DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0065

REQUEST FOR CERTIFICATION IN THE MEDICARE AND/OR MEDICAID PROGRAM TO PROVIDE OUTPATIENT PHYSICAL THERAPY AND/OR SPEECH PATHOLOGY SERVICES

REQUEST TO ESTABLISH ELIGIBILITY IN	MEDICARE/MEDICAID PROVIDER NUMBER	STATE/COUNTY	STATE REGION	RELATED PROVIDER NUMBER
☐ 1. MEDICARE ☐ 2. MEDICAID ☐ 3. BOTH R22	R1	R2	R3	R12

I. IDENTIFYING INFORMATION	NAME OF ORGANIZATION	STREET ADDRESS	
	CITY, COUNTY, AND STATE	ZIP CODE	TELEPHONE NO. *(INCLUDE AREA CODE)* R6

II. SERVICES PROVIDED R18	1. ☐ PHYSICAL THERAPY	2. ☐ SPEECH PATHOLOGY	3. ☐ OCCUPATIONAL THERAPY	4. ☐ ALL
III. TYPE OF ORGANIZATION *(CHECK ONE)* R9	1. ☐ HOSPITAL 2. ☐ SKILLED NURSING FACILITY 3. ☐ HOME HEALTH AGENCY	4. ☐ REHABILITATION AGENCY 5. ☐ PUBLIC CLINIC 6. ☐ PRIVATE CLINIC	7. ☐ PUBLIC HEALTH AGENCY	
IV. TYPE OF CONTROL *(CHECK ONE)* R10	1. ☐ VOLUNTARY NON-PROFIT OTHER THAN CHURCH 2. ☐ VOLUNTARY NON-PROFIT CHURCH 3. ☐ STATE GOVERNMENT		4. ☐ LOCAL GOVERNMENT 5. ☐ COMBINATION GOVERNMENT & VOLUNTARY 6. ☐ PROPRIETARY	

NUMBER OF QUALIFIED PERSONNEL (FULL-TIME EQUIVALENTS)

V. PHYSICAL THERAPISTS	1. TOTAL (2 & 3) R13	2. ON STAFF R14	3. BY ARRANGEMENT R15
VI. SPEECH PATHOLOGISTS	1. TOTAL (2 & 3) R19	2. ON STAFF R20	3. BY ARRANGEMENT R21
VII. OCCUPATIONAL THERAPISTS	1. TOTAL (2 & 3) R22	2. ON STAFF R23	3. BY ARRANGEMENT R24

WHOEVER KNOWINGLY AND WILLINGLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWING AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THIS INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE, OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OF CONTRACT WITH THE STATE AGENCY OR THE SECRETARY AS APPROPRIATE.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE R17

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INSTRUCTIONS FOR THE COMPLETION OF THE REQUEST TO ESTABLISH ELIGIBILITY IN THE MEDICARE AND/OR MEDICAID PROGRAM TO PROVIDE OUTPATIENT PHYSICAL THERAPY AND/OR SPEECH PATHOLOGY SERVICES

Submission of this form will initiate the process of obtaining a decision as to whether the conditions of participation are met. Do not delay returning the form even though certain information is not now available. Assistance in completing the form is available from the State agency.

Answer all questions as of the current date. Return the original and first two copies to the State agency in the envelope provided; 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 or definitions are given below for questions other than those considered self-explanatory.

MEDICARE/MEDICAID PROVIDER NUMBER—Leave blank on all initial certifications. On all recertifications, insert the facility's assigned six-digit provider number.

State/County Code and State Region—Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.

Related Provider Number—Complete this block when a facility is participating under more than one provider number, such as a facility having distinct parts or more than one level of care. The number in this block for each related provider will be the provider number of the highest level of care, e.g.,

a) If a hospital has a Distinct Part SNF, ICF and an independently-owned OPT Service, the Related Provider Number block on the application for each provider (including the hospital) will have the hospital provider number.
b) If an OPT is SNF-based, the Related Provider Number block on both the SNF and the OPT applications will have the SNF provider number.

NOTE: If a facility has both a participating and non-participating provider number, the related provider number on both applications will be the participating number.

Question I—Insert the full name under which the organization operates.

Question III—Definitions: **Rehabilitation agency** is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of handicapped, disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, it must provide physical therapy or speech pathology services, and a rehabilitation program which, in addition to physical therapy or speech pathology services, includes social or vocational adjustment services. **Clinic** is a facility established primarily for providing outpatient physician's services. It must meet the following test of physician participation: (1) The medical services of the clinic are provided by a group of physicians, i.e., more than two, practicing medicine together, and (2) a physician is present in the clinic at all times to perform medical (rather than administrative) services. **Public Health Agency** is an official agency established by a State or local government, the primary function of which is to maintain the health of the population served by performing environmental health services, preventive medical services, and, in certain cases, therapeutic services.

Questions V and VI—To determine full-time equivalents, add the total number of hours worked by the appropriate professionals in the week ending prior to the week of filing the request and divide by the number of hours in the standard work week. If the result is not a whole number, express it as a quarter fraction (e.g., .00, .25, .50, .75). Include only qualified physical therapists and qualified speech pathologists.

A qualified physical therapist is a person who is licensed as a physical therapist by the State in which practicing and (1) has graduated from a physical therapy curriculum approved by the American Physical Therapy Association or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education and Hospitals of the American Medical Association and the American Physical Therapy Association; or (2) prior to January 1, 1966: (a) was admitted to membership by the American Physical Therapy Association; or (b) was admitted to registration by the American Registry of Physical Therapists; or (c) has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or (3) has 2 years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or (4) was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or (5) if trained outside the United States: (a) was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; (b) meets the requirements for membership in a member organization of the World Confederation for Physical Therapy; (c) has 1 year of experience under the supervision of an active member of the American Physical Therapy Association; and (d) has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

A qualified speech pathologist is a person who is licensed, if applicable, by the State in which practicing: (1) is eligible for a certificate of clinical competence in speech pathology granted by the American Speech and Hearing Association under its requirements in effect on January 17, 1974; or (2) meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification.

Completing the Request at Resurvey—At the time of resurvey, the surveyor will bring this form and either, request that a facility representative complete, sign, date, and return it at the completion of the onsite visit at which time the surveyor will review it for completeness and accuracy; or the surveyor may complete the form and have the facility representative review and sign it. In either case, the surveyor will initial after the facility representative's signature.