
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. Complete and return this form to your State Agency (found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/state_agency_contacts.pdf), and retain a copy for your files.

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" in 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.

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 0938-0313. Expiration date: XX/XX/XXXX. The time required to complete this information collection is estimated to average [Insert Time (hours or 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. *****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: SCG_Hospice@cms.hhs.gov.

HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

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

I. Identifying Information	Name of Hospice		Street Address						
	Request to Establish Eligibility In 1. <input type="checkbox"/> Medicare PH1			City, County and State			Zip Code		
	Medicare/Certification Number PH2	State/County PH3	State/Region PH4	Telephone Number (include area code) PH5		Related Certification Number PH6			
II. Type of Hospice (Check One) PH7	1. <input type="checkbox"/> Hospital 2. <input type="checkbox"/> Skilled Nursing Facility 3. <input type="checkbox"/> Intermediate Care Facility 4. <input type="checkbox"/> Home Health Agency 5. <input type="checkbox"/> Freestanding Hospice			For Hospitals Only (Check One) A. <input type="checkbox"/> The Joint Commission Accredited B. <input type="checkbox"/> AOA Accredited C. <input type="checkbox"/> Both The Joint Commission and AOA Accredited D. <input type="checkbox"/> Non-Accredited			Fiscal Year Ending Date		
	Non-Profit: 1. <input type="checkbox"/> Church 2. <input type="checkbox"/> Private 3. <input type="checkbox"/> Other PH8			Proprietary: 4. <input type="checkbox"/> Individual 5. <input type="checkbox"/> Partnership 6. <input type="checkbox"/> Corporation 7. <input type="checkbox"/> Other			Government: 8. <input type="checkbox"/> State 9. <input type="checkbox"/> County 10. <input type="checkbox"/> City 11. <input type="checkbox"/> City-County 12. <input type="checkbox"/> Combination Government and Nonprofit 13. <input type="checkbox"/> Other		
IV. Services Provided: 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)	Core: 1. <input type="checkbox"/> Physician Services 2. <input type="checkbox"/> Nursing Services 3. <input type="checkbox"/> Medical Social Services 4. <input type="checkbox"/> Counseling Services								
	5. <input type="checkbox"/> Physical Therapy 6. <input type="checkbox"/> Occupational Therapy 7. <input type="checkbox"/> Speech-Language Pathology 8. <input type="checkbox"/> Hospice Aide 9. <input type="checkbox"/> Homemaker 10. <input type="checkbox"/> Medical Supplies 11. <input type="checkbox"/> Short Term Inpatient Care PH10 12. <input type="checkbox"/> Other(Specify) A. _____ Acute B. _____ Respite			Name and Address of Contractee			Medicare Certification/Supplier Number		
	Physicians PH11		Registered Professional Nurses PH12		Licensed Practical Nurses/ Licensed Vocational Nurses PH13		Medical Social Workers PH14		Total Number PH19
Employees A. _____	Volunteers B. _____	Employees A. _____	Volunteers B. _____	Employees A. _____	Volunteers B. _____	Employees A. _____	Volunteers B. _____		
Homemakers PH15		Hospice Aide PH16		Counselors PH17		Others PH18		Employees	Volunteers
Employees A. _____	Volunteers B. _____	Employees A. _____	Volunteers B. _____	Employees A. _____	Volunteers B. _____	Employees A. _____	Volunteers B. _____	A. _____	B. _____
V. Number of Employees/ Volunteers Full-time Equivalent Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18)									

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this form may be prosecuted under applicable Federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary as appropriate.

Name of Authorized Representative and Title (Typed)	Signature	Date
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