

**END STAGE RENAL DISEASE APPLICATION/NOTIFICATION AND SURVEY AND CERTIFICATION
REPORT - Version 2**

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Name of Facility		2. CCN	
3. Street Address		4. NPI	
5. City	6. County	7. Fiscal Year End Date	
8. State	9. ZIP Code	10. Administrator's Email Address	
11. Telephone No.	12. Facsimile No.	13. Medicare Enrollment (CMS 855A) completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
14. Facility Administrator Name		Address:	
City:	State:	Zip Code:	Telephone No:
15. Type of Application/Notification: (V1) (check all that apply. If "Other", specify in Remarks section [Item 33])			
<input type="checkbox"/> 1. Initial	<input type="checkbox"/> 2. Recertification	<input type="checkbox"/> 3. Relocation	
<input type="checkbox"/> 4. Expansion	<input type="checkbox"/> 5. Change of Ownership	<input type="checkbox"/> 6. Change of services	
<input type="checkbox"/> 7. Other (specify)			
16. Ownership (V2) <input type="checkbox"/> 1. For Profit <input type="checkbox"/> 2. Not For Profit <input type="checkbox"/> 3. Public			
17. Is this Facility Hospital-Owned? (V3) <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No If Yes, hospital CCN (V4):			
If yes, is this Facility on the main hospital-campus? (V5) <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No			
(V6) Hospital name:			
18. Is this Facility SNF-Owned? (V7) <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No If Yes, SNF CCN (V8):			
19. Is facility owned and/or managed by a multi-facility organization? (V9) <input type="checkbox"/> 1. No <input type="checkbox"/> 2. Yes			
<input type="checkbox"/> Owned <input type="checkbox"/> Managed			
(V10) If Yes, name of parent or managing organization:			
(V11) Address:			
20. Current Services: (check all that apply)			
(V12) <input type="checkbox"/> 1. In-center Hemodialysis (HD)	<input type="checkbox"/> 2. In-center Peritoneal Dialysis (PD)(CAPD/CCPD)		
<input type="checkbox"/> 3. Home HD Training & Support	<input type="checkbox"/> 4. Home PD (CAPD/CCPD) Training & Support		
21. Requested Services: (check all that apply)			
(V13) <input type="checkbox"/> 1. In-center HD	<input type="checkbox"/> 2. In-center PD(CAPD/CCPD)		
<input type="checkbox"/> 3. Home HD Training & Support	<input type="checkbox"/> 4. Home PD (CAPD/CCPD) Training & Support		
22. Do Facility staff provide and/or support dialysis in nursing home(s)?			
(V14) <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.No If yes, list all nursing homes under "Remarks" (Item 33) and answer the next question on Staffing(V15)			
(V15) Staffing for dialysis provided by:	<input type="checkbox"/> 1. DME	<input type="checkbox"/> 2. Nursing home staff	<input type="checkbox"/> 3. This facility
(V16) Dialysis type:	<input type="checkbox"/> 1. HD	<input type="checkbox"/> 2. PD	
23. Number of dialysis <u>patients</u> :			
(V17) ___ In-center HD	(V18) ___ In-center Nocturnal HD	(V19) ___ In-center PD	
(V20) ___ Home PD	(V21) ___ Daily Home HD	(V22) ___ Conventional Home HD	
24. Number of dialysis <u>stations</u> including isolation stations (complete all sections that apply):			
(V23) ___ Total Stations	(V24) ___ In-center Hemodialysis	(V ___) ___ Home Training Station(s)/Room(s)	

INSTRUCTIONS FOR FORM CMS-3427

PART I - DOCUMENTATION NEEDED TO PROCESS FACILITY APPLICATION/NOTIFICATION

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.

IDENTIFYING INFORMATION (ITEM 1-14, 16-19)

Enter the name and address (*actual physical location*) of the ESRD facility or unit where the services are performed. If the mailing address is different, show the mailing address in the Remarks block (*Item 33*). Check the applicable block to indicate whether the facility is hospital or SNF-owned (*Item 18*) and enter the CCN of the hospital or SNF. 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 corporate or a LLC that owns more than one facility.

TYPE OF APPLICATION (ITEM15)

Check appropriate category. If this is an in-unit expansion request, show the location of the additional stations. 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 have a separate CCN for that service at the new location.

TYPES OF SERVICE AND DIALYSIS STATIONS (ITEMS 20-26)

Provide information on current services offered (*Item 20*). Check each service for which you are requesting approval (*Item 21*). Note that facilities providing home therapies must provide both training and support. If you provide or support dialysis being done in a nursing home, list all nursing homes (name, CCN, and address) participating in this service under Remarks (*Item 33*), and complete Items 22 and 23. Enter the number of stations for which you are asking approval (*Items 24-26*). If this is an expansion request, enter the total number of stations (including those previously approved) for which you are asking approval.

STAFFING

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 and enter that number in the numerator. Enter into the denominator the number of hours that facility policy defines as full-time for that discipline. Include bio-medical staff in "other" and clarify in Remarks (*Item 33*). Please report 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 a week. To calculate the FTEs for the RD, divide 20 by 40 to equal 0.50. 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 your 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 1 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 a CMS-855A approved by the applicable MAC. Complete the Statement of Deficiencies (CMS Form 2567) in ASPEN. Complete the CMS-1539, entering recommended action(s) in "Remarks" (*Item 33*). All required information must be entered in ASPEN and uploaded in order for the survey to be counted in the state workload.