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.

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 certification number:
 Insert the facility's six digit Medicare Certification 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 certification number:
 If Hospice is affiliated with any other type Medicare provider, insert the related facility's six digit Medicare Certification Number.

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.
- If a service is provided both directly and through arrangement, place a "3" in the appropriate box.

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

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

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I. Identifying Information	Name of Hospice				Street Address								
	Request to Esta	ablish Eligibility In		City, County and State						Zip Code			
	1. Medicare	,		PH1									
	Medicare/Certification Number State/Co				State/Region Telephone Number (include area code)			F	Related Certification Number				
		P	H2	PH3		PH4			PH5			PH6	
II. Type of Hospice (Check One)	4. Home He	ursing Facility diate Care Facility ealth Agency			For Hospitals Only (Check One) A. The Joint Commission Accredited B. AOA Accredited C. Both The Joint Commission and AOA Accredited D. Non-Accredited					Fiscal Year Ending Date			
III. Type of Control	Non-Profit:		Proprie	tary:		Government:							
(Check One) PH8	2. Private 5. P			dividual artnership orporation ther						ombination Government d Nonprofit her			
IV. Services Provided:	Core:												
By staff, place a "1" in the block(s) If under arrangement, place a "2" in the block(s) If by staff and arrangement, place a "3" in the block(s)	8. Hospice 9. Homema 10. Medical 11. Short Te 12. Other(Sp	Therapy ional Therapy Language Patholo Aide aker Supplies erm Inpatient Care	9y PH10 A B	Acute Respite	Name and Addi		ctee	Medica			upplier Numbe	r	
V. Number of Employees/	Physicians	PH11	Registered P	rofessional Nurs	tes Licensed Pra H12 Licensed Vo	actical Nurses/		Medical Social	Norkers	PH14	Total Number		
Volunteers Full-time Equivalent Top section of professional category reflects total	Employees A. Homemakers	Volunteers B.	Employees A. Hospice Aide	Volunteers B.	Employees A. Counselors	Volunt B.	eers E	Employees A. Others	Voluntee B.	ers	Employees	PH19 Volunteers	
number of FTE (i.e., PH 11	Employees	PH15 Volunteers	Employees	Volunteers	H16 Employees	Volunt	PH17	Employees	Voluntee	PH18	. ,		
through PH 18)	A.		A.	B.	A.	B.		4.	B.	510	A.	В.	
Whoever knowingly or willfully maddition, knowingly and willfully participates, a termination of its a	failing to fully	s to be made a f and accurately	alse stateme	ent or represe information	entation on this requested may	s form may by result in de					ıl or State law	rs. In	
Name of Authorized Representative and Title (Typed)				Signature					Date	Date			
												PH20	
Form CMC 417 (09/10)													

PART 2 – REGIONAL OFFICE

PART 3 – STATE AGENCy

PART 4

PART 5 - PROVIDER