LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

SURVEY TEAM WILL COMPLETE:

Standard Survey:		**Extended Survey:**	
From: F1 *(mm/dd/yyyy)*	To: F2 *(mm/dd/yyyy)*	From: F3 *(mm/dd/yyyy)*	To: F4 *(mm/dd/yyyy)*

GENERAL INSTRUCTIONS:

This form is to be completed by the Facility. For the purpose of this form, "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Name of Facility	Provider Number	F5: Fiscal Year Ending *(mm/dd/yyyy)*

Street Address

City	County	State	Zip Code

F6: Telephone Number:	F7: State/County Code:	F8: State/Region Code:

F8a: Medicare	F8b: Medicaid	F8c: Other	F8d: Total Residents

F9:

	01 Skilled Nursing Facility (SNF) - Medicare Participation 02 Nursing Facility (NF) - Medicaid Participation 03 SNF/NF - Medicare/Medicaid

F10: Is this facility hospital based? ..... ◯ Yes ◯ No

If yes, indicate Hospital Provider Number: F11

F12: Ownership

For-Profit	**Non-Profit**	**Government**	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal
13 Limited Liability Corporation			

F13: Owned or leased by Multi-Facility Organization ..... ◯ Yes ◯ No

F14: Name of Multi-Facility Organization

Dedicated Special Care Units: *(show number of beds for all that apply)*

F15: AIDS	F16: Alzheimer's Disease	F17: Dialysis
F18: Disabled Children/Young Adults	**F19: Head Trauma**	**F20: Hospice**
F21: Huntington's Disease	**F22: Ventilator/Respiratory Care**	**F23: Other Specialized Rehabilitation**

F24: Does the facility currently have an organized residents' group? ..... ◯ Yes ◯ No

F25: Does the facility currently have an organized group of family members of residents? ..... ◯ Yes ◯ No

F26: Does the facility conduct experimental research? ..... ◯ Yes ◯ No

F27: Is the facility part of a continuing care retirement community (CCRC)? ..... ◯ Yes ◯ No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement:		**Waiver of 24 hr licensed nursing requirement:**	
F28: Date *(mm/dd/yyyy)*	F29: Hours waived per week:	F30: Date *(mm/dd/yyyy)*	F31: Hours waived per week

F32: Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? ..... ◯ Yes ◯ No

Name of Person Completing Form	Time
Signature	Date

TO BE COMPLETED BY SURVEY TEAM:

1. Was ombudsman office notified prior to survey?..... ◯ Yes ◯ No

2. Was ombudsman present during any portion of the survey?..... ◯ Yes ◯ No

3. Medication error rate _____% (The medication error rate at the time of survey, based upon observation by the surveyor. This is a percentage. You can enter only whole numbers up to 999.)

DEFINITIONS

Name of Facility: Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number: Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address: Street name and number refers to physical location, not mailing address, if two addresses differ.

City: Rural addresses should include the city of the nearest post office.

County: County refers to parish name in Louisiana and township name where appropriate in the New England States.

State: For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code: Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number: Include the area code.

State/County Code: LEAVE BLANK. State Survey Office will complete.

State/Region Code: LEAVE BLANK. State Survey Office will complete.

Block F8a: Residents whose stay is covered by their Medicare Part A Skilled Nursing Facility (SNF) benefit (primary payer is Original Medicare or a Medicare Advantage (Part C) plan).

Block F8b: Residents whose stay is covered by a state's Nursing Facility (NF) benefit (primary payer is Medicaid or Medicaid Managed Care).

Block F8c: Residents for whom a bed is maintained on the day the survey begins, including those temporarily away in a hospital or on leave. This should be representative of residents in the nursing facility or those who have a bed-hold.

Block F9: Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10: If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11: The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12: Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to Determine Ownership are:

- **For-Profit:** If operated under commercial ownership, indicate whether owned by individual, partnership, corporation, or limited liability corporation (LLC).
- **Non-Profit:** If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.
- **Government:** If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13: Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no."

A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14: If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23: Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8"in F19.

Block F24: Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to sup- port each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25: Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

Block F26: Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27: Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31: If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.35(e) or (f), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32: Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."