



## Application / Reapplication for Accreditation For Critical Access Hospitals

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 Critical Access Hospitals*, Section One, Eligibility for Accreditation and must submit this application in accordance with the application procedures listed under Section One, Accreditation Process. ***The HFAP recognizes the limited resources available to Critical Access Hospitals in frontier or remote areas. For this reason, these facilities should thoroughly review the eligibility criteria and HFAP Accreditation Requirements for Critical Access Hospitals before completion of this application.***

A **triennial fee for accreditation must accompany this application.** Contact the HFAP office for specifics regarding your facility.

It is very important that all questions on this application be answered. This document forms the basis for a profile of your facility to be used by the surveyors during the onsite survey. **Print or type the information requested**, or check the appropriate boxes. If an item or question is not applicable to the facility, enter "NA". If you have questions regarding this application form or any aspect of the accreditation process, contact the HFAP office at (800) 621-1773, x8258.

When the application is complete, make a copy for your records; submit the original application with **four (4) copies** of the documents listed below to:

Sheryl R. Miller  
Healthcare Facilities Accreditation Program  
142 East Ontario Street  
Chicago, IL 60611

Re-applicants are reminded to submit their application at least **90 days prior to their expiration date**. Alternatively, applications, with accompanying documents, may be submitted via email (only 1 copy is needed) to [smiller@hfap.org](mailto:smiller@hfap.org)

*Documents to be submitted with completed application:*

1. *Governing Body Bylaws*
2. *Medical Staff Bylaws, Rules & Regulations, Credentialing Manual*
3. *Master Staffing Plan for Nursing*
4. *Facility Floor Plan (8 1/2 x 11 size paper only)*
5. *Copy of the latest Life Safety Code Inspection by local or state agency*
6. *Quality Assessment & Performance Improvement Plan*
7. *Organization Chart*
8. *Facility State License*
9. *Completed 855 Form (NEW FACILITIES)*
10. *All CLIA certificates*
11. *All Laboratory Accreditation Certificates & Specialty / Subspecialty Information*
12. *Copy of State Letter indicating CAH designation*
13. **Additionally, please provide:**
  - a. *the name of the nearest major airport,*
  - b. *the names of three moderately priced motels/hotels in your vicinity, and*
  - c. *a map of your community showing the hospital location .*
14. **If you have multiple sites that will be surveyed, please provide:**
15. *a map that identifies all locations to be visited.*

***Use current or most recent edition of all documents. These will be used by the surveyors to score your standards compliance. Please do NOT place documents in binders or utilize any type of page protectors. Rubber bands or clips are acceptable to differentiate the various documents***

## SECTION A: FACILITY INFORMATION

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

Street Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Facility Main Telephone Number \_\_\_\_\_

Web Site Address \_\_\_\_\_

**\*\*A copy of the current state license, if applicable, must be attached to this application. \*\***

Medicare Provider Number: \_\_\_\_\_

Medicaid Provider Number: \_\_\_\_\_

CMS Critical Access Certification Number: \_\_\_\_\_

Swing Bed Provider Number: \_\_\_\_\_

Date of original CAH status: \_\_\_\_\_

Date of most recent inspection by State agency: \_\_\_\_\_

Is this facility:     For Profit                       Not for Profit

Is this facility part of a Rural Health Network?     Yes                       No

Name of the nearest acute care hospital: \_\_\_\_\_

Mileage to the nearest acute care hospital: \_\_\_\_\_

Total Number of Licensed Beds: \_\_\_\_\_

Total Number of Swing Beds: \_\_\_\_\_

**\*\*\*Define / Name each unit within the facility and the average number of occupied beds for each for the most recent 12 month reporting period (calendar or fiscal).\*\*\***

UNIT	AVERAGE # OCCUPIED BEDS	UNIT	AVERAGE # OCCUPIED BEDS
i.e. <i>Medical – 2 West</i>	6		
i.e. <i>Swing Beds – 1 North</i>	8		

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**This facility or portion thereof is also accredited by the following organizations** (check all that apply):

- |                                 |                                      |
|---------------------------------|--------------------------------------|
| <input type="checkbox"/> JCAHO  | <input type="checkbox"/> AABB        |
| <input type="checkbox"/> CARF   | <input type="checkbox"/> ASHI        |
| <input type="checkbox"/> CHAP   | <input type="checkbox"/> CAP         |
| <input type="checkbox"/> AAAHC  | <input type="checkbox"/> COLA        |
| <input type="checkbox"/> AAAASF | <input type="checkbox"/> Other _____ |

Is this facility part of, or is it owned, operated, or managed by, or affiliated with another organization such as a corporate health system or a multi-hospital group?     Yes             No

\_\_\_\_\_  
Corporate Name

\_\_\_\_\_  
Corporate Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Corporate CEO

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email

## SECTION B: SERVICE INFORMATION

**Check the services provided within / by this facility. For any service added or deleted since the last accreditation survey, list the effective date.** Service definitions are defined in the AHA Guide® to the Health Care Field 2003 pages A6 – A10 using the numbers listed. For items with \*\*, call HFAP for definitions.

**IMPORTANT!: If a service listed does not have a specific location, please list “NONE” in the service location column (i.e., pain management, 1 North Outpatient Clinic, or “None” because it is integrated throughout the organization).**

