

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

WITHDRAWAL OF PARTICIPATION

This form must be completed and mailed or faxed to your Inpatient Psychiatric Facility Quality Reporting Support Contractor contact if your facility wants to withdraw from participation Inpatient Psychiatric Facility Quality Reporting.

Our facility is withdrawing from participation in Inpatient Psychiatric Facility Quality Reporting at this time. Based on this withdrawal, it is our understanding that our facility will not be listed as a participant on the CMS.gov web site.

Facility Name: _____

CMS Certification Number (CCN) _____

City, State, ZIP Code: _____

Facility/Health System CEO (or designee):

Name (please print): _____

Title: _____

Date: _____ Signature: _____

PRA Disclosure Statement

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-XXXX . The time required to complete this information collection is estimated to average 10 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.