



*A Program of the American Osteopathic Association*

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## **Application / Reapplication for Accreditation For Critical Access Hospitals**

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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.

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

*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 ½ 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. *Restraint Policy & Procedure*
8. *Patient Rights Documents*
9. *Organization Chart*
10. *Facility State License*
11. *Completed 855 Form (NEW FACILITIES)*
12. *All CLIA certificates*
13. *All Laboratory Accreditation Certificates & Specialty / Subspecialty Information*
14. *Copy of State Letter indicating CAH designation*
15. *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 .*
16. *If you have multiple sites that will be surveyed, please provide:*
17. *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***

**SECTION A: FACILITY INFORMATION**

**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. \*\***

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

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		

**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

SAMPLE

## 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 checked="" type="checkbox"/>	No <input checked="" 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"/>			

#	Services	Yes ☑	No ☑	Service Location (Unit, Floor, or Street Address)	Service Added Effective Date	Service Deleted Effective Date
46	Endoscopic ultrasound	<input type="checkbox"/>	<input type="checkbox"/>			
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"/>			

#	Services	Yes ☑	No ☑	Service Location (Unit, Floor, or Street Address)	Service Added Effective Date	Service Deleted Effective Date
103	Multi-slice spiral computed tomography (MSCT)(64+ slice CT)	<input type="checkbox"/>	<input type="checkbox"/>			
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.**

<b>Area of Focused Surveillance:</b>	<b>Low</b>	<b>High</b>	<b>Avg</b>	<b>Rate Denominator</b>
<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.

Most recent 12-month period: <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				
Previous 12-month period: <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. \_\_\_/\_\_\_/\_\_\_

SAMPLE

SECTION F: 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

## 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.

## APPLICATION FOR ACCREDITATION SURVEY AGREEMENT

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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)*