#	Services	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Service Location (Unit, Floor, or Street Address)	Service Added Effective Date	Service Deleted Effective Date
1	Acute long-term care	<input type="checkbox"/>	<input type="checkbox"/>			
2	Adult Day Care program	<input type="checkbox"/>	<input type="checkbox"/>			
3	Airborne infection isolation room	<input type="checkbox"/>	<input type="checkbox"/>			
4	Alcoholism-drug abuse or dependency inpatient services	<input type="checkbox"/>	<input type="checkbox"/>			
5	Alcoholism-drug abuse or dependency outpatient services	<input type="checkbox"/>	<input type="checkbox"/>			
6	Alzheimer Center	<input type="checkbox"/>	<input type="checkbox"/>			
7	Ambulance Services	<input type="checkbox"/>	<input type="checkbox"/>			
8	Ambulatory Surgery Center	<input type="checkbox"/>	<input type="checkbox"/>			
9	Arthritis treatment center	<input type="checkbox"/>	<input type="checkbox"/>			
10	Assisted living	<input type="checkbox"/>	<input type="checkbox"/>			
11	Auxiliary organization	<input type="checkbox"/>	<input type="checkbox"/>			
12	Bariatric/weight control services	<input type="checkbox"/>	<input type="checkbox"/>			
13	Birthing room-LDR room-LDRP room	<input type="checkbox"/>	<input type="checkbox"/>			
14	Blood donor center	<input type="checkbox"/>	<input type="checkbox"/>			
15	Breast cancer screening/mammograms	<input type="checkbox"/>	<input type="checkbox"/>			
16	Burn care services	<input type="checkbox"/>	<input type="checkbox"/>			
17	Cardiac intensive care services	<input type="checkbox"/>	<input type="checkbox"/>			
18	Adult diagnostic/invasive catheterization	<input type="checkbox"/>	<input type="checkbox"/>			
19	Pediatric diagnostic/invasive catheterization	<input type="checkbox"/>	<input type="checkbox"/>			
20	Adult interventional cardiac catheterization	<input type="checkbox"/>	<input type="checkbox"/>			
21	Pediatric interventional cardiac catheterization	<input type="checkbox"/>	<input type="checkbox"/>			
22	Adult cardiac surgery	<input type="checkbox"/>	<input type="checkbox"/>			
23	Pediatric cardiac surgery	<input type="checkbox"/>	<input type="checkbox"/>			
24	Cardiac rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>			
25	Case management	<input type="checkbox"/>	<input type="checkbox"/>			
26	Chaplain/pastoral care services	<input type="checkbox"/>	<input type="checkbox"/>			
27	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>			
28	Children wellness program	<input type="checkbox"/>	<input type="checkbox"/>			
29	Chiropractic services	<input type="checkbox"/>	<input type="checkbox"/>			
30	Community health reporting	<input type="checkbox"/>	<input type="checkbox"/>			
31	Community health status assessment	<input type="checkbox"/>	<input type="checkbox"/>			
32	Community health status based service planning	<input type="checkbox"/>	<input type="checkbox"/>			
33	Community outreach	<input type="checkbox"/>	<input type="checkbox"/>			
34	Complementary medicine	<input type="checkbox"/>	<input type="checkbox"/>			
35	Computer assisted orthopedic surgery (CAOS)	<input type="checkbox"/>	<input type="checkbox"/>			
36	Crisis prevention	<input type="checkbox"/>	<input type="checkbox"/>			
37	Dental services	<input type="checkbox"/>	<input type="checkbox"/>			
38	Emergency department	<input type="checkbox"/>	<input type="checkbox"/>			
39	Freestanding/Satellite emergency department	<input type="checkbox"/>	<input type="checkbox"/>			
40	Trauma center (certified)	<input type="checkbox"/>	<input type="checkbox"/>			
41	Enabling services	<input type="checkbox"/>	<input type="checkbox"/>			
42	Hospice program	<input type="checkbox"/>	<input type="checkbox"/>			
43	Pain management	<input type="checkbox"/>	<input type="checkbox"/>			
44	Palliative care program	<input type="checkbox"/>	<input type="checkbox"/>			
45	Inpatient Palliative care unit	<input type="checkbox"/>	<input type="checkbox"/>			
46	Endoscopic ultrasound	<input type="checkbox"/>	<input type="checkbox"/>			

