

**ORGAN PROCUREMENT ORGANIZATION (OPO) REQUEST FOR DESIGNATION AS AN OPO
Under § 1138 of the Social Security Act
(CMS-576)**

To Be Completed by CMS Staff Only

OPO's CMS Certification Number (CCN):		Hospital CCN Number:		Related CCN (e.g., for CHOWs/Mergers/Consolidations):	
CMS Location (Region) Name:	CMS Location (Region) Number	Current Fiscal Year End Date:		Date of CMS Receipt:	

To Be Completed by the OPO Provider Staff

I. Identifying Information	Name of OPO:		CMS Certification Number (CCN):	
	Street Address:		City, County:	
	State:	Zip Code:	Telephone Number:	
	Name of OPO CEO or Director:			
	Area Served by This OPO Provider			
List Counties Served (or State if entire State is served):				
List All Acute Care Hospitals with the Resources Necessary to Retrieve Organs (i.e. - Operating Rooms, Equipment, Staff)				

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II. Type of Control	<table border="0"> <tr> <td>Independent</td> <td>Individual</td> <td>Corporation</td> <td>Partnership</td> <td>State Government</td> </tr> <tr> <td>Hospital-Based</td> <td>For-Profit</td> <td>Non-Profit (under §501)</td> <td></td> <td>Federal Government</td> </tr> </table>	Independent	Individual	Corporation	Partnership	State Government	Hospital-Based	For-Profit	Non-Profit (under §501)		Federal Government		
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III. Administration and Staffing	<table border="1"> <thead> <tr> <th data-bbox="411 483 1377 542">Names of OPO Administrative Staff</th> <th data-bbox="1377 483 2049 542">Title of OPO Administrative Staff</th> </tr> </thead> <tbody> <tr> <td data-bbox="411 542 1377 662">1. Name OPO's Administrator:</td> <td data-bbox="1377 542 2049 662">Title of OPO 's Administrator:</td> </tr> <tr> <td data-bbox="411 662 1377 782">2. Name of OPO's Medical Director:</td> <td data-bbox="1377 662 2049 782">Title of OPO's Medical Director:</td> </tr> <tr> <td data-bbox="411 782 1377 902">3. Name of OPO's Program Manager:</td> <td data-bbox="1377 782 2049 902">Title of OPO's Program Manager:</td> </tr> <tr> <td data-bbox="411 902 1377 1023">4. Name of OPO's Donation Coordinator:</td> <td data-bbox="1377 902 2049 1023">Title of OPO's Donation Coordinator:</td> </tr> <tr> <td data-bbox="411 1023 1377 1133">5. Name of OPO's Organ Procurement Specialist:</td> <td data-bbox="1377 1023 2049 1133">Title of OPO's Organ Procurement Specialist:</td> </tr> </tbody> </table>	Names of OPO Administrative Staff	Title of OPO Administrative Staff	1. Name OPO's Administrator:	Title of OPO 's Administrator:	2. Name of OPO's Medical Director:	Title of OPO's Medical Director:	3. Name of OPO's Program Manager:	Title of OPO's Program Manager:	4. Name of OPO's Donation Coordinator:	Title of OPO's Donation Coordinator:	5. Name of OPO's Organ Procurement Specialist:	Title of OPO's Organ Procurement Specialist:
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5. Name of OPO's Organ Procurement Specialist:	Title of OPO's Organ Procurement Specialist:												
IV. Narrative	<p>Provide narrative responses to the following questions regarding your OPO (in a separate document) and provide all documentation required to support your responses:</p> <ol style="list-style-type: none"> 1. Submit a plan to show evidence of transition planning to ensure continuity of organ procurement services if a CHOW takes place. 2. Specify the number of hospitals in your OPO's service area with which you have agreements and provide plan for how these hospitals will notified if a CHOW is to take place. 												

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3. Describe the role of the OPO in training hospital designated requestor(s) in establishing and implementing protocols for making routine inquiries about organ donations by potential donors.
4. Provide your organization's plan for the allocation of donated organs among potential transplant recipients.
5. Describe procedures for complying with OPTN allocation policies.
6. Provide documentation of your coordination activities with transplant programs in the service area.
7. Discuss your organization's arrangements for tissue typing of donated organs.
8. Document your affiliation with tissue banks for the retrieval, processing, preservation, storage and distribution of tissues to assure that all usable tissues from potential donors are obtained.
9. Discuss and document your accounting procedures and provide an audit letter on letterhead with the name and address of your accounting firm.
10. Provide your written procedures for screening and testing for HIV and other infectious diseases.
11. Provide your procedures for ensuring the confidentiality of patient records.
12. Discuss and document your activities relating to professional education concerning organ procurement.

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ATTESTATION STATEMENT

Whoever knowingly or willfully makes or causes to be made a false statement or representation on this statement, 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.

Printed Name of Authorized OPO Representative:	Title of Authorized OPO Representative:
Signature of Authorized OPO Representative:	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 **0938-0512 (Expires XX/XX/20XX)**. This is a required information collection. The time required to complete this information collection is estimated to average of **24 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_OPO@cms.hhs.gov.

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INSTRUCTIONS FOR COMPLETION OF THE CMS-576 FORM

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions for Coverage: OPOs, are met. The form provides information and data about the OPO that is necessary to determine compliance with the Conditions and provides a data base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

General Instructions:

- Answer all questions as of the current date.
- Return the original form and the signed agreement to the CMS Location serving your area and make a copy for your files.
- Failure to return this form may result in termination for the service area.
- Detailed instructions are given below for questions other than those considered self-explanatory.

Item I: Identifying Information:

- Medicare CMS Certification Number (CCN): Insert the facility's six-digit Provider Number.
- Leave blank on initial request for designation.
- State: The state the OPO is located.
- Related CCN: If the OPO is affiliated with any other Medicare provider, insert the related facility's six-digit Medicare provider number.

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**INSTRUCTIONS FOR COMPLETION OF THE CMS-576 FORM
(continued)**

Item II: Type of Control:

- Check the category(ies) that is most descriptive of the type of organization operating the facility. Check “nonprofit under §501 if the organization is exempt from Federal income taxation under §501 or the Internal Revenue Code of 1986.

Item III: OPO Administrative and Staffing:

- Give the name and title of members of the Board of Directors, Advisory Board and staff members.

Item IV: Narrative:

- Please answer the questions in this section completely and concisely.
- Failure to do so may hinder consideration. Attach supporting documentation, such as agreements, statistical data, etc. The documentation should explain the OPO’s plans or systematic efforts to provide its organ procurement services. The preferable documentation is a copy of the written agreements with the various hospitals and transplant centers in the service area that list the OPO’s responsibilities and functions.
- If an organization seeking designation as an OPO does not have a written agreement with a given facility, we will accept a letter of intent from a hospital or transplant center that it will enter into such agreement within not more than 12 months after the OPO’s designation.
- If an organization does not have either a written agreement or letter of intent, it must submit other documentation of its working relationship.