

END STAGE RENAL DISEASE APPLICATION AND SURVEY AND CERTIFICATION REPORT

PART 1 – APPLICATION – TO BE COMPLETED BY FACILITY

1. Type of Application/Notification (check all that apply; if "Other," specify in "Remarks" section [Item 33]): (v1)

1. Initial 2. Recertification 3. Relocation 4. Expansion/change of services 5. Change of ownership
 6. Other, specify:

2. Name of 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA

15. Facility Administrator Name:

Address:

City: _____ State: _____ Zip Code: _____ Telephone No: _____

16. Ownership (v2) 1. For Profit 2. Not for Profit 3. Public

17. Is this facility owned and managed by a hospital and on the hospital campus (i.e., hospital-based)? (v3) 1. Yes 2. No
Is this facility owned and managed by a hospital and located off the hospital campus (i.e., satellite)? (v4) 1. Yes 2. No
Is this facility not owned or managed by a hospital (i.e., independent)? (v5) 1. Yes 2. No
If owned and managed by a hospital: hospital name: (v6) _____ CCN: (v7) _____

18. Is this facility located in a SNF/NF (check one): (v8) 1. Yes 2. No
If Yes, SNF/NF name: (v9) _____ CCN: (v10) _____

19. Is this 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 Services (check all that apply): (v13)
 1. In-center Hemodialysis (HD) 2. In-center Peritoneal Dialysis (PD) 3. In-center Nocturnal HD 4. Reuse
 5. Home HD Training & Support 6. Home PD Training & Support 7. Home Training & Support **only**

21. New services being requested (check all that apply): (v14)
 1. N/A 2. In-center HD 3. In-center PD 4. In-center Nocturnal HD 5. Reuse
 6. Home HD Training & Support 7. Home PD Training & Support 8. Home Training & Support **only**

22. Does the facility have any home dialysis (PD/HD) patients receiving dialysis in 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
Type of home dialysis provided in this LTC facility: (v19) 1. HD 2. PD
For additional LTC facilities, record this information and attach to the "Remarks" (item 33) section.

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 approved in-center dialysis stations: (v26) _____ Onsite home training room(s) provided? (v27) 1. Yes 2. N/A

25. Additional stations being requested: (v28) None In-center HD: (v29) _____ In-center nocturnal HD: (v30) _____
In-center PD: (v31) _____

26. How is isolation provided? (V32)

1. Room 2. Area (established facilities only) 3. CMS Waiver/Agreement (Attach copy)

27. If applicable, number of hemodialysis stations designated for isolation: (V33)

28. Days & time for in-center patient shifts (check all days that apply and complete time field in military time): (V34)

1 st shift starts:	M	T	W	Th	F	Sat	Sun
Last shift ends:	M	T	W	Th	F	Sat	Sun

29. Dialyzer reprocessing system: (V35) 1. Onsite 2. Centralized/Offsite 3. N/A

30. Staff (List full-time equivalents):

Registered Nurse: (V36)	Certified Patient Care Technician: (V37)
LPN/LVN: (V38)	Technical Staff (water, machine): (V39)
Registered Dietitian: (V40)	Masters Social Worker: (V41)
Others: (V42)	

31. State license number (if applicable): (V43)	32. Certificate of Need required? (V44) <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. NA
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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
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PART II TO BE COMPLETED BY STATE AGENCY

35. Medicare Enrollment (CMS 855A approved by the MAC/FI)? (V45) 1. Yes 2. No

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

36. Type of Survey: (V46) 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: (V47)	38. State County Code: (V48)
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39. Network Number: (V49)

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:
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INSTRUCTIONS FOR FORM CMS-3427

PART 1 – 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 narrative statement describing the need for the service(s) to be provided, and
- 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. “Expansion” refers to addition of 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 2-24)

Enter the name and address (*actual physical location*) of the ESRD 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 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 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 facility.

TYPES OF SERVICE, DIALYSIS STATIONS, AND DAYS/HOURS OF OPERATION (ITEMS 20-28)

Provide information on current services offered (*Item 20*). Check N/A or each **New** service for which you are requesting approval (*Item 21*). Note that 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. A new “home training and support only” service applies to initial applications. If you request **any** home training and support program (*Item 21*), you must also indicate “Yes” for a training room (*Item 24*). If you provide or support dialysis within one or more a LTC facilities (SNF/NF), list all LTCs (name, CCN, and address) participating in this service under Remarks (*Item 33*), and complete Item 22. Enter the number of stations for which you are asking approval (*Item 25*). Provide information on isolation (*Items 26-27*). 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 all days and start time for the first shift of patients and end time for the last shift of patients (in military time) for each day of operation (*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 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.

REMARKS (ITEM 33)

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

LICENSING AND CERTIFICATE OF NEED

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.

Upon completion, forward a copy of form CMS-3427 (Part I) to the State agency.

PART II - SURVEY AND CERTIFICATION REPORT 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 CMS-855A approved 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.