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#	Services	Yes ☑	No ☑	Service Location (Unit, Floor, or Street Address)	Service Added Effective Date	Service Deleted Effective Date
47	Ablation of Barrett's esophagus	<input type="checkbox"/>	<input type="checkbox"/>			
48	Esophageal impedance study	<input type="checkbox"/>	<input type="checkbox"/>			
49	Endoscopic retrograde	<input type="checkbox"/>	<input type="checkbox"/>			
50	Enrollment assistance services	<input type="checkbox"/>	<input type="checkbox"/>			
51	Extracorporeal shock wave lithotripter (ESWL)	<input type="checkbox"/>	<input type="checkbox"/>			
52	Fitness center	<input type="checkbox"/>	<input type="checkbox"/>			
53	Freestanding outpatient care center	<input type="checkbox"/>	<input type="checkbox"/>			
54	Geriatric services	<input type="checkbox"/>	<input type="checkbox"/>			
55	Health fair	<input type="checkbox"/>	<input type="checkbox"/>			
56	Community health education	<input type="checkbox"/>	<input type="checkbox"/>			
57	Health screenings	<input type="checkbox"/>	<input type="checkbox"/>			
58	Health research	<input type="checkbox"/>	<input type="checkbox"/>			
59	Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>			
60	HIV-AIDS services	<input type="checkbox"/>	<input type="checkbox"/>			
61	Home health services	<input type="checkbox"/>	<input type="checkbox"/>			
62	Hospital-based outpatient care center services	<input type="checkbox"/>	<input type="checkbox"/>			
63	Immunization program	<input type="checkbox"/>	<input type="checkbox"/>			
64	Indigent care clinic	<input type="checkbox"/>	<input type="checkbox"/>			
65	Intermediate nursing care	<input type="checkbox"/>	<input type="checkbox"/>			
66	Linguistic/translation services	<input type="checkbox"/>	<input type="checkbox"/>			
67	Meals on Wheels	<input type="checkbox"/>	<input type="checkbox"/>			
68	Medical surgical intensive care services	<input type="checkbox"/>	<input type="checkbox"/>			
69	Mobile health services	<input type="checkbox"/>	<input type="checkbox"/>			
70	Neonatal intensive care	<input type="checkbox"/>	<input type="checkbox"/>			
71	Neonatal immediate care	<input type="checkbox"/>	<input type="checkbox"/>			
72	Neurosurgical services	<input type="checkbox"/>	<input type="checkbox"/>			
73	Nutrition programs	<input type="checkbox"/>	<input type="checkbox"/>			
74	Obstetrics services	<input type="checkbox"/>	<input type="checkbox"/>			
75	Occupational health services	<input type="checkbox"/>	<input type="checkbox"/>			
76	Oncology services	<input type="checkbox"/>	<input type="checkbox"/>			
77	Orthopedic services	<input type="checkbox"/>	<input type="checkbox"/>			
78	Other special care	<input type="checkbox"/>	<input type="checkbox"/>			
79	Outpatient surgery	<input type="checkbox"/>	<input type="checkbox"/>			
80	Patient Controlled Analgesia (PCA)	<input type="checkbox"/>	<input type="checkbox"/>			
81	Patient education center	<input type="checkbox"/>	<input type="checkbox"/>			
82	Patient representative services	<input type="checkbox"/>	<input type="checkbox"/>			
83	Pediatric intensive care services	<input type="checkbox"/>	<input type="checkbox"/>			
84	Pediatric medical-surgical care	<input type="checkbox"/>	<input type="checkbox"/>			
85	Physical rehabilitation inpatient services	<input type="checkbox"/>	<input type="checkbox"/>			
86	Physical rehabilitation outpatient services	<input type="checkbox"/>	<input type="checkbox"/>			
87	Primary care department	<input type="checkbox"/>	<input type="checkbox"/>			
88	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>			
89	Psychiatric-child adolescent services	<input type="checkbox"/>	<input type="checkbox"/>			
90	Psychiatric consultation-liaison services	<input type="checkbox"/>	<input type="checkbox"/>			
91	Psychiatric education services	<input type="checkbox"/>	<input type="checkbox"/>			
92	Psychiatric emergency services	<input type="checkbox"/>	<input type="checkbox"/>			
93	Psychiatric geriatric services	<input type="checkbox"/>	<input type="checkbox"/>			
94	Psychiatric outpatient services	<input type="checkbox"/>	<input type="checkbox"/>			
95	Psychiatric partial hospitalization services	<input type="checkbox"/>	<input type="checkbox"/>			
96	CT Scanner	<input type="checkbox"/>	<input type="checkbox"/>			
97	Diagnostic radioisotope facility	<input type="checkbox"/>	<input type="checkbox"/>			
98	Electron beam computed tomography (EBCT)	<input type="checkbox"/>	<input type="checkbox"/>			
99	Full-field digital mammography (FFDM)	<input type="checkbox"/>	<input type="checkbox"/>			
100	Magnetic resonance imaging (MRI)	<input type="checkbox"/>	<input type="checkbox"/>			
101	Intraoperative magnetic resonance imaging	<input type="checkbox"/>	<input type="checkbox"/>			
102	Multi-slice spiral computed tomography (MSCT)(<64 slice CT)	<input type="checkbox"/>	<input type="checkbox"/>			
103	Multi-slice spiral computed tomography (MSCT)(64+ slice CT)	<input type="checkbox"/>	<input type="checkbox"/>			

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#	Services	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/>	Service Location (Unit, Floor, or Street Address)	Service Added Effective Date	Service Deleted Effective Date
104	Positron Emission Tomography (PET)	<input type="checkbox"/>	<input type="checkbox"/>			
105	Positron Emission Tomography/CT (PET/CT)	<input type="checkbox"/>	<input type="checkbox"/>			
106	Single Photon Emission Computerized Tomography (SPECT)	<input type="checkbox"/>	<input type="checkbox"/>			
107	Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>			
108	Image-guided radiation therapy (IGRT)	<input type="checkbox"/>	<input type="checkbox"/>			
109	Intensity-Modulated Radiation Therapy (IMRT)	<input type="checkbox"/>	<input type="checkbox"/>			
110	Proton Therapy	<input type="checkbox"/>	<input type="checkbox"/>			
111	Shaped beam radiation system	<input type="checkbox"/>	<input type="checkbox"/>			
112	Stereotactic radiosurgery	<input type="checkbox"/>	<input type="checkbox"/>			
113	Fertility clinic	<input type="checkbox"/>	<input type="checkbox"/>			
114	Genetic testing/counseling	<input type="checkbox"/>	<input type="checkbox"/>			
115	Retirement housing	<input type="checkbox"/>	<input type="checkbox"/>			
116	Robotic surgery	<input type="checkbox"/>	<input type="checkbox"/>			
117	Skilled nursing	<input type="checkbox"/>	<input type="checkbox"/>			
118	Sleep center	<input type="checkbox"/>	<input type="checkbox"/>			
119	Social work services	<input type="checkbox"/>	<input type="checkbox"/>			
120	Sports medicine	<input type="checkbox"/>	<input type="checkbox"/>			
121	Support groups	<input type="checkbox"/>	<input type="checkbox"/>			
122	Swing bed services	<input type="checkbox"/>	<input type="checkbox"/>			
123	Teen outreach services	<input type="checkbox"/>	<input type="checkbox"/>			
124	Tobacco treatment/cessation program	<input type="checkbox"/>	<input type="checkbox"/>			
125	Bone marrow transplant	<input type="checkbox"/>	<input type="checkbox"/>			
126	Heart transplant	<input type="checkbox"/>	<input type="checkbox"/>			
127	Kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>			
128	Liver transplant	<input type="checkbox"/>	<input type="checkbox"/>			
129	Lung transplant	<input type="checkbox"/>	<input type="checkbox"/>			
130	Tissue transplant	<input type="checkbox"/>	<input type="checkbox"/>			
131	Other transplant	<input type="checkbox"/>	<input type="checkbox"/>			
132	Transportation to health services	<input type="checkbox"/>	<input type="checkbox"/>			
133	Urgent care center	<input type="checkbox"/>	<input type="checkbox"/>			
134	Virtual colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>			
135	Volunteer services department	<input type="checkbox"/>	<input type="checkbox"/>			
136	Women's health center/services	<input type="checkbox"/>	<input type="checkbox"/>			
137	Wound management services	<input type="checkbox"/>	<input type="checkbox"/>			

**SECTION C: STATISTICAL INFORMATION**

**All statistics reported in this section must cover the most recent twelve (12) month reporting period used by the facility unless otherwise stated. Please indicate the reporting period used:**

