Form Approved
OMB No. 0938-0379

HOSPICE SURVEY AND DEFICIENCIES REPORT

CERTIFICATION NUMBER	NAME OF FACILITY	SURVEY DATE

1. Was this hospice surveyed for compliance with 42 CFR 418.110? L50
   ❑ Yes ❑ No

2. If this hospice provides inpatient care directly, is the inpatient care provided on the premises? L51
   ❑ Yes ❑ No

3. Has a waiver of core nursing services been granted? L52
   ❑ Yes ❑ No

4. If “Yes” indicate date L53

5. Indicate type of setting(s) in which the hospice provides routine home care. L54
   ❑ Private residence ❑ SNF ❑ NF ❑ Other (specify)

6. Number of hospice patients residing in a SNF, NF or other residential facility who receive routine home care from the hospice. L55

7. Number of hospice patients admitted during recent 12 month period. L56

8. Number of records reviewed during survey. L57

9. Number of home visits conducted to patients in a private residence. L58

10. Number of home visits conducted to patients in residential facilities. L59

11. Does this hospice operate under the same certification number at more than one location? L60
    ❑ Yes ❑ No

12. If “Yes” enter number of locations. L61

13. Does this hospice operate as part of another entity that participates in the Medicare program? L62
    ❑ Yes ❑ No

14. If “Yes” enter the Medicare certification number of the entity. L63

SURVEYOR 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 0938-0379 (Expiration date: XX/XX/XXXX). The time required to complete this information collection is estimated to average 1 hour per response,including the time to review instructions,search existing data resources,gather the data needed, and complete and review the information collection. ****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 any comments concerning the accuracy of the time estimate(s), or suggestions for improving this form, or where to submit your documents contact: QSOG_Hospice@cms.hhs.gov.

HOSPICE SURVEY AND DEFICIENCIES REPORT

DEFICIENCIES

DATA TAG NUMBER	COP/STND. NO.	COMMENTS

I certify that I have reviewed each hospice Condition of Participation and related standards and except as indicated on this form the facility was found to be in compliance with the standards and/or the Conditions of Participation.

SURVEYOR SIGNATURE	TITLE	DATE
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