A Program of the American Osteopathic Association

Application / Reapplication for Accreditation For Mental Health/Substance Abuse/Behavioral Health Centers

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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 Mental Health Facilities*.

All applications must be accompanied by the appropriate fees. Contact the HFAP office for specifics regarding your facility.

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

Documents to be submitted with completed application:

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

Use current or most recent edition of all documents. These will be used by the surveyors to score your standards compliance

SAMPLE

FACILITY INFORMATION

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

____
Street Address

____
City/State/Zip

______________________________ ____
Facility Main Telephone Number **Web Site Address**

Medicare Provider Number: _______________________________________

Medicaid Provider Number: _______________________________________

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

______Emergency Care

______Inpatient Including Detox days/per year (Number of beds)

______Intermediate/Residential (Number of beds)

______Outpatient visits per year

______Methadone or other chemotherapy treatment

______Research

Number of: Licensed Beds: _______________ Occupied Beds: ______________

Organization Date: ___________ Incorporation Date: ____________ In State Of : _______

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

Date of First Admission: _______________ Type of Ownership________________________

Date of Last State License/Registration Certificate: ___________________________________

Is Your Facility Currently Accredited? ______ Yes ______ No

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

______ AOA, ______ JCAHO, ______ CARF, ______ State ______Other

History of Prior Accreditation by Whom_____________ Dates _____________

Is this Institution Part of a Multi-Hospital Group? ______Yes ______No

If yes, Name of Group: ____

Are there any Satellite Facilities Associated with this Facility? ______ Yes ______ No
If Yes, List Names, Addresses, and Types (i.e. Day Care Residential, Children, Adolescents, Geriatric, etc.) on a Separate Sheet and Attach.

SAMPLE

PROFESSIONAL STAFFING DATA

	Number Licensed by State	Number Certified by State	Number Certified by Other	Number of Non-Licensed Non-Certified
Physician DOs/MDs				
Psychologist				
Certified Social Worker				
Psychiatric Nurse, RN, MA/MSN				
Registered Social Worker, MSW				
Social Work Technician, BA				
Mental Health Counselor				
Rehabilitation Counselor				
Physician Assistant				
Nurse Practitioner, RN, MSN				
Registered Nurse				
Registered Nurse, BSN				
Licensed Practical Nurse, LPN				
Occupational Therapist				
Speech Pathologist/Audiologist				
Dietitian				
Case Manager				
Mental Health Technician				
Other				

SAMPLE

PATIENT DATA

Patient Data:

______Number of Beds

______Total Patient Admitted

______Total Patients Discharge

______Total Inpatient Days

______Average Daily Census

______Average Stay all Patients

______Occupancy Rate

______Number Patients Over Age 65

______Average Stay Patients Over Age 65

______Number Patients Under 21

______Average Stay Patients Under 21

Outpatient Data:

____Total Outpatients for Year

____Total Outpatient Visits for Year

____Total Number of Referrals Out (AA, Hospital, Etc.)

____Total Number Emergency Care

____Average Length of Care (Number of Months) Per Patient

____Family Counseling Services

____Forensic Mental Health

____Mental Retardation/Developmental Disabilities

____Adult Mental Health Visits per month/year

____Child/Adolescent Mental Health Visits per month/year

____Intake/Diagnostic (Behavioral Health Setting)

____Substance Abuse Psychological Counseling

Statistics of Patients for the Last Calendar Year

Total Admissions: ____________

Total Discharges (Include Deaths): ____________

Number of patients by category:

____________Emergency Care

____________Inpatient Including Detox

____________Intermediate/Residential

____________Methadone or Other Chemotherapy Treatment

____________Outpatient

____________Research

SAMPLE

CONTACT INFORMATION

SAMPLE

Chief Executive Officer:

Name ____________________ Preferred Title ____________________

Telephone ____________________ Fax ____________________

Email ____________________

Chief Operating Officer:

Name ____________________ Preferred Title ____________________

Telephone ____________________ Fax ____________________

Email ____________________

Medical Director:

Name ____________________ Preferred Title ____________________

Telephone ____________________ Fax ____________________

Email ____________________

Chief Nursing Officer:

Name ____________________ Preferred Title ____________________

Telephone ____________________ Fax ____________________

Email ____________________

Accreditation Coordinator / Contact Person:

Name ____________________ Preferred Title ____________________

Telephone ____________________ Fax ____________________

Email ____________________

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

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

Corporate Name____

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

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

SAMPLE

REQUEST FOR SURVEY BLACKOUT DATES:

It is preferred that facilities submit application for survey **at least six (6) months prior to the facility's accreditation expiration date.** Whereas accreditation surveys are unannounced, HFAP allows facilities to request "black-out" dates. In this manner, facilities have a degree of control for planning retreats, conferences and other activities. Your survey will not be scheduled during those requested "black-out" dates. No more than three (3) black-out dates (days) will be permitted.

Requests for survey "black out" dates must be made at the time of application. Due to scheduling issues we are unable to honor requests after the application has been received.

Blackout Dates: 1. ___/____/____ 2. ___/____/____ 3. ___/_____/___

SAMPLE

INSTITUTIONAL PLANNING DATA

Does the facility, under direction of the Governing Body, prepare an overall plan and budget which provides for an annual operating budget and capital expenditure plan? ______YES ______NO

Does the annual operating budget include all anticipated income and expenses related to items which would under generally accepted accounting principles to be considered income and expense items?
______YES ______NO

Is there a capital expenditure plan for at least a 3-year period which includes and identified in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000?______YES ______NO

Is the overall plan and budget prepared under the direction of the governing body of the facility by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff of the facility?______YES ______NO

(a) ______Governing Body (b) ______Administrative Staff (c) ______Medical Staff

COMPOSITION OF COMMITTEE

NAME	TITLE

If 4 is yes, is the overall plan and budget reviewed and updated at least annually by the committee referred to in (4) under the direction of the governing body of the facility?______YES ______NO

Please list any contract services the facility utilizes.

SAMPLE

APPLICATION FOR ACCREDITATION SURVEY AGREEMENT

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

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

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

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

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

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

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

______________________________ ______________________________
Signature of Chief Executive Officer Date

____
Name of Organization (*Please PRINT*)

SAMPLE