
INSTRUCTIONS FOR COMPLETING HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

STATEMENT CONCERNING INFORMATION COLLECTION REQUIREMENTS AND USES

This form is required to obtain or retain Medicare benefits. It serves two purposes. First, it provides basic information about the Hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions are met.

Item IV – If a service is provided directly by the facility place a “1” the appropriate block. If a service is provided through an outside source (i.e., by contract/arrangement), place a “2” in the appropriate block.

Answer all questions as of the current date. Return the original and first two copies to the State Agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State Agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Item I

- Request to establish eligibility in - current Hospice Benefits are available only through the Medicare program.
- Medicare provider number - insert the facility's six digit Medicare Provider Number. Leave blank on initial requests for certification.
- State/County and State/Region Codes – Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.
- Related provider number – If Hospice is affiliated with any other type Medicare provider, insert the related facility's six digit Medicare Provider Number.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0313. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

I. Identifying Information	Name of Hospice		Street Address							
	Request to Establish Eligibility In 1. <input type="checkbox"/> Medicare				City, County and State			Zip Code		
	Medicare/Provider Number PH2		State/County PH3		State/Region PH4		Telephone Number (include area code) PH5		Related Provider Number PH6	
II. Type of Hospice (Check One) PH7	1. <input type="checkbox"/> Hospital 2. <input type="checkbox"/> Skilled Nursing Facility 3. <input type="checkbox"/> Intermediate Care Facility 4. <input type="checkbox"/> Home Health Agency 5. <input type="checkbox"/> Freestanding Hospice				For Hospitals Only (Check One) A. <input type="checkbox"/> JCAH Accredited B. <input type="checkbox"/> AOA Accredited C. <input type="checkbox"/> Both JCAH and AOA Accredited D. <input type="checkbox"/> Non-Accredited				Fiscal Year Ending Date	
	Non-Profit 1. <input type="checkbox"/> Church 2. <input type="checkbox"/> Private 3. <input type="checkbox"/> Other			Proprietary 4. <input type="checkbox"/> Individual 5. <input type="checkbox"/> Partnership 6. <input type="checkbox"/> Corporation 7. <input type="checkbox"/> Other		Government 8. <input type="checkbox"/> State 9. <input type="checkbox"/> County 10. <input type="checkbox"/> City 11. <input type="checkbox"/> City-County			12. <input type="checkbox"/> Combination Government and Nonprofit 13. <input type="checkbox"/> Other	
III. Type of Control (Check One) PH8	Core:									
	1. <input type="checkbox"/> Physician Services		2. <input type="checkbox"/> Nursing Services			3. <input type="checkbox"/> Medical Social Services		4. <input type="checkbox"/> Counseling Services		
	5. <input type="checkbox"/> Physical Therapy 6. <input type="checkbox"/> Occupational Therapy 7. <input type="checkbox"/> Speech-Language Pathology 8. <input type="checkbox"/> Home Health Aide 9. <input type="checkbox"/> Homemaker 10. <input type="checkbox"/> Medical Supplies 11. <input type="checkbox"/> Short Term Inpatient Care 12. <input type="checkbox"/> Other(Specify)				PH10 A. <input type="checkbox"/> Acute B. <input type="checkbox"/> Respite			Name and Address of Contractee _____ _____ _____ _____ _____ _____ _____ _____		Medicare Provider/Supplier Number _____ _____ _____ _____ _____ _____ _____ _____
IV. Services Provided: By staff, place a "1" in the block(s) If under arrangement, place a "2" in the block(s) PH9	Physicians PH11		Registered Professional Nurses PH12		Licensed Practical Nurses/ Licensed Vocational Nurses		Medical Social Workers PH14		Total Number	
	Employees	Volunteers	Employees	Volunteers	Employees	Volunteers	Employees	Volunteers		
	A. _____	B. _____	A. _____	B. _____	A. _____	B. _____	A. _____	B. _____	PH19	
	Homemakers PH15		Home Health Aide PH16		Counselors PH17		Others PH18		Employees	Volunteers
Employees	Volunteers	Employees	Volunteers	Employees	Volunteers	Employees	Volunteers	A. _____	B. _____	
A. _____	B. _____	A. _____	B. _____	A. _____	B. _____	A. _____	B. _____	A. _____	B. _____	

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date
		PH20