Abuse/Behavioral Health 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 Mental Health Facilities*.

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. *Copy of State License*
2. *Fire Inspection Report*
3. *Governing Body Bylaws*
4. *Medical Staff Bylaws*
5. *List of Program Sites*
6. *Facility's Floor Maps*
7. *Master Staffing Plans*
8. *Restraint Policy & Procedure*
9. *Patient Rights Documents*
10. *Quality Assessment and Improvement Plan*
11. *A Copy of your Facilities most Current Annual Report*
12. *Organizational Chart*
13. *Name of the nearest major airport*
14. *Names of three moderately priced motels/hotels in your vicinity*
15. *A map of your community showing hospital location.*

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 _____

Medicare Provider Number: _____

Medicaid Provider Number: _____

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

____ Emergency Care

____ Inpatient Including Detox days/per year (Number of beds)

____ Intermediate/Residential (Number of beds)

____ Outpatient visits per year

____ Methadone or other chemotherapy treatment

____ Research

Number of: Licensed Beds: _____ Occupied Beds: _____

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

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 _____ Other

History of Prior Accreditation by Whom _____ Dates _____

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

If yes, Name of Group: _____

Are there any Satellite Facilities Associated with this Facility? _____ Yes _____ No

If Yes, List Names, Addresses, and Types (i.e. Day Care Residential, Children, Adolescents, Geriatric, etc.) on a Separate Sheet and Attach.

PATIENT DATA

<p><u>Patient Data:</u></p> <p>_____ Number of Beds</p> <p>_____ Total Patient Admitted</p> <p>_____ Total Patients Discharge</p> <p>_____ Total Inpatient Days</p> <p>_____ Average Daily Census</p> <p>_____ Average Stay all Patients</p> <p>_____ Occupancy Rate</p> <p>_____ Number Patients Over Age 65</p> <p>_____ Average Stay Patients Over Age 65</p> <p>_____ Number Patients Under 21</p> <p>_____ Average Stay Patients Under 21</p>	<p><u>Outpatient Data:</u></p> <p>_____ Total Outpatients for Year</p> <p>_____ Total Outpatient Visits for Year</p> <p>_____ Total Number of Referrals Out (AA, Hospital, Etc.)</p> <p>_____ Total Number Emergency Care</p> <p>_____ Average Length of Care (Number of Months) Per Patient</p> <p>_____ Family Counseling Services</p> <p>_____ Forensic Mental Health</p> <p>_____ Mental Retardation/Developmental Disabilities</p> <p>_____ Adult Mental Health Visits per month/year</p> <p>_____ Child/Adolescent Mental Health Visits per month/year</p> <p>_____ Intake/Diagnostic (Behavioral Health Setting)</p> <p>_____ Substance Abuse Psychological Counseling</p>
<p><u>Statistics of Patients for the Last Calendar Year</u></p> <p>Total Admissions: _____</p> <p>Total Discharges (Include Deaths): _____</p> <p>Number of patients by category:</p> <p>_____ Emergency Care</p> <p>_____ Inpatient Including Detox</p> <p>_____ Intermediate/Residential</p> <p>_____ Methadone or Other Chemotherapy Treatment</p> <p>_____ Outpatient</p> <p>_____ Research</p>	

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

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

When you have multiple facilities associated under your corporate or system name list them below:

Corporate Name _____

NAME OF EACH FACILITY				
MEDICAID NUMBER				
MEDICARE NUMBER				
ADDRESS OF EACH FACILITY TO BE INCLUDED IN THE SURVEY				
CONTACT PERSON AT EACH FACILITY				
PHONE NUMBER FAX NUMBER				
DATE OF STATE LICENSURE	YES NO	YES NO	YES NO	YES NO
DETAILED FLOOR PLAN INCLUDED?				
INCLUDE MILEAGE BETWEEN FACILITIES				
LIST THE TYPE OF PATIENT CARED FOR AT EACH FACILITY				
PSYCHOLOGICAL COUNSELING				
MENTAL HEALTH				
SUBSTANCE ABUSE				

If your facility has more than 6 sites please make a copy of page 4.

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

INSTITUTIONAL PLANNING DATA

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

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

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

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

Please list any contract services the facility utilizes.

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*)