Calendar year: 200\_\_\_                       Fiscal year ending \_\_\_\_\_

1. Total Admissions:	8. Total Deaths:
2. Total Inpatient days:	9. Mortality Rate:
3. Occupancy Rate (%):	10. Total Autopsies:
4. Average Length of Stay (ALOS):	11. Autopsy Rate (%):
5. Total Outpatient Visits:	12. Total Surgical cases:
6. Total Emergency Department (ED) Visits:	13. Unexpected returns to surgery within 48 hours (%):
7. ED Return Visits within 48 hours:	

14. **Infection Control:** For the focused surveillance areas listed below, list the nosocomial infection rates for the past 24 months stating the low rate, high rate, average rate, and rate denominator. If these areas are non-applicable for your facility, please indicate N/A. **List any additional areas of focused surveillance done during the past 24 months with corresponding rates.**

<u>Area of Focused Surveillance:</u>	Low	High	Avg	Rate Denominator
<b>Bloodstream Infections</b>				
<b>Central Line Infections</b>				
<b>Ventilator Associated Pneumonia Infections</b>				
<b>Surgical Site Infections – Class I surgery</b>				
<b>Surgical Site Infections – Class II surgery</b>				
<b>MRSA Infections</b>				
<b>VRE Infections</b>				

**SECTION D: DRG INFORMATION**

Please list the top 15 DRGs for your facility for **each of the past two (2) years**. Indicate calendar or fiscal year.

<b>Most recent 12-month period:</b> <input type="checkbox"/> calendar year 200__ <input type="checkbox"/> fiscal year ending _____				
	DRG #	Description	Volume (patient days)	ALOS (days)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
<b>Previous 12-month period:</b> <input type="checkbox"/> calendar year 200__ <input type="checkbox"/> fiscal year ending _____				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

**SECTION E: MEDICAL & PROFESSIONAL STAFF INFORMATION**

**Composition of Medical Staff:** Indicate the current number of medical staff members for each category.

	Certified		Active	Associate	Adjunct	Honorary
DO						
MD						
DPM						
DDS						
Other						

**Composition of Nursing Staff:** Indicate the current numbers of the nursing staff for each category.

	Total FTEs		Total FTEs
Chief Nursing Officer		RNs	
Supervisors / Managers		LPNs / LVNs	
Clinical Specialists		Nursing Assistant / Aides	
CRNAs		Mental Health Techs	
Nurse Practitioners			

**Composition of Allied Health Staff:** Indicate the current numbers of staff for each category.

	Total FTEs		Total FTEs
Audiologist		Psychologists	
Certified Coding Specialist (CCS)		Radiological Technologists	
Dieticians		Registered Health Information Administrator (RHIA)	
Licensed Social Workers		Registered Health Information Technician (RHIT)	
Nuclear Medicine Technologists		Respiratory Therapists	
Occupational Therapists		Speech Therapists	
Pharmacists		Other:	
Physician Assistants		Other:	
Physical Therapists		Other:	

**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. \_\_\_\_\_

**SECTION F: CONTACT INFORMATION**

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**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

## SECTION G: FACILITY OFF-SITE LOCATIONS

If this facility (Hospital Name) owns, operates, or is affiliated with off-site facilities at which healthcare services are rendered, and which **provide and bill for services under the hospital Medicare Provider number**, complete this sheet for **each** off-site location / entity.

### IMPORTANT!

**All departments or off-site facilities which provide services under the hospital medicare provider number must be surveyed as a department of the hospital under the hospital accreditation standards and must be identified to the HFAP.**

**Facilities providing services under a separate provider number, or which bill for services under a physician billing number may be surveyed and accredited, but as a separate entity. Call HFAP offices regarding appropriate applications and standards for these facilities.**

Duplicate this sheet, as needed, utilizing **one off-site facility per page**. Examples of off-site locations would be ambulatory care centers, surgical centers, sleep clinics, primary care and specialty care physician offices. Number any additional sheets used as G-2, G-3, G-4, etc.

\_\_\_\_\_  
Name of Off-Site Facility (as it should appear on accreditation certificate)

\_\_\_\_\_  
Address, City, State, Zip

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

Type of service provided at this site (Check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Ambulatory Care (includes primary care physician offices)               | <input type="checkbox"/> Psychological Counseling          |
| <input type="checkbox"/> Ambulatory Surgery<br>(sedation / anesthesia administered at this site) | <input type="checkbox"/> Physical Rehabilitation           |
| <input type="checkbox"/> Diagnostic Center (MRI, etc.)   | <input type="checkbox"/> Sub Acute Care                    |
| <input type="checkbox"/> Hospice   | <input type="checkbox"/> Substance Abuse                   |
| <input type="checkbox"/> Long Term Care  | <input type="checkbox"/> Opioid Treatment                  |
| <input type="checkbox"/> Mental Health   | <input type="checkbox"/> Urgent / Immediate / Walk-in Care |
|  | <input type="checkbox"/> Other _____                       |

Total Patient Visits for the most recent 12 month reporting period: \_\_\_\_\_

\_\_\_\_\_  
Name of Contact Individual for this site

\_\_\_\_\_  
Title

This site or portion thereof is accredited by the following organizations (check all that apply):

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> AAAASF      | <input type="checkbox"/> AABB           |
| <input type="checkbox"/> AAAHC       | <input type="checkbox"/> ASHI           |
| <input type="checkbox"/> CARF        | <input type="checkbox"/> CAP            |
| <input type="checkbox"/> CHAP        | <input type="checkbox"/> COLA           |
| <input type="checkbox"/> HFAP        | <input type="checkbox"/> JCAHO          |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Not accredited |

**SECTION H: LABORATORY INFORMATION**

All areas within the facility that provide moderate or high complexity laboratory testing for patients must be surveyed under the Clinical Laboratory Improvement Amendments (CLIA). This may be accomplished through an accreditation organization deemed by the Centers for Medicare & Medicaid Services (CMS). CLIA mandates that all laboratories be inspected on a two (2) year cycle.

