

MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA

SECTION I: to be completed by hospital

| | | | | |
|--|------------------------------------|--|---|------------------------|
| Name of Hospital B1 | Street Address B2 | City or County B3 | State B4 | ZIP Code B5 |
| Hospital Provider Number B6 | Total Number of Beds B7 | Total Number of Certified Beds B8 | Other Data — Does the hospital operate a forensic unit? <input type="checkbox"/> Yes <input type="checkbox"/> No B9 | |

| | |
|--|---------------------------------|
| For the past year: A. Total number of admissions to certified areas from (month) _____ (year) _____ B10 | B. Age Range of Patients B11 |
|--|---------------------------------|

| C. Medicare/Medicaid Billings <table border="1" style="width:100%; border-collapse: collapse; margin-left: 20px;"> <thead> <tr> <th style="width:15%;"></th> <th style="width:20%;">Billed</th> <th style="width:20%;">Collected</th> </tr> </thead> <tbody> <tr> <td style="background-color: black; color: white; text-align: center;">MEDICARE/Part A</td> <td></td> <td></td> </tr> <tr> <td style="background-color: black; color: white; text-align: center;">MEDICARE/Part B</td> <td></td> <td></td> </tr> <tr> <td style="background-color: black; color: white; text-align: center;">MEDICAID</td> <td></td> <td></td> </tr> </tbody> </table> | | Billed | Collected | MEDICARE/Part A | | | MEDICARE/Part B | | | MEDICAID | | | D. Other Data — Does the hospital operate a separate MEDICAID ONLY-Residential Treatment Program for Psychiatric patients under the age of 22? <input type="checkbox"/> Yes <input type="checkbox"/> No B12 |
|--|--------|-----------|-----------|------------------------|--|--|------------------------|--|--|-----------------|--|--|---|
| | Billed | Collected | | | | | | | | | | | |
| MEDICARE/Part A | | | | | | | | | | | | | |
| MEDICARE/Part B | | | | | | | | | | | | | |
| MEDICAID | | | | | | | | | | | | | |

13. Current Hospital Statistics *(on days of survey) [certified beds only]*

| Name of Ward | Bed Capacity | Patient Census |
|--------------|--------------|-----------------------------|
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| | | |
| | | |
| | | |
| | | Total Patient Census |
| | | B13 |

MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA (contd)

SECTION II: to be completed by the survey team

| | | |
|---|---|--|
| Dates of Survey (beginning) ____/____/____ (mm) (day) (year) B14 | Dates of Survey (ending date) ____/____/____ (mm) (day) (year) B15 | Type of Survey: <input type="checkbox"/> Initial (B16) <input type="checkbox"/> Recertification (B17) <input type="checkbox"/> Follow-up (B18) <input type="checkbox"/> Complaint (B19) <input type="checkbox"/> Second Follow-up (B20) <input type="checkbox"/> Concurrent with General Hospital (B21) |
| Survey Team Composition <input type="checkbox"/> Administrator (B22) <input type="checkbox"/> Nurse (B23) <input type="checkbox"/> Dietician (B24) <input type="checkbox"/> Pharmacist (B25) <input type="checkbox"/> Social Worker (B26) <input type="checkbox"/> LSC Specialist (B27) <input type="checkbox"/> Sanitarian (B28) <input type="checkbox"/> Physician (B29) <input type="checkbox"/> Psychologist (B30) <input type="checkbox"/> Other _____ (B31) | | Total Number of Surveyors on Site <input type="checkbox"/> SA (B32) <input type="checkbox"/> RO (B33) <input type="checkbox"/> Consultant (B34) <input type="checkbox"/> CO (B35) Total Number of Surveyors on Site _____ (B36) |

19. Certification of Findings

I certify that I have reviewed each Condition of Participation and Related Standards for Psychiatric Hospitals, and unless indicated on the CMS-2567, the Facility was found to be in compliance with the Conditions and/or Standards.

| | | |
|-----------|-------|------|
| Signature | Title | Date |
| Signature | Title | Date |
| Signature | Title | Date |
| Signature | Title | Date |

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 0938-0378 Expiration Date: XX/XX/XXXX. The time required to complete this information collection is estimated to average 15 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 any 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, C4-26-05, Baltimore, Maryland 21244-1850. *****CMS Disclaimer*****Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact HospitalSCG@cms.hhs.gov.