Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program
Notice of Participation

Please review the Notice of Participation below:

Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program

Notice of Participation Agreement

The Inpatient Psychiatric Facility (IPF) agrees to follow procedures for participating in the IPFQR Program as outlined in the federal regulations found in the *Federal Register*, or is indicating its decision to decline participation. The IPF understands that participation in the IPFQR Program is voluntary for the applicable fiscal year.

Each IPF must complete this "IPFQR Notice of Participation" (IPFQR Notice) as outlined in the IPFQR *QualityNet* and in the federal regulations found in the *Federal Register*. In an effort to alleviate the burden associated with submitting this form annually, effective with the IPFQR Notice submitted for participation in FY 2014 program year or later, an IPF that indicated its intent to participate will be considered an active IPFQR Program participant until CMS determines a need to resubmit the IPFQR Notice, or the IPF submits a request for withdrawal to CMS.

This information is in compliance with the CMS guidelines for IPFs submitting their quality performance data in accordance with section 1886(s) (4) of the Social Security Act. Pursuant to section 1886(s)(4)(E) of the Act, IPFs agreeing to participate in the IPFQR Program will have their data publicly displayed on a CMS' website after being afforded the opportunity to review their data.

We entities operating under the submitted Provider ID: _____

_____*Agree to participate.*

_____*Do not agree to participate.*

_____*Request to be withdrawn from participation.*

This acknowledgement (to participate or not to participate or to withdraw) remains in effect until an electronically signed acknowledgement applying changes has been entered.

_____*By entering my acknowledgement, I hereby issue this IPFQR Notice of Participation with the specified direction contained within.*

By entering this pledge, I agree to:

(1). Transmit or have data transmitted to CMS and/or the QIO Clinical Warehouse; and
(2). Permit my hospital's performance information to be publicly reported.

Facility Name: _____

CEO Signature:_____ Date: _____

CEO Email Address: _____

Complete and submit the Notice of Participation Agreement form using one of the following options:

1) via Secure File transfer in the QualityNet Secure Portal,
2) via Secure Fax to IPFQR Support Contractor at (877) 789-4443, or
3) via mail to:

HSAG
5201 W Kennedy Blvd Suite 900
Tampa, FL 33607
Attn. IPFQR Support
Contractor

DO NOT SEND the completed form via email.

Following receipt of the request form, an email acknowledgement will be sent confirming the form has been received.

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 **0938-1171**. 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. Expiration Date: xx/xx/xxxx