The main laboratory is accredited by the following agency(ies) (check all that apply):

- |                                       |                               |                                |
|---------------------------------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> HFAP         | <input type="checkbox"/> CAP  | <input type="checkbox"/> COLA  |
| <input type="checkbox"/> ASHI         | <input type="checkbox"/> AABB | <input type="checkbox"/> JCAHO |
| <input type="checkbox"/> State agency |                               |                                |

The laboratory is not currently accredited by HFAP and wishes to seek accreditation by the HFAP Laboratory Accreditation Program.     Yes    No

Laboratory CLIA Number: \_\_\_\_\_

Test Complexity Level (check one):     Moderate     High

\_\_\_\_\_  
 Legal Name of Laboratory

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City, State, Zip

\_\_\_\_\_  
 Telephone

\_\_\_\_\_  
 Fax

\_\_\_\_\_  
 Name of Laboratory Director as is appears on CLIA certificate

\_\_\_\_\_  
 Name of Laboratory Manager or Contact Person

\_\_\_\_\_  
 Preferred Title

\_\_\_\_\_  
 Manager / Contact Telephone

\_\_\_\_\_  
 Email

**Is laboratory testing performed in any other areas of the facility (i.e., Respiratory Therapy, ER, Nursing, POC, etc.)?**     No     Yes – Complete the following table.

*All testing, even testing that is categorized as waived, must be performed under a CLIA number, either the CLIA number of the main laboratory or under a separate CLIA number for the area performing the testing.*

Testing Department / Location (i.e. ICU, ER, Nursing, Resp.)	CLIA Number	Test Complexity (waived, moderate, high)	Accreditation Agency (List all that apply)

**Attach copies of all CLIA certificates and accreditation certificates for all laboratory testing locations within the facility. For each CLIA number, list all Specialty / Subspecialty areas that the laboratory is accredited to perform.**

## SECTION I: CRITICAL ACCESS HOSPITAL ELIGIBILITY

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### **Critical Access Hospitals Located in Frontier or Remote Areas:**

The HFAP recognizes the limited resources that may be available to Critical Access Hospitals in frontier or remote areas. For this reason, these facilities should thoroughly review the eligibility criteria and HFAP Accreditation Requirements for Critical Access Hospitals before completion of this application.

### **Important Information for Critical Access Hospitals:**

Any facility designated as a Critical Access Hospital by the State in which it is located shall meet all State and local licensing requirements in addition to the Medicare Conditions of Participation (CoP) for Critical Access Hospitals as found in 42 CFR Part 485, Subpart F (see below). HFAP standards reflecting these Medicare requirements are incorporated throughout the HFAP Accreditation Requirements for Critical Access Hospitals manual (January 2008 edition.)

### **Subpart F—Conditions of Participation: Critical Access Hospitals (CAHs)**

- § 485.601 Basis and scope.
- § 485.602 Definitions.
- § 485.603 Rural health network.
- § 485.604 Personnel qualifications.
- § 485.606 Designation and certification of CAHs.
- § 485.608 Condition of participation: Compliance with Federal, State, and local laws and regulations.
- § 485.610 Condition of participation: Status and location.
- § 485.612 Condition of participation: Compliance with hospital requirements at the time of application.
- § 485.616 Condition of participation: Agreements.
- § 485.618 Condition of participation: Emergency services.
- § 485.620 Condition of participation: Number of beds and length of stay.
- § 485.623 Condition of participation: Physical plant and environment.
- § 485.627 Condition of participation: Organizational structure.
- § 485.631 Condition of participation: Staffing and staff responsibilities.
- § 485.635 Condition of participation: Provision of services.
- § 485.638 Conditions of participation: Clinical records.
- § 485.639 Condition of participation: Surgical services.
- § 485.641 Condition of participation: Periodic evaluation and quality assurance review.
- § 485.643 Condition of participation: Organ, tissue, and eye procurement.
- § 485.645 Special requirements for CAH providers of long-term care services (“swing-beds”)
- § 485.647 Condition of participation: psychiatric and rehabilitation distinct part units.

Healthcare Facilities Accreditation Program (HFAP)  
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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*)

**HEALTHCARE FACILITIES ACCREDITATION PROGRAM  
BUSINESS ASSOCIATE AGREEMENT**

**WHEREAS**, the American Osteopathic Association’s Healthcare Facilities Accreditation Program (“HFAP”) provides certain accreditation and related services to healthcare facilities (HFAP’s work shall be referred to hereafter in this Agreement as “Accreditation Services”); and

**WHEREAS**, \_\_\_\_\_ (“Surveyed Organization”) has entered into an agreement with HFAP, pursuant to which HFAP will provide Accreditation Services to Surveyed Organization and, in connection therewith, Surveyed Organization may from time-to-time disclose to HFAP certain Protected Health Information (“PHI,”) (as defined in 45 C.F.R. §164.501) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”); and

**WHEREAS**, Surveyed Organization is a “Covered Entity” as that term is defined in the HIPAA implementing regulations – 45 C.F.R. Parts **142**, 160 and Part 164, Subparts A and E, the Standards for Privacy of Individually Identifiable Health Information (“Privacy Rule”);

**WHEREAS**, HFAP, as a recipient of PHI from Surveyed Organization, is a “Business Associate” as that term is defined in the Privacy Rule;

**WHEREAS**, pursuant to the Privacy Rule, all Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI; and

**WHEREAS**, the purpose of this Business Associate Agreement (“Agreement”) is to comply with the requirements of HIPAA and the Privacy Rule, including, but not limited to, the Business Associate contract requirements at 45 C.F.R. §164.504(e);

**NOW, THEREFORE**, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. Definitions. Unless otherwise provided in this Agreement, capitalized terms have the same meanings as set forth in the Privacy Rule.
  - 1.1 **Definitions. Except as otherwise provided capitalized terms shall have the same meaning as set forth in the HIPAA regulations, 45 CFR parts 142 and 160-164.**
2. Scope of Use and Disclosure by HFAP of Protected Health Information
  - A. HFAP shall be permitted to use and disclose PHI that is disclosed to it by Surveyed Organization as necessary for HFAP to provide Accreditation Services;
  - B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Agreement or required by law, HFAP may:
    - (a) use the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of HFAP;

(b) disclose the PHI in its possession to a third party for the purpose of HFAP's proper management and administration or to fulfill any legal responsibilities of HFAP; provided, however, that the disclosures are required by law or HFAP has received from the third party written assurances that (i) the information will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the third party; and (ii) the third party will notify the HFAP of any instances of which it becomes aware in which the confidentiality of the information has been breached; and

(c) de-identify any and all PHI created or received by HFAP under this Agreement; provided, that the de-identification conforms to the requirements of the Privacy Rule.

