Form Approved
OMB No. 0938-0065

REQUEST FOR CERTIFICATION IN THE MEDICARE AND/OR MEDICAID PROGRAM TO PROVIDE OUTPATIENT PHYSICAL THERAPY (OPT) AND/OR SPEECH PATHOLOGY SERVICES (OSP)- INITIAL AND EXTENSION SITE REQUESTS

PART I- REQUEST INFORMATION

A. If this request is an initial request by an organization to be certified as a participating OPT/OSP, please complete the following and proceed to Part II:

REQUEST TO ESTABLISH ELIGIBILITY IN	INITIAL REQUEST	COUNTY	STATE	SEEKING DEEMED STATUS
☐ MEDICARE ☐ MEDICAID ☐ BOTH	☐ YES ☐ NO			☐ YES ☐ NO

NAME OF ACCREDITING ORGANIZATION

B. If this request is to establish a new extension site, please complete the following and proceed to Part II:

CMS CERTIFICATION NUMBER OF PRIMARY SITE	EXTENSION SITE REQUEST	NAME OF ACCREDITING ORGANIZATION (IF DEEMED):
	☐ YES ☐ NO	

PART II- PRIMARY SITE WHERE THE OPT/OSP SERVICES ARE PROVIDED

I. IDENTIFYING INFORMATION	LEGAL NAME OF ORGANIZATION		
	DOING BUISNESS AS (DBA) NAME OF ORGANIZATION	STREET ADDRESS	
	CITY, COUNTY, AND STATE	ZIP CODE	TELEPHONE NO. *(INCLUDE AREA CODE)*

III. SERVICES PROVIDED *(CHECK ALL THAT APPLY)*

1. ☐ PHYSICAL THERAPY 2. ☐ SPEECH PATHOLOGY 3. ☐ OCCUPATIONAL THERAPY 4. ☐ ALL

IV. TYPE OF ORGANIZATION *(CHECK ONE)*

1. ☐ HOSPITAL
2. ☐ SKILLED NURSING FACILITY
3. ☐ HOME HEALTH AGENCY
4. ☐ REHABILITATION
5. ☐ PUBLIC CLINIC
6. ☐ PRIVATE CLINIC
7. ☐ PUBLIC HEALTH AGENCY

PART II CONTINUED- PRIMARY SITE WHERE THE OPT/OSP SERVICES ARE PROVIDED

V. TYPE OF CONTROL *(CHECK ONE)*	1. ☐ VOLUNTARY NON-PROFIT OTHER THAN CHURCH	4. ☐ LOCAL GOVERNMENT
	2. ☐ VOLUNTARY NON-PROFIT CHURCH	5. ☐ COMBINATION GOVERNMENT & VOLUNTARY
	3. ☐ STATE GOVERNMENT	6. ☐ PROPRIETARY

VI. HOURS OF OPERATION

DOES YOUR PRIMARY LOCATION OPERATE: (check one) ☐ Full-time ☐ Part-time

Full-Time Hours of Operation: _____

IF PART-TIME, IDENTIFY DAYS AND HOURS OF OPERATION:

Hours of Operation: Monday (from) _____ (to) _____ Tuesday (from) _____ (to) _____ Wednesday (from) _____ (to) _____ Thursday (from) _____ (to) _____ Friday (from) _____ (to) _____

VII. QUALIFIED STAFF

PHYSICAL THERAPISTS	1. TOTAL (2 & 3)	2. ON STAFF	3. BY ARRANGEMENT
SPEECH PATHOLOGISTS	1. TOTAL (2 & 3)	2. ON STAFF	3. BY ARRANGEMENT
OCCUPATIONAL THERAPISTS	1. TOTAL (2 & 3)	2. ON STAFF	3. BY ARRANGEMENT

PART III- NEW EXTENSION SITE REQUEST WHERE THE OPT/OSP SERVICES ARE PROVIDED

I. IDENTIFYING INFORMATION	LEGAL NAME OF ORGANIZATION		
	DOING BUISNESS AS (DBA) NAME OF ORGANIZATION	STREET ADDRESS	
	CITY, COUNTY, AND STATE	ZIP CODE	TELEPHONE NO. *(INCLUDE AREA CODE)*

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II. SERVICES PROVIDED *(CHECK ALL THAT APPLY)*	1. ☐ PHYSICAL THERAPY 2. ☐ SPEECH PATHOLOGY 3. ☐ OCCUPATIONAL THERAPY 4. ☐ ALL

PART III CONTINUED- NEW EXTENSION SITE WHERE THE OPT/OSP SERVICES ARE PROVIDED

III. HOURS OF OPERATION

WILL YOUR NEW EXTENSION LOCATION OPERATE: (check one) ☐ Full-time ☐ Part-time

Hours of Operation: _____

IF PART-TIME, IDENTIFY DAYS AND HOURS OF OPERATION:

_____ Monday _____ Tuesday _____ Wednesday _____Thursday _____Friday

Hours of Operation: _____

PART IV- EXISTING OR CLOSURES FOR EXTENSION SITES (Complete only for address changes and/or closures)

☐ CLOSURE	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
☐ ADDRESS CHANGE	NEW ADDRESS, STATE, ZIP CODE	
	IF CLOSURE (DATE OF TERMINATION: _____/_____/_____	

PART V- REQUEST TO CHANGE EXISTING EXTENSION SITE TO PRIMARY SITE (Complete only if your organization is already participating)

Is this a request to change an existing extension site to a primary site? Or is the existing primary location relocating and the current primary site requested to be the extension location?

☐ YES ☐ NO

If YES, COMPLETE BELOW:

I. PRIMARY LOCATION CONVERTING TO EXTENSION SITE	NAME OF ORGANIZATION	PRIMARY SITE CMS CERTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE
II. EXTENSION SITE CONVERTING TO PRIMARY SITE	NAME OF ORGANIZATION	EXISTING EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE

PART VI- EXISTING EXTENSION SITES (Complete only if your organization is already participating)

I. LOCATION #1	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE
II. LOCATION #2	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE
III. LOCATION #3	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE