

---

## INSTRUCTIONS FOR COMPLETING HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

---

### STATEMENT CONCERNING INFORMATION COLLECTION REQUIREMENTS AND USES:

This form is required to obtain or retain Medicare benefits. It serves two purposes. First, it provides basic information about the Hospice which is necessary for the State to properly schedule a survey. Second, it provides a data-base necessary for responding to questions frequently asked by Congress, Federal agencies, and interested members of the public.

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions are met.

Answer all questions as of the current date. Return the original and first two copies to the State Agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State Agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

#### Item I:

- Request to establish eligibility in—current Hospice Benefits are available only through the Medicare program.
- Medicare certification number:  
Insert the facility's six digit Medicare Certification Number. Leave blank on initial requests for certification.
- State/County and State/Region Codes:  
Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.
- Related certification number:  
If Hospice is affiliated with any other type Medicare provider, insert the related facility's six digit Medicare Certification Number.

#### Item IV:

- If a service is provided directly by the facility place a "1" in the appropriate block.
- If a service is provided through an outside source (i.e., by contract/arrangement), place a "2" in the appropriate block.

## HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Read Instructions and Information Collection Statement On Cover Sheet of Form Prior to Completion)

<b>I. Identifying Information</b>	Name of Hospice		Street Address							
	Request to Establish Eligibility In 1. <input type="checkbox"/> Medicare PH1			City, County and State			Zip Code			
	Medicare/Certification Number PH2	State/County PH3	State/Region PH4	Telephone Number (include area code) PH5		Related Certification Number PH6				
<b>II. Type of Hospice</b> (Check One) PH7	1. <input type="checkbox"/> Hospital 2. <input type="checkbox"/> Skilled Nursing Facility 3. <input type="checkbox"/> Intermediate Care Facility 4. <input type="checkbox"/> Home Health Agency 5. <input type="checkbox"/> Freestanding Hospice			For Hospitals Only (Check One) A. <input type="checkbox"/> The Joint Commission Accredited B. <input type="checkbox"/> AOA Accredited C. <input type="checkbox"/> Both The Joint Commission and AOA Accredited D. <input type="checkbox"/> Non-Accredited			Fiscal Year Ending Date			
	<b>Non-Profit:</b> 1. <input type="checkbox"/> Church 2. <input type="checkbox"/> Private 3. <input type="checkbox"/> Other PH8			<b>Proprietary:</b> 4. <input type="checkbox"/> Individual 5. <input type="checkbox"/> Partnership 6. <input type="checkbox"/> Corporation 7. <input type="checkbox"/> Other		<b>Government:</b> 8. <input type="checkbox"/> State 9. <input type="checkbox"/> County 10. <input type="checkbox"/> City 11. <input type="checkbox"/> City-County 12. <input type="checkbox"/> Combination Government and Nonprofit 13. <input type="checkbox"/> Other				
<b>IV. Services Provided:</b> By staff, place a "1" in the block(s) If under arrangement, place a "2" in the block(s) PH9	<b>Core:</b> 1. <input type="checkbox"/> Physician Services 2. <input type="checkbox"/> Nursing Services 3. <input type="checkbox"/> Medical Social Services 4. <input type="checkbox"/> Counseling Services			5. <input type="checkbox"/> Physical Therapy 6. <input type="checkbox"/> Occupational Therapy 7. <input type="checkbox"/> Speech-Language Pathology 8. <input type="checkbox"/> Hospice Aide 9. <input type="checkbox"/> Homemaker 10. <input type="checkbox"/> Medical Supplies 11. <input type="checkbox"/> Short Term Inpatient Care PH10 12. <input type="checkbox"/> Other(Specify) A. _____ Acute B. _____ Respite			Name and Address of Contractee		Medicare Certification/Supplier Number	
	<b>V. Number of Employees/Volunteers Full-time Equivalent</b> Top section of professional category reflects total number of FTE (i.e., PH 11 through PH 18)		Physicians PH11	Registered Professional Nurses PH12	Licensed Practical Nurses/ Licensed Vocational Nurses PH13		Medical Social Workers PH14		Total Number PH19	
		Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.			
		Homemakers PH15		Hospice Aide PH16		Counselors PH17		Others PH18		
		Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	Employees A.	Volunteers B.	

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

Name of Authorized Representative and Title (Typed)	Signature	Date
---	-----------	------

**PART 2 – REGIONAL OFFICE**

**PART 3 – STATE AGENCY**

**PART 4**

**PART 5 – PROVIDER**