**2.1 Safeguards for Protection of EPHI. Business Associate agrees that it will:**

**2.1.1 Use administrative, physical and technical safeguards to protect the security of  
of  
Surveyed Organization;**

**2.1.2 Require its agents and/or subcontractors to provide the same administrative, physical and technical safeguards to protect the security of Surveyed Organization;**

**2.1.3 Report any Security Incidents to Surveyed Organization designated security official not later than five (5) business days of becoming aware of the same; and**

**2.1.4 Allow for governmental access to its records.**

**3. Obligations of HFAP. In connection with its use and disclosure of PHI, HFAP agrees that it will:**

**A. Use or further disclose PHI only as permitted or required by this Agreement or as required by law.**

**B. Use reasonable and appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement;**

**C. To the extent practicable, mitigate any harmful effect that is known to HFAP of a use or disclosure of PHI by HFAP in violation of this Agreement.**

**D. Report to Surveyed Organization any use or disclosure of PHI not provided for by this Agreement of which HFAP becomes aware.**

Healthcare Facilities Accreditation Program (HFAP)  
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- E. Require contractors or agents to whom HFAP provides PHI to agree to the same restrictions and conditions that apply to HFAP pursuant to this Agreement and the Privacy Rule.
  - F. Make available to the Secretary of Health and Human Services HFAP's internal practices, books and records relating to the use of disclosure of PHI for purposes of determining Surveyed Organization's compliance with the Privacy Rule, subject to any applicable legal privileges.
  - G. Within (15) days of receiving a request from Surveyed Organization, make available the information necessary for Surveyed Organization to make an accounting of disclosures of PHI about an Individual.
  - H. Within ten (10) days of receiving a written request from Surveyed Organization, make available PHI necessary for Surveyed Organization to respond to Individuals' requests for access to PHI about them in the event that the PHI in HFAP's possession constitutes a Designated Record Set.
  - I. Within fifteen (15) days of receiving a written request from Surveyed Organization incorporate any amendments or corrections to the PHI in accordance with the Privacy Rule in the event that the PHI in HFAP's possession constitutes a Designated Record Set.
4. Obligations of Surveyed Organization. Surveyed Organization agrees that it:
- A. Has included, and will include, in Surveyed Organization's Notice of Privacy Practices required by the Privacy Rule that Surveyed Organization may disclose PHI for health care operations purposes.
  - B. Has obtained, and will obtain, from Individuals consents, authorizations and other permissions necessary or required by laws applicable to Surveyed Organization for HFAP to provide Accreditation Services and for HFAP and Surveyed Organization to fulfill their obligations under this Agreement.
  - C. Will promptly notify HFAP in writing of any restrictions on the use and disclosure of PHI about Individuals that Surveyed Organization has agreed to that may affect HFAP's ability to perform its obligations in providing Accreditation Services and/or its obligations under this Agreement.
  - D. Will promptly notify HFAP in writing of any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes or revocation may affect HFAP's ability to perform its obligations in providing Accreditation Services and/or its obligations under this Agreement.
5. Termination.
- A. Termination for Breach. Surveyed Organization may terminate this Agreement if Surveyed Organization determines that HFAP has breached a material term of this

Agreement. Alternatively, Surveyed Organization may choose to provide HFAP with notice of the existence of an alleged material breach and afford HFAP an opportunity to cure the alleged material breach. In the event that HFAP fails to cure the breach to the satisfaction of Surveyed Organization, Surveyed Organization may immediately thereafter terminate this Agreement.

- B. Automatic Termination. This Agreement will automatically terminate upon the termination or expiration of the agreement pursuant to which HFAP provides Surveyed Organization with Accreditation Services.
- C. Effect of Termination.
- (a) Termination of this Agreement will result in termination of the underlying agreement pursuant to which HFAP provides Surveyed Organization with Accreditation Services.
  - (b) Upon termination of this Agreement or termination of the underlying agreement pursuant to which HFAP provides Surveyed Organization with Accreditation Services, HFAP will return or destroy all PHI received from Surveyed Organization or created or received by HFAP on behalf of Surveyed Organization that HFAP still maintains and retain no copies of such PHI; provided that if such return or destruction is not feasible, HFAP will extend the protections of this Agreement to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
6. Amendment. This Agreement constitutes the entire agreement between the parties hereto with respect to PHI and the Privacy Rule and supersedes any earlier agreements or understandings between the parties, regardless of whether oral or written. This Agreement may not be modified or amended, except by means of a writing duly signed by the authorized representative(s) of each party. However, notwithstanding the foregoing, HFAP and Surveyed Organization agree to take such action as is necessary to amend this Agreement from time to time as is necessary to comply with the requirements of HIPAA and the Privacy Rule.
7. Survival. The obligations of HFAP under Section 5.C.(b) of this Agreement shall survive any termination of this Agreement or the underlying agreement pursuant to which HFAP provides Surveyed Organization with Accreditation Services.
8. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
9. Effective Date. This Agreement shall be effective on \_\_\_\_\_

Healthcare Facilities Accreditation Program (HFAP)  
Accreditation Application /Reapplication for Critical Access Hospitals

**Surveyed Organization**

**HFAP**

**By:** \_\_\_\_\_

**By:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Name:** George A. Reuther

**Title:** \_\_\_\_\_

**Title:** Chief Operating Officer  
Healthcare Facilities Accreditation Program

**Date:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**ADDENDUM TO BUSINESS ASSOCIATE AGREEMENT FOR  
HEALTHCARE FACILITIES ACCREDITATION PROGRAM**

Business Associate Agreement

Addendum to Agreements with Healthcare Facilities Accreditation Program.

