DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0360

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 0938-0360 (Expires 03/31/2022). The time required to complete this information collection is estimated to average 20 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 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 ESRDQuestions@cms.hhs.gov.

END STAGE RENAL DISEASE APPLICATION AND SURVEY AND CERTIFICATION REPORT

PART I – APPLICATION – TO BE COMPLETED BY FACILITY

1. Type of Application/Notification (check all that apply; if "Other," specify in "Remarks" section [Item33]): (V1)

☐ 1. Initial ☐2. Recertification ☐3. Relocation ☐4. Expansion/change of services

☐ 5. Change of ownership ☐6. Other, specify_____

2. Name of Dialysis Facility_____3. CCN _____

4. Street Address_____5. NPI _____

6. City_____7. County_____8. Fiscal Year End Date _____

9. State_____10. Zip Code: _____

11. Administrator's Email Address_____

12. Telephone No._____13. Facsimile No. _____

14. Medicare Enrollment (CMS 855A) completed? ☐Yes ☐No ☐NA

15. Dialysis Facility Administrator Name:_____Business Address: _____

City:_____ State:_____Zip Code:_____Telephone No: _____

16. Ownership (V2) ☐1. For Profit ☐2. Not for Profit ☐3.Public

17. Is this dialysis facility independent (i.e., not owned or managed by a hospital)? (V3)☐1. Yes ☐2. No

Is this dialysis facility owned and managed by a hospital and on the hospital campus (i.e., hospital- based)? (V4) ☐1. Yes ☐2. No

Is this dialysis facility owned and managed by a hospital and located off the hospital campus (i.e., satellite)? (V5)☐1. Yes ☐2. No

18. Is this dialysis facility located in a SNF/NF (LTC) (check one): (V6) ☐1. Yes ☐2.No

If SNF/NF owned and managed by a hospital: hospital name: (V7)_____CCN: (V8) _____

If Yes, SNF/NF name: (V9)_____CCN: (V10) _____

19. Is this dialysis facility owned &/or managed by a multi-facility organization? (V11) ☐1. No ☐2. Yes, Owned ☐3. Yes, Managed

If Yes, name of multi-facility organization: (V12) _____

Multi-facility organization's address: _____

20. Current modalities/services for dialysis facilities requesting recertification only (check all that apply): (V13)

☐ 1. In-center Hemodialysis (HD) ☐2. In-center Peritoneal Dialysis (PD)

☐ 3. In-center Nocturnal HD ☐4. Home HD Training & Support ☐5. HD in LTC

☐ 6. Home PD Training & Support ☐7. PD in LTC ☐8. Dialyzer Reuse

21. New modalities/services being requested (check all that apply; must have 1 permanent patient for any modality requested): (V14)

☐ 1. In-center HD ☐2. In-center PD ☐3. In-center Nocturnal HD

☐ 4. Home HD Training & Support ☐5. HD in LTC

☐ 6. Home PD Training & Support ☐7. PD in LTC ☐8. Dialyzer Reuse ☐9. N/A

NOTE: For dialysis in more than 1 LTC facility, record this same information in the "Remarks" (item 33) section or attach list

22. Does the dialysis facility have any dialysis (PD/HD) patients physically receiving dialysis within long-term care (LTC) facilities? (V15)

☐ 1. Yes ☐2. No

LTC (SNF/NF) facility name: (V16)_____ CCN: (V17) _____

Staffing for home dialysis in LTC provided by: (V18)

☐ 1. This dialysis facility ☐2. LTC staff ☐3. Other, specify: _____

Number of dialysis residents by modality receiving dialysis within this LTC facility: (V19)

