Centers for Medicare & Medicaid Services (CMS)
PPS-exempt Cancer Hospital Quality Reporting Program
Healthcare Associated Infection (HAI) Exception Form

This exception must be renewed at least annually

Specify the calendar year, applicable quarter(s), and location for the specific National Healthcare Safety Network (NHSN) HAI Measure exception request(s). Please use this form to indicate that your facility does not have one or more of the location(s) provided below for the respective quarter.

* Indicates required fields

***HAI Measure Exception Information** (The exception(s) you are requesting must be selected)

Select all that apply

- **Catheter-Associated Urinary Tract Infection (CAUTI)**
  Hospital does not have the location(s) as indicated below.

Calendar Year (YYYY)_____________

- January 1 through March 31
- April 1 through June 30
- July 1 through September 30
- October 1 through December 31

***I have reviewed NHSN definitions for (select all that apply):**

ICU locations

- Oncology Medical ICU
- Oncology Med/Surg ICU
- Oncology Surg ICU
- Oncology Pediatric ICU

Non-ICU locations

- Step Down Unit
- Solid Tumor Ward
- Leukemia Ward
- Hematopoietic Stem Cell Transplant Ward
- Leukemia/Lymphoma Ward
- General Hematology/Oncology Ward
- Lymphoma Ward
- Pediatric Hematopoietic Stem Cell Transplant Ward
- Pediatric general Hematology/Oncology Ward

- **Central Line-Associated Bloodstream Infection (CLABSI)**
  Hospital does not have the location(s) as indicated below.

Calendar Year (YYYY)_____________

- January 1 through March 31
- April 1 through June 30
- July 1 through September 30
- October 1 through December 31

***I have reviewed NHSN definitions for (select all that apply):**

ICU locations

- Oncology Medical ICU
- Oncology Med/Surg ICU
- Oncology Surg ICU
- Oncology Pediatric ICU

Non-ICU locations

- Step Down Unit
- Solid Tumor Ward
- Leukemia Ward
- Hematopoietic Stem Cell Transplant Ward
- Leukemia/Lymphoma Ward
- General Hematology/Oncology Ward
- Lymphoma Ward
- Pediatric Hematopoietic Stem Cell Transplant Ward
- Pediatric general Hematology/Oncology Ward

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PPS-exempt Cancer Hospital Quality Reporting Program
Healthcare Associated Infection (HAI) Exception Form

Facility Contact Information

*CMS Certification Number (CCN): ____

*Facility Name: ____

*CEO/Designee Last Name: ____

*CEO/Designee First Name: ____

*Title

____

*CEO/Designee E-Mail Address: ____

*CEO/Designee Telephone Number: ___-___-____ ext. __________

Additional Comments:

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I hereby certify that the facility meets the exception criteria and therefore has no data to submit for the specified location(s) related to the specified HAI measure(s)

Name ________________________

Position ______________________

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.