**THIS ADDENDUM** supplements and is made a part of the business associate agreement between

\_\_\_\_\_ (“Surveyed Organization”) and the Healthcare Facilities Accreditation Program (HFAP) and all other current and future agreements between them that involve the use and/or disclosure of any Protected Health Information (as defined below). Each such agreement may be referred to here in as an “Underlying Agreement”.

**WHEREAS**, HFAP and the Surveyed Organization are parties to one or more underlying agreements pursuant to which HFAP provides accreditation services to the Surveyed Organization and in connection with the provisions of those services, the Surveyed Organization may disclose to HFAP certain Protected Health Information (“PHI” as defined in 45 CFR. Part 164.501) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and may allow HFAP to use and further disclose such PHI;

**WHEREAS**, the Surveyed Organization is a "Covered Entity" as that term is defined in the implementing regulations of the Health Insurance Portability and Accountability Act ("HIPAA"), 45 CFR Part 160 and Part 164, Subparts A and E, the Standards for Privacy of C, the Security Standards for the Protection of Electronic Protected Health Information (“Security Rule”),

**WHEREAS**, HFAP, to the extent that it is a recipient of PHI from the Surveyed Organization, is a "Business Associate" as that term is defined in the Privacy Rule;

**WHEREAS**, pursuant to the Privacy Rule and the Security Rule, all Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI;

**WHEREAS**, the purpose of this Addendum is to comply with the requirements of the Privacy Rule, and the Security Rule, including, but not limited to, the Business Associate contract requirements at 45 CFR Parts 164.314(a), 164.502(e), 164.504(e), and as may be amended; and

**WHEREAS**, this Addendum is also intended to satisfy the HITECH BA Provisions (as defined in Section 3 below).

**NOW, THEREFORE**, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions.** Unless otherwise provided in this Addendum, capitalized terms had the same meaning as set forth in the HIPAA, the Privacy Rule, the Security Rule or the HITECH BA Provisions.
2. **Scope of Use and Disclosure by HFAP of Protected Health Information.**

- A. HFAP shall be permitted to Use and Disclose PHI that is disclosed to it by the Surveyed Organization as necessary to perform its obligations under the Underlying Agreement.
- B. Unless otherwise, limited herein, in addition to any other Uses and/or Disclosures permitted or authorized by this Addendum or Required by Law, HFAP may:
  - (1) Make use of the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of HFAP;
  - (2) Disclose the PHI in its possession to a third party for the purpose of HFAP's proper management and administration or to fulfill any legal responsibilities of HFAP; provided, however, that the Disclosures are Required by Law or HFAP has received from the third party written assurances that (i) the information will be held confidentially and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the third party; and (ii) the third party will notify the HFAP of any instances in which it becomes aware in which the confidentiality of the information has been breached;
  - (3) Aggregate the PHI in its possession with the PHI of other covered entities that HFAP has in its possession or through its capacity as a business associate to other covered entities provided the purpose of such aggregation is to provide the Surveyed Organization with data analysis relating to the Health Care Operations of the Surveyed Organization. Under no circumstances may HFAP disclose PHI of one Surveyed Organization to another covered entity absent the explicit authorization of the Surveyed Organization. Except as otherwise limited in this Addendum, HFAP may use the PHI to provide Data Aggregation services to the Surveyed Organization as permitted by 45 CFR 164.504(e)(2)(i)(B).
  - (4) De-identify any and all PHI created or received by HFAP under this Addendum; provided, that the de-identification conforms to the requirements of the Privacy Rule.

3. **Obligations of HFAP.** In connection with its Use and Disclosure of PHI, HFAP agrees that it will:

- A. Use or further Disclose PHI only as permitted or required by this Addendum or as Required by Law.
- B. Use reasonable and appropriate safeguards to prevent Use or Disclosure of the PHI other than as provided for by this Addendum.
- C. To the extent practicable, mitigate any harmful effect is known to HFAP of the Use Disclosure of PHI by HFAP in violation of this Addendum.

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- D. Report to the Surveyed Organization any Use or Disclosure of PHI not provided for by this Addendum of which HFAP becomes aware.
- E. Require contractors or agents to whom HFAP provides PHI to agree to the same restrictions and conditions that apply to HFAP pursuant to this Addendum.
- F. Make available to the Secretary of HHS HFAP's internal practices, books and records relating to the Use and Disclosure of PHI for purposes of determining the Surveyed Organizations compliance with the Privacy Rule, subject to any applicable legal privileges.
- G. Within fifteen (15) days of receiving a request from the Surveyed Organization, make available the information necessary for the Surveyed Organization to make an accounting of Disclosures of PHI about an Individual.
- H. Within ten (10) days of receiving a written request from the Surveyed Organization, make available PHI necessary for the Surveyed Organization to respond to Individuals' requests for access to PHI about them in the event that the PHI in HFAP's possession constitutes a Designated Record Set.
- I. Within fifteen (15) days of receiving a request from the Surveyed Organization incorporate any amendments or corrections to the PHI in accordance with the Privacy Rule in the event that the PHI in HFAP's possession constitutes a Designated Record Set.
- J. Implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Surveyed Organization, and make its policies and procedures, and documentation required by the Security Rule relating to such safeguards, available to the Secretary of HHS for purposes of determining the Surveyed Organization's compliance with the Security Rule;
- K. Insure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate safeguards to protect that Electronic PHI; and
- L. Promptly report to the Surveyed Organization any security incident with respect to Electronic PHI of which he becomes aware; provided, however, that unless specifically requested by the Surveyed Organization, HFAP shall not be obligated to report unsuccessful attempts to penetrate computer networks or servers that do not result in loss of data or degradation of computer networks or servers.

