FORM APPROVED
OMB No. 0938-0379

HOSPICE SURVEY AND DEFICIENCIES REPORT
(CMS-643)

Medicare Certification Number:	Name of Facility:	Survey Date:

1. Was this Hospice surveyed for compliance with 42 CFR 418.110? **1.50**

   YES NO

2. If this hospice provides inpatient care directly, is this inpatient care provided on the premises? **1.51**

   YES NO

3. Has a waiver of core nursing services been granted? **1.52**

   YES NO

4. If "Yes" indicate date **1.53**

5. Indicate type of setting(s) in which the hospice provides routine home care. **1.54**

   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. **1.55**

7. Number of hospice patients admitted during the most recent 12-month period. **1.56**

8. Number of records reviewed during survey. **1.57**

9. Number of home visits conducted to patients in a private residence. **1.58**

10. Number of home visits conducted to patients in residential facilities. **1.59**

11. Does this hospice operate under the same certification number at more than one location? **1.60**

    YES NO

12. If YES, enter number of locations **1.61**

13. Does this hospice operate as part of another entity that participates in the Medicare Program? **1.62**

    YES NO

14. If YES, enter the Medicare certification number of the entity **1.65**

Surveyor's Signature:	Title:	Date:

FORM APPROVED
OMB No. 0938-0379

HOSPICE SURVEY AND DEFICIENCIES REPORT
(CMS-643)

Deficiencies

Data Tag Number	COP/Standard No.	Comments

FORM APPROVED
OMB No. 0938-0379

ATTESTATION STATEMENT

I certify that I have reviewed each CMS hospice Condition of Participation and related standards and except as indicated on this form the above-stated facility was found to comply with the CMS standards and/or the Conditions of Participation.

Surveyor's Signature	Title	Date

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 **0938-0379 (Expires 09/30/2022)**. This is a **mandatory** information collection. The time required to complete this information collection is estimated to average **twenty-four hours** 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 QSOG_Hospice@cms.hhs.gov.