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

FORM
OMB NO. 0938-0074

VERIFICATION OF CLINIC DATA - RURAL HEALTH CLINIC PROGRAM CMS-29

Each rural health clinic (RHC) site providing RHC services and seeking to participate in the Medicare program must complete this form and return it to the State agency that is handling the certification process. If a return envelope is not provided, the name and address of the State agency may be obtained from the Center for Medicare & Medicaid Services (CMS) regional office at http://www.cms.hhs.gov/RegionalOffices/. This form is also to be completed when the State agency surveys a participating RHC.

CMS CERTIFICATION NO. (RH1)

STATE/COUNTY (RH2)

STATE REGION (RH3)

I. IDENTIFYING INFORMATION (TO BE COMPLETED FOR EACH CLINIC SITE)	NAME OF CLINIC	STREET ADDRESS	
	CITY, COUNTY AND STATE	ZIP CODE	TELEPHONE NO. (Including Area Code) (RH4)
NAME AND ADDRESS OF CLINIC OWNER(S)			
II. MEDICAL DIRECTION			

III. CLINIC PERSONNEL (FULL TIME EQUIVALENTS)	(A) PHYSICIAN (RH6)	(B) NURSE PRACTITIONER (RH7)	(C) PHYSICIAN ASSISTANT (RH8)	(D) OTHER (RH9)

IV. TYPE OF CONTROL (check one) (RH10)	A. INDIVIDUAL	B. CORPORATION	C. PARTNERSHIP	D. GOVERNMENT
1. PROFIT				3. STATE _____
2. NON-PROFIT				4. LOCAL _____
				5. FEDERAL ____

Is the RHC a provider-based entity to a hospital or critical access hospital (CAH)? Yes ○ No ○ (RH11)
(check one)

If yes, please indicate the CMS Certification Number of the hospital/CAH _____ (RH12)

I certify that this information is true, correct, and complete. I agree, if approval is granted, that all services rendered by the clinic shall be in conformity with Federal, State, and local laws. I further understand that a violation of such laws will constitute grounds for withdrawal of approval under the regulations. If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C.
§§ 552(b)(4) and/or (b)(6), respectively.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE (RH13)

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 **0938-0074 (Expires XX/XX/XXXX)**. The time required to complete this information collection is estimated to average **47 minutes** per response, including the time to review instructions, search existing data resources, to 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 Disclosure**** 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 Shontee Carter at (410) 786-3532.**

INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF CLINIC DATA RURAL HEALTH CLINIC PROGRAM

(CMS-29 Form)

The filing of this verification of clinic data is part of the process of obtaining a decision as to whether the rural health clinic conditions for certification are met.

Please do not delay returning the form. Assistance in filling out the form is available from the State agency.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date.

Do not complete the categories identified as State/County or State Region. 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 your Center for Medicare & Medicaid Services (CMS) regional office at http://www.cms.hhs.gov/RegionalOffices/.

Detailed Instructions for Specific Questions

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

The Following to be Completed by the Clinic

Question I – Identifying Information

Insert the full name under which the clinic operates. A rural health clinic site is the location at which health services are furnished. If a central organization operates more than one permanent clinic site, a separate Verification of Clinic Data form for each rural health clinic site must be submitted. In these instances, the location of the health clinic site, rather than of the central organization, will determine eligibility to participate. The applicant site must be situated in a rural area which is designated as either an area with a shortage of personal health services or as a health manpower shortage area because of its shortage of primary medical care manpower. If the name of the rural health clinic site does not identify the owner(s), the name and address of the owner(s) are to be inserted in the space provided; otherwise, that space is to be left blank.

Question II – Medical Direction

Insert the name and address of the physician(s) responsible for providing medical direction for the health clinic site.

Question III – Clinic Personnel

(A), (B), and (C) – Personnel are to be described in terms of full-time equivalents. To arrive at full-time equivalents, add the total number of hours worked by personnel in each category in the week ending prior to the week of filing the request and divide by the number of hours in the standard work week (as determined by the clinic policies). If the result is not a whole number, express it as a quarter fraction only (e.g., .00, .25, .50, or .75).

Exclude all trainees and volunteers.

In addition to the physician, a nurse practitioner, physician assistant or a certified nurse-midwife is required for clinic eligibility and must be shown in B and/or C respectively.

(D) – Where other types of personnel are utilized (e.g., technicians, aides, etc.), the discipline, by name is to be indicated in addition to the full-time equivalents.

Under (A), (B), and (C), include in the count only those personnel defined as follows:

Physician – A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which such function or action is performed. (A physician listed in II, above, should be included in this category for purposes of determining full-time equivalents.)

Nurse practitioner – A registered professional nurse who is currently licensed to practice in the State, who meets the State's requirements governing the qualifications of nurse practitioners and who meets one of the following conditions:

1. Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or

2. Has satisfactorily completed a formal one academic year educational program that:

   (i) prepares registered nurses to perform an expanded role in the delivery of primary care;includes as least four months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and

   (ii) awards a degree, diploma, or certificate to persons who successfully complete the program; or

3. Has successfully completed a formal educational program for preparing registered nurses to perform an expanded role in the delivery of primary care that does not meet the requirements of paragraph (2) of this section, and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

Physician assistant – A person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians and who meets at least one of the following conditions:

1. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or

2. Has satisfactorily completed a program for preparing physician's assistants that:

   (i) was at least one academic year in length:
   (ii) consisted of supervised clinical practice and at least four months (in the aggregated) of classroom instruction directed toward preparing students to deliver health care; and
   (iii) was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

3. Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of paragraph (2) of this section and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

Question IV – Type of Control

Identify the rural health clinic in terms of its type of control by checking the appropriate column and row under A, B, C or D. Nonprofit status is based on Internal Revenue Service tax exemption interpretation; i.e., section 501 of the Internal Revenue Code of 1954.

Indicate if the rural health clinic site is or will be a provider-based entity to a hospital or critical access hospital (CAH), in accordance with the provider-based rules located at 42 CFR 413.65. If yes, provide the hospital or CAH's CMS Certification Number (CCN) for the main provider to which the clinic is/will be provider-based.

State Agency Responsibility

A function of the resurvey process is to obtain updated statistical information on organizations providing rural health clinic services. At the time of resurvey, the surveyor will bring this form and request that a representative of the organization complete, sign, and date it by the completion of the onsite visit. The surveyor will review the form for completeness and accuracy and initial after the signature of the organization's representative. On all resurveys insert the clinic's assigned CCN.