☐1. HD_____ ☐2. PD_____

23. Number of dialysis patients currently on census:

In-Center HD: (V20)_____ In-Center Nocturnal HD: (V21) _____

In-Center PD: (V22)_____ Home PD: (V23) _____

Home HD <= 3x/week: (V24)_____ Home HD >3x/week: (V25) _____

24. Number of currently approved in-center dialysis stations: (V26) _____

Are onsite home training room(s) provided? (V27) ☐1. Yes ☐2. N/A

25. Additional in-center stations requested: (V28)_____ or ☐ None

26. How is isolation provided? (V29) ☐1. Room ☐2. Area (existing 2/9/2009 only) ☐3. CMS Waiver/Agreement (Attach copy)

27. If applicable, number of hemodialysis stations designated for isolation: (V30) _____

28. Days/times for in-center shifts or operating hours if home only (check all days that apply and complete time field in military time): (V31)

1st in-center shift starts or home only facility opens: M_____ T_____ W_____ Th_____ F_____ Sat_____ Sun_____

Last in-center shift ends or home only facility closes: M_____ T_____ W_____ Th_____ F_____ Sat_____ Sun _____

29. Dialyzer reprocessing: (V32) ☐1. Onsite ☐2. Centralized/Offsite ☐3. N/A

30. Staff (List full-time equivalents):

Registered Nurse: (V33)_____ Certified Patient Care Technician: (V34) _____

LPN/LVN: (V35)_____ Technical Staff (water, machine): (V36) _____

Registered Dietitian: (V37)_____ Masters Social Worker: (V38) _____

Others: (V39) _____

31. State license number (if applicable): (V40) _____

32. Certificate of Need required? (V41) ☐1. Yes ☐2. No ☐3. NA

33. Remarks (copy if more and attach additional pages if needed):_____

_____

_____

_____

_____

_____

34. The information contained in this Application Survey and Certification Report (Part I) is true and correct to the best of my knowledge. I understand that incorrect or erroneous statements may cause the request for approval to be denied, or facility approval to be rescinded, under 42 C.F.R. 494.1 and 488.604 respectively.

I have reviewed this form and it is accurate:

Signature of Administrator/Medical Director	Title	Date

PART II TO BE COMPLETED BY STATE AGENCY

35. Medicare Enrollment (CMS 855A recommended for approval by the Medicare Administrative Contractor)? (V42) ☐1. Yes ☐ 2. No

(*Note: approved CMS 855A required prior to certification*)

36. Type of Survey: (V43)

☐ 1. Initial ☐2. Recertification ☐3. Relocation ☐ 4. Expansion/change of services ☐ 5. Change of ownership

☐ 6. Complaint ☐7. Revisit ☐8. Other, specify_____

37. State Region: (V44)_____ 38. State County Code: (V45) _____

39. Network Number: (V46) _____

My signature below indicates that I have reviewed this form and it is complete.

40. Surveyor Team Leader (sign)	41. Name/Number (print)	42. Professional Discipline (print)	43. Survey Exit Date

INSTRUCTIONS FOR FORM CMS-3427

PART I – DOCUMENTATION NEEDED TO PROCESS FACILITY APPLICATION/NOTIFICATION TO BE COMPLETED BY APPLICANT

A completed request for approval as a supplier of End Stage Renal Disease (ESRD) services in the Medicare program (Part I – Form CMS-3427) must include a copy of the Certificate of Need approval, if such approval is required by the state.

TYPE OF APPLICATION (ITEM 1)

Check appropriate category. A "change of service" refers to an addition or deletion of services, e.g. home dialysis, dialysis in LTC, dialyzer reuse, in-center nocturnal HD, in-center PD, etc. "Expansion" refers to addition of in-center stations. If you relocate one of your services to a different physical location, you may be required to obtain a separate CCN for that service at the new location.

IDENTIFYING INFORMATION (ITEMS 2-19)

Enter the name and address *(actual physical location)* of the dialysis facility where the services are performed. If the mailing address is different, show the mailing address in Remarks (*Item 33*). Check the applicable blocks (*Item 17* and *Item 18*) to indicate the dialysis facility's hospital and/or SNF/NF affiliation, if any. If so, enter the CCN of the hospital and/or SNF/NF. Check whether the dialysis facility is owned and/or managed by a "multi-facility" organization (*Item 19*) and provide the name and address of the parent organization. A "multi-facility organization" is defined as a corporation or a LLC that owns more than one dialysis facility.

