

HOSPICE SURVEYOR WORKSHEET

(CMS-643)

CMS Certification Number:

Name of Facility:

Survey Date:

1. If this hospice provides inpatient care directly, is this inpatient care provided on the premises?

YES

NO

2. Was this Hospice surveyed for compliance with 42 CFR 418.110?

YES

NO

3. Is the hospice using contracted staff to meet the requirements for 42 CFR 418.64 (Condition of Participation: Core Services)?

YES

NO

4. If using contracted staff to supplement hospice employees to meet the needs of patients under extraordinary or other non-routine circumstances, indicate date since when this has been in effect:

Part I- Survey Details

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

6. Number of hospice patients admitted during the most recent 12-month period.

7. Number of medical records reviewed during survey.

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

9. Number of home visits conducted to patients in residential facilities

Part II- Additional Operating Details

10. Does this hospice operate under the same certification at more than one location?

YES

NO

11. If yes, do the locations match the locations annotated in the surveyor database?

YES

NO

Note: If locations do not match, list the differing multiple locations in Part III. Instruct the facility to submit the change to CMS.

Part III- Multiple Locations (Inconsistent with Survey Record)				
12. Name of Location #1				Related Certification No.
Type: Hospital	SNF	ICF	HHA	Free-Standing
Street Address:				City
State:				Zip Code:
Additional Surveyor Comments:				
13. Name of Location #2				Related Certification No.
Type: Hospital	SNF	ICF	HHA	Free-Standing
Street Address:				City
State:				Zip Code:
Additional Surveyor Comments:				
14. Name of Location #3				Related Certification No.
Type: Hospital	SNF	ICF	HHA	Free-Standing
Street Address:				City
State:				Zip Code:
Additional Surveyor Comments:				
15. Name of Location #4				Related Certification No.
Type: Hospital	SNF	ICF	HHA	Free-Standing
Street Address:				City
State:				Zip Code:
Additional Surveyor Comments:				

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 XX/XX/20XX)**. 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.

HOSPICE SURVEYOR WORKSHEET

(CMS-643)

INSTRUCTIONS

This form is required to be completed upon initial and recertification surveys by the State Survey Agency (SA) and Accrediting Organization (AO)(if applicable). The information collected by the surveyor is necessary to ensure a full survey record and verification of the hospice's operating details. The purpose of the form is to guide elements of the survey in addition to the full interpretive guidelines provided in the State Operations Manual (SOM), [Appendix M](#).

CMS Certification Number: Enter the CMS certification number (CCN) or leave blank for initial surveys.

Name of Facility: Enter the name of the facility, as listed on the CMS 855.

Survey Date: Enter the start date of the survey.

1. Determine if inpatient care is provided. Annotate yes or no, if it is provided on the premises.
2. A hospice that provides inpatient care directly in its own facility must demonstrate compliance with the requirements of 42 CFR 418.110. If the hospice provides inpatient care, confirm review of compliance with 42 CFR 418.110 and select yes. If the hospice does not provide inpatient care, select no.
3. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under [extraordinary or other non-routine circumstances](#) 42 CFR 418.64 (Condition of Participation: Core Services). Identify through record review, if the hospice uses contracted staff and select yes or no.
4. If using contracted staff, annotate the date since when contracted staff have been used.

Part I- Survey Details

5. Enter the number of hospice patients residing in a SNF, NF, or other residential facility who receive routine home care from the hospice at the time of the survey.
6. Enter the number of hospice patients admitted during the most recent 12-month period.
7. Enter the number of medical records reviewed during survey.
8. Enter the number of home visits conducted to patients in a private residence.
9. Enter the number of home visits conducted to patients in residential facilities

Part II- Additional Operating Details

10. Select yes or no, if this hospice operates under the same certification at more than one location?
11. If yes, do the locations match the locations annotated in the surveyor database? Verify in the surveyor database and survey record if the multiple locations match. If locations do not match, list the differing multiple locations in Part III. Instruct the facility to submit the change to the State Survey Agency and the Medicare Administrative Contractor (MAC) consistent with [Admin Info 24-22](#). Hospices must report all changes and seek approval for each location, administrative changes, and closures. The hospice must also complete a new Form CMS-417 with the submission of the administrative changes.

Part III- Multiple Locations - (Inconsistent with Survey Record)

List any multiple locations which are currently not in the survey record or surveyor database.

Note: Hospice Multiple locations fall under the parent Hospice's Medicare provider agreement and CCN.