INSTRUCTIONS FOR COMPLETING THE COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY REQUEST FOR CERTIFICATION TO PARTICIPATE IN THE MEDICARE PROGRAM

The filing of this request for certification will initiate the process of obtaining a decision as to whether the Conditions of Participation are (continue to be) met.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date. Return the form to the State agency in the envelope provided; retain a 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 District Office.

Question I. **Identifying Information**

Insert the full name under which the CORF operates, its address and telephone number.

Medicare/Medicaid provider number - Leave blank on all initial certifications. On all recertifications, insert the facility's six digit provider number.

State/County/Region code - Leave blank. CMS Regional Office will complete.

Question II. **Eligibility**

All applicants are to check block #1 (Medicare). CORF services are covered only under the Medicare program, hence, blocks #2 and #3 are for future use only. No entry for related provider number. State agency will complete.

Question III. **Type of Control**

Check the one category that is most descriptive of the type of organization operating the facility. Use the following as a guide:

Proprietary - For profit corporation.

Non-profit church - A church affiliated facility governed by a board of directors and financed by contributions and earnings.

Non-profit other than church - A facility which is generally governed by a community based board of directors and financed by contributions and earnings.

Government - A facility primarily administered by the State, county, city or other local unit of government.

Question IV. **Services Provided**

Please indicate in each block how services are provided, using the following figures:

1. Employees
2. Under Arrangement
3. Independent Contractor

These terms are defined below. Note that more than one figure may be used for each block. Blocks #1, #2 and either #3 or #4 must be completed for the facility to be eligible for participation since these are mandatory services.

Employee - An individual who is paid a salary per unit time of work (i.e., hourly, yearly), is covered under Social Security and Workmen's Compensation and accrues benefits (i.e., sick leave, vacation).

Under Arrangement - The facility has an agreement with an organization to use their personnel. The facility pays the organization and not the individuals providing the services.

Independent Contractor - An individual who is paid a sum of money based upon services rendered or units of time. However, the independent contractor is not covered under Social Security through the facility and does not accrue benefits. The individual generally has a contract with the facility.

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

Form Approved
OMB No. 0938-0267

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY REPORT FOR CERTIFICATION TO PARTICIPATE IN THE MEDICARE PROGRAM

(Please read instructions on back before completing form)

I. IDENTIFYING INFORMATION	NAME OF FACILITY		STREET ADDRESS	MEDICARE/MEDICAID PROVIDER NUMBER RD01	
	CITY, COUNTY, STATE	ZIP CODE	TELEPHONE NO. *(Area Code)* RD02	STATE/COUNTY RD03	STATE REGION RD04

II. ELIGIBILITY	REQUEST TO ESTABLISH ELIGIBILITY IN: ☐ 1. MEDICARE ☐ 2. MEDICAID ☐ 3. BOTH RD05	RELATED PROVIDER NUMBER RD06
III. TYPE OF CONTROL *(Check one)*	**PROPRIETARY** ☐ **NON-PROFIT** ☐ CHURCH ☐ OTHER **GOVERNMENT** RD07	Does your organization currently participate in Medicare as a provider of Outpatient Physical Therapy/Speech Pathology (e.g., Rehabilitation Agency)? ☐ YES ☐ NO RD08 If yes, list Provider No. _____ RD09

IV. SERVICE PROVIDED:

Indicate in each block how services are provided using the following numbers.

NOTE: More than one number may be used for each block.

1. Employees
2. Under Arrangement
3. Independent Contractor

These terms are defined in the instructions on the reverse side of this form.

☐ 1. PHYSICAL THERAPY	☐ 4. PSYCHOLOGICAL SERVICES	☐ 7. SPEECH PATHOLOGY
☐ 2. PHYSICIAN SERVICES	☐ 5. OCCUPATIONAL THERAPY	☐ 8. ORTHOTIC/PROSTHETIC SERVICES
☐ 3. SOCIAL SERVICES	☐ 6. RESPIRATORY THERAPY	☐ 9. NURSES

Blocks #1, #2, and either #3 or #4 must be completed for the facility to be eligible for participation.

RD10

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable Federal or State law. In addition, knowingly and willfully failing to fully and accurately disclose this requested information 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 RD11