The Health Information Technology for Economic and Clinical Health Act ("HITECH") was adapted as part of the American Recovery and Reinvestment Act of 2009. HITECH imposes certain requirements on Business Associates with respect to privacy, security and breach notification and contemplates that such requirements shall be implemented by regulations to be adopted by the Department of Health and Human Services. Such provisions of HITECH and the

final regulations adopted thereunder applicable to Business Associates may be referred to collectively herein as the "HITECH BA Provisions". The HITECH BA Provisions shall apply commencing on February 17, 2010 or such other date as may be specified in such law or regulations (the "Applicable Effective Date").

HFAP hereby acknowledges and agrees that HFAP shall be subject to each of the HITECH BA Provisions with respect to HFAP's role as a Business Associate of the Surveyed Organization commencing on the Applicable Effective Date of such provision. HFAP and the Surveyed Organization each further agree that the provisions of HITECH that apply to Business Associates that are required to be incorporated by reference in a business associate agreement are hereby incorporated into this Addendum as of the Applicable Effective Dates.

4. **Obligations of the Surveyed Organization.** The Surveyed Organization agrees that it:
- A. Has included, and will include, in the Surveyed Organizations Notice of Privacy Practices required by the Privacy Rule that the Surveyed Organization may disclose PHI for Healthcare Operations purposes.
  - B. Has obtained, and will obtain, from Individuals consents, authorizations and other permissions necessary or required by laws applicable to the Surveyed Organization for HFAP and the Surveyed Organization to fulfill their obligations under the Underlying Agreement and this Addendum.
  - C. Will promptly notify HFAP in writing of any restrictions on the Use and Disclosure of PHI about Individuals that the Surveyed Organization has agreed to that may affect HFAP's ability to perform its obligations under the Underlying Agreement or this addendum
  - D. Will promptly notify HFAP in writing of any change in, or revocation of, permission by an Individual to Use or Disclose PHI, if such a change or revocation may affect HFAP's ability to perform its obligations under the Underlying Agreement or this Addendum.

5. **Termination.**

- A. **Termination for Breach.** The Surveyed Organization and HFAP may each terminate this Addendum, in whole or in part, by giving written notice as described below if either of them (the "Terminating Party") determines that the other party (the "Non-Terminating Party") has breached a material term of this Addendum. Alternatively, the Terminating Party may choose to provide the Non-Terminating Party with notice of the existence of an alleged material breach and provide the Non-Terminating Party an opportunity to cure the alleged material breach within a specified period.

If no cure was provided or if the Non-Terminating Party fails to cure the breach to the satisfaction of the Terminating Party within the cure period provided, the Terminating Party may immediately thereafter terminate this Addendum with respect to, in its discretion, all Underlying Agreements or

the Underlying Agreement with respect to which the breach occurred. Such termination shall be effective as of the date specified in a written notice given by the Terminating Party to the Non-Terminating Party (the "Termination Notice"). The Termination Notice shall be given as required in the Underlying Agreement or by nationally recognized overnight courier, receipt requested, if no means of notice is set forth in the Underlying Agreement. The Termination Notice shall specify the extent of termination of this Addendum and which related Underlying Agreement(s) are terminated.

B. Automatic Termination. This Addendum will automatically terminate upon the termination or expiration of the Underlying Agreement but only with respect to the PHI that was Used or Disclosed pursuant to the Underlying Agreement that has expired or terminated.

C. Effect of Termination.

- (1) If this Addendum is completely terminated, it will result in the termination of all Underlying Agreement(s) pursuant to which PHI was disclosed subject to this Addendum. If this Addendum is terminated only in part, than only the Underlying Agreements related to the terminated portion of this Addendum shall be terminated.
- (2) Upon termination of this Addendum or the Underlying Agreement(s), to the extent that HFAP then retains any PHI, HFAP will return or destroy all PHI received from the Surveyed Organization or created or received by HFAP on behalf of the Surveyed Organization with respect to the portion of this Addendum and the Underlying Agreement(s) being terminated and HFAP will retain no copies of such PHI; provided that if such return or destruction is not feasible, HFAP will extend the protections of this Addendum to such PHI and limit further Uses and Disclosures to those purposes make the return or destruction of the information infeasible.

6. **Amendment.**

- A. HFAP and the Surveyed Organization agree to take such action as is necessary to amend this Addendum from time to time as is necessary for the Surveyed Organization and/or HFAP to comply with requirements of HIPAA, the Privacy Rule, the Security Rule and the HITECH BA Provisions as currently in effect and as they may be amended from time to time in the future, including any interpretations thereof under federal law (each a "Change in Law").
- B. To the extent necessary to amend this Addendum to include specific language to enable the Surveyed Organization and/or HFAP to comply with any Change in

Law, such language shall automatically be deemed incorporated by reference and included in this Addendum as of the date required by such Change in Law.

- C. Notwithstanding Sections 6.A and 6.B above, if a party to this Addendum (and "Objecting Party") deems compliance with any Change in Law to be impractical or likely to materially increase its costs, risks or obligations under this Addendum or any of the Underlying Agreements, the Objecting Party may give written notice to the other party describing its concerns. Upon receipt of such notice, the parties shall negotiate in good faith to develop an amendment to address the concerns of the Objecting Party. If such amendment is not executed within thirty (30) days of such notice, the Objecting Party may terminate this Addendum by written notice to other party and shall not have any obligation hereunder for early termination.
7. **Survival.** The obligations of HFAP under Section 5.C. (2) of this Addendum shall survive any termination of this Addendum.
8. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, or obligations or liabilities whatsoever.
9. **Effective Date.** This Addendum shall be effective as of the earlier of April 21, 2005 the effective date of the earliest Underlying Agreement; provided, however, that the HITECH BA Provisions shall each be effective as of their respective Applicable Effective Date.
10. **Independent Contractor.** Unless and to the extent otherwise provided in an underlying agreement, HFAP is an independent contractor and not an agent of the Accredited Facility.

**Surveyed Organization:  
Program:**

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**Healthcare Facilities Accreditation**

By: \_\_\_\_\_

Title: Chief Operating Officer

Date: \_\_\_\_\_