HFAP
Healthcare Facilities Accreditation Program

A Program of the American Osteopathic Association

Application / Reapplication for Accreditation For Acute Care 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 Healthcare Facilities*, Section One, Eligibility for Accreditation and must submit this application in accordance with the application procedures listed under Section One, Accreditation Process.

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. For reapplications, applications are due nine (9) to twelve (12) months in advance of your expiration date. For questions regarding this process, please contact our offices at info@hfap.org or 312-202-8258.

Documents to be submitted with completed application -

1. *Governing Body Bylaws*
2. *Medical Staff Bylaws, Rules & Regulations, Credentialing Manual*
3. *Master Staffing Plan for Nursing*
4. *Plan for the Provision of Nursing Care*
5. *Facility Floor Plan (8 ½ x 11 size paper only)*
6. *Facility Demographic Report*
7. *Restraint Policy & Procedure*
8. *Patient Rights Documents*
9. *Copy of the latest Life Safety Code Inspection by local or state agency*
10. *Quality Assessment & Performance Improvement Plan*
11. *Organization Chart*
12. *Facility State License*
13. *Completed 855 Form (NEW FACILITIES)*
14. *All CLIA certificates*
15. *All Laboratory Accreditation Certificates & Specialty / Subspecialty Information*
16. *All accrediting agency(s) surveys (including CMS) for the past 3 years if applicable (including all pertinent letters, citations, and corrective action plans)*
17. *Additionally, please provide:*
    - *the name of the nearest major airport,*
    - *the names of three moderately priced motels/hotels in your vicinity, and*
    - *a map of your community showing the hospital location .*
18. *If you have multiple sites that will be surveyed, please provide 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:_____

Hospital Type:

___Acute Care Hospital **___Orthopedic Hospital** **___Psychiatric Hospital**

___Cardiovascular/Heart Hospital **___Rehabilitation Hospital** **___Long Term Acute Care**

___Women's/Obstetrical Hospital **___Other**

Total Number of Licensed Beds:	**Total Number of Beds Staffed:**	**Number of Bassinets:**

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

IMPORTANT!: Do not use unfamiliar abbreviations when indicating unit name and/or scope of service. See examples below.

UNIT	AVERAGE # OCCUPIED BEDS	UNIT	AVERAGE # OCCUPIED BEDS
i.e. *Medical – 4 West*	*14*		
i.e. *OB – 3 North*	*22*		
i.e. Bariatric Care Unit – 4 West	*5*		

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

- ☐ JCAHO
- ☐ CARF
- ☐ CHAP
- ☐ AAAHC
- ☐ AAAASF
- ☐ AABB
- ☐ ASHI
- ☐ CAP
- ☐ COLA
- ☐ Other_____

Does post-doctoral training occur within this facility? ☐ Yes ☐ No

If Yes, post-doctoral training is:

☐ Allopathic – Medical School Affiliation (if applicable):_____

☐ Osteopathic – Medical School Affiliation**:**_____

If osteopathic, Name of OPTI:_____

	Number of MDs	Number of DOs
Interns		
Residencies, MD or DO		
i.e., *Internal Medicine*	*5*	

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 Phone

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

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

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

REQUEST FOR SURVEY BLACK OUT DATES:

It is preferred that facilities submit application for survey at least nine (9) 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 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:	10. Total Autopsies:
2. Total Inpatient days:	11. Autopsy Rate (%):
3. Occupancy Rate (%):	12. OB – Total vaginal deliveries:
4. Average Length of Stay (ALOS):	13. OB – Total C-Sections:
5. Total Outpatient Visits:	14. OB – Repeat C-Sections:
6. Total Emergency Department (ED) Visits:	15. OB – VBAC:
7. ED Return Visits within 48 hours:	16. Total Surgical cases:
8. Total Deaths:	17. Unexpected returns to surgery within 48 hours (%):
9. Mortality Rate:	

18. **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.**

Area of Focused Surveillance:	**Low**	**High**	**Avg**	**Rate Denominator**
Bloodstream Infections				
Central Line Infections				
Ventilator Associated Pneumonia Infections				
Surgical Site Infections – Class I surgery				
Surgical Site Infections – Class II surgery				
MRSA Infections				
VRE Infections				
Other:				
1.				
2.				
3.				
4.				
5.				
6.				
7.				

SECTION D: DRG INFORMATION

Please list the top **10** DRGs for your facility for **the past year**. Indicate calendar or fiscal year.

Most recent 12-month period: ☐ calendar year 200__ ☐ fiscal year ending ____				
	DRG #	**Description**	**Volume (patient days)**	**ALOS (days)**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

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:	

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

Distance from main campus_____

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

- ☐ Ambulatory Care (includes primary care physician offices)
- ☐ Ambulatory Surgery (sedation / anesthesia administered at this site)
- ☐ Diagnostic Center (MRI, etc.)
- ☐ Hospice
- ☐ Long Term Care
- ☐ Mental Health
- ☐ Psychological Counseling
- ☐ Physical Rehabilitation
- ☐ Sub Acute Care
- ☐ Substance Abuse
- ☐ Opioid Treatment
- ☐ Urgent / Immediate / Walk-in Care
- ☐ 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):

- ☐ AAAASF
- ☐ AAAHC
- ☐ CARF
- ☐ CHAP
- ☐ HFAP
- ☐ AABB
- ☐ ASHI
- ☐ CAP
- ☐ COLA
- ☐ JCAHO

☐ Other_____ ☐ 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):

☐ HFAP ☐ CAP ☐ COLA
☐ ASHI ☐ AABB ☐ JCAHO
☐ 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.

APPLICATION FOR ACCREDITATION SURVEY AGREEMENT

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

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

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

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

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

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

_____ _____
Chief Executive Officer (*Please PRINT*) Title

_____ _____
Signature of Chief Executive Officer Date

_____
Name of Organization (*Please PRINT*)