FORM APPROVED
OMB NO. 0938-0378

MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA

SECTION I: *to be completed by hospital*

Name of Hospital	Street Address	City or County	State	ZIP Code
B1	B2	B3	B4	B5

Hospital Provider Number	Total Number of Beds	Total Number of Certified Beds	Other Data — Does the hospital operate a forensic unit?
B6	B7	B8	☐ Yes ☐ No B9

For the past year: A. Total number of admissions to certified areas

from (month)_____ (year)_____ B10

B. Age Range of Patients B11

C. Medicare/Medicaid Billings

	Billed	Collected
MEDICARE/Part A		
MEDICARE/Part B		
MEDICAID		

D. Other Data — Does the hospital operate a separate MEDICAID ONLY-Residential Treatment Program for Psychiatric patients under the age of 22?

☐ Yes ☐ No

B12

13. Current Hospital Statistics *(on days of survey) [certified beds only]*

Name of Ward	Bed Capacity	Patient Census
		Total Patient Census B13

MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA *(contd)*

SECTION II: *to be completed by the survey team*

Dates of Survey (beginning)	Dates of Survey (ending date)	Type of Survey:
___ ___/ ___ ___/ ___ ___ (mm) (day) (year) B14	___ ___/ ___ ___/ ___ ___ (mm) (day) (year) B15	☐ Initial (B16) ☐ Recertification (B17) ☐ Follow-up (B18) ☐ Complaint (B19) ☐ Second Follow-up (B20) ☐ Concurrent with General Hospital (B21)

Survey Team Composition		Total Number of Surveyors on Site	
☐ Administrator	(B22)	☐ SA	(B32)
☐ Nurse	(B23)	☐ RO	(B33)
☐ Dietician	(B24)	☐ Consultant	(B34)
☐ Pharmacist	(B25)	☐ CO	(B35)
☐ Social Worker	(B26)		
☐ LSC Specialist	(B27)		
☐ Sanitarian	(B28)		
☐ Physician	(B29)		
☐ Psychologist	(B30)	Total Number of Surveyors on Site _____	(B36)
☐ Other _____	(B31)		

19. Certification of Findings

I certify that I have reviewed each Condition of Participation and Related Standards for Psychiatric Hospitals, and unless indicated on the CMS-2567, the Facility was found to be in compliance with the Conditions and/or Standards.

Signature	Title	Date
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date

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 0938-0378. 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.