DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AUTHORIZATION FOR STATE AGENCY HOSPICE VALIDATION SURVEY

1. NAME AND ADDRESS OF STATE AGENCY	2. NAME AND ADDRESS OF HOSPICE CMS CERTIFICATION NUMBER: _____

3. THIS HOSPICE IS CURRENTLY DEEMED BY *(NONE OR MORE THAN 1 MAY BE CHECKED)*:

☐ ACHC ☐ TJC
☐ CHAP ☐ NONE

4. ***CHECK A OR B; DO NOT CHECK BOTH***

A. ☐ **THIS VALIDATION SURVEY IS BASED ON A SAMPLE SELECTION. CHECK 1 OR 2. DO NOT CHECK BOTH.**

1. ☐ PLEASE CONDUCT A FULL VALIDATION SURVEY FOLLOWING THE PROTOCOLS AND PROCEDURES FOR A MEDICARE CERTIFICATION SURVEY WITHIN 60 CALENDAR DAYS OF _____ *(ENTER AO NAME)* ACCREDITATION SURVEY END DATE.
THE SCHEDULED END DATE OF THE ACCREDITATION SURVEY IS: _____

IF APPLICABLE, CHECK ONE OR MORE OF THE FOLLOWING:

☐ THIS IS AN INITIAL ACCREDITATION SURVEY FOR THIS CURRENTLY PARTICIPATING, NON-DEEMED FACILITY.

☐ THIS IS AN INITIAL ACCREDITATION SURVEY FOR THIS AO; HOSPICE IS CURRENTLY DEEMED.

2. ☐ THIS IS A MID-CYCLE VALIDATION SURVEY. PLEASE CONDUCT A FULL VALIDATION SURVEY FOLLOWING THE PROTOCOLS AND PROCEDURES FOR A MEDICARE CERTIFICATION SURVEY

SA MUST COMPLETE ALL VALIDATION PACKET DOCUMENTS LISTED IN EXHIBIT 63 FOR ANY FULL VALIDATION SURVEY.

B. ☐ **THIS VALIDATION SURVEY IS BASED ON ALLEGATIONS OF SIGNIFICANT DEFICIENCIES WHICH COULD AFFECT THE HEALTH AND SAFETY OF PATIENTS. *CHECK ONE OF THE FOLLOWING:***

☐ POTENTIAL IJ—INITIATE SURVEY WITHIN 2 WORKING DAYS; OR

☐ INITIATE SURVEY WITHIN 45 CALENDAR DAYS

SA MUST NOT NOTIFY THE FACILITY OR AO IN ADVANCE OF THE SURVEY

5. ***AREAS TO BE SURVEYED (FOR SAMPLE VALIDATION SURVEYS, CHECK ALL; FOR ALLEGATION SURVEYS, CHECK ALL APPLICABLE CONDITIONS, &, IF APPLICABLE, THE LIFE SAFETY CODE STANDARD):***

☐ 418.52 PATIENT'S RIGHTS
☐ 418.54 INITIAL/ COMPREHENSIVE ASSESSMENT OF THE PATIENTS
☐ 418.56 INTERDISCIPLINARY GROUP, CARE PLANNING, AND COORDINATION
☐ 418.58 QUALITY ASSESSMENT/ PERFORMANCE IMPROVEMENT
☐ 418.60 INFECTION CONTROL
☐ 418.62 LICENSED PROFESSIONAL SERVICES
☐ 418.64 CORE SERVICES
☐ 418.66 NURSING SERVICES—WAIVER
☐ 418.70 FURNISHING OF NON-CORE SERVICES
☐ 418.72 THERAPY SERVICES
☐ 418.74 THERAPY & DIETARY –WAIVER
☐ 418.76 HOSPICE AIDE AND HOMEMAKER SERVICES
☐ 418.78 VOLUNTEERS
☐ 418.100 ORGANIZATION AND ADMINISTRATION OF SERVICES
☐ 418.102 MEDICAL DIRECTOR
☐ 418.104 CLINICAL RECORDS
☐ 418.106 DRUGS AND BIOLOGICALS, MEDICAL SUPPLIES AND DME
☐ 418.108 SHORT-TERM INPATIENT CARE
☐ 418.110 HOSPICES THAT PROVIDE INPATIENT CARE DIRECTLY
☐ 418.110(d) LIFE SAFETY CODE
☐ 418.112 HOSPICES THAT PROVIDE CARE TO SNF/NF OR ICF/MR RESIDENTS
☐ 418.114 PERSONNEL QUALIFICATIONS
☐ 418.116 COMPLIANCE WITH FEDERAL, STATE & LOCAL LAWS & REGULATIONS

6. SIGNATURE OF REGIONAL REPRESENTATIVE	7. REGION	8. DATE

ORIGINAL TO: STATE SURVEY AGENCY
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