TYPES OF MODALITIES/SERVICES, DIALYSIS STATIONS, AND DAYS/HOURSOF OPERATION (ITEMS 20-29)

Check the modalities/services that are already offered ("current modalities/services") by a dialysis facility requesting recertification (*Item 20*). Check N/A or check each **NEW** modality/service for which you are requesting approval. Any new modality/service must be requested on the CMS-3427 and filed with the State agency. At the time of survey, one permanent patient must be on the dialysis facility's census in-center or in training/trained by the facility for each modality requested (*Item 21*). Note that dialysis facilities providing home therapies must provide both training and support. If you are requesting to offer home training and support **only** (*Item 21*), you must have a functional plan/arrangement to provide backup dialysis as needed. If you request any home training and support program (*Item 21*), you must also indicate "Yes" for a training room (only count stations for in-center dialysis, not for home training) (*Item 24*). **If you currently provide or support home dialysis within one or more LTC facilities (SNF/NF), complete *Item 22* and list for all LTCs: name, CCN, staffing provided by, and number of dialysis patients treated by modality under Remarks (*Item 33*). Notifications of any agreement initiated between the facility and a LTC facility for providing home dialysis to residents within any LTC facility require completion of *Item 22* (and 33 if applicable) and submission of this form to the State agency .** You must answer *Yes* (*Item 22*) and have at least one LTC dialysis resident for addition of services for home dialysis in LTC. Enter the number of additional in-center stations for which you are asking approval (*Item 25*). Provide information on isolation *(Items 26-27).* Dialysis facilities not existing prior to October 14, 2008 which do not have an isolation room must attach evidence of CMS waiver and written agreement with geographically proximal facility with isolation room. Provide current information on all days and start time for the first shift and end time for the last shift of in-center patients (in military time) for each day of operation. If the dialysis facility offers home training and support only, provide current operating hours for each day *(Item 28)*. Provide information on dialyzer reprocessing *(Item 29)*.

STAFFING (ITEM 30)

"Other" includes non-certified patient care technicians, administrative personnel, etc. To calculate the number of full-time equivalents of any discipline (*Item 30*), add the total number of hours that all members of that discipline work at this dialysis facility and enter that number in the numerator. Enter into the denominator the number of hours that facility policy defines as full-time work for that discipline. Report FTEs in 0.25 increments only. Example: An RD works 20 hours a week at Facility A. Facility A defines full time work as 40 hours/week. To calculate FTEs for the RD, divide 20 by 40. The RD works 0.50 FTE at Facility A.

LICENSING AND CERTIFICATE OF NEED, IF APPLICABLE (Items 31-32)

If your state requires licensing for ESRD facilities, include your current license number in Item 31. If your state requires a Certificate of Need (CON) for an initial ESRD or for the change you are requesting, mark the applicable box in Item 32 and include a copy of the documentation of the CON approval.

REMARKS (ITEM 33)

You may use this block for explanatory statements related to Items 1-32.

The administrator/medical director signs and dates. Upon completion, forward a copy of form CMS-3427 (Part I) to the State agency.

PART II - TO BE COMPLETED BY STATE AGENCY

The surveyor should review and verify the information in Part I with administrator or medical director and complete Part II of this form.

Recognize that CMS cannot issue a CCN for an initial survey until all required steps are complete, including recommended approval of the CMS-855A by the applicable MAC. Complete the Statement of Deficiencies (CMS Form 2567) in ASPEN. Complete the CMS-1539 in ASPEN entering recommended action(s). All required information must be entered in ASPEN and uploaded in order for the survey to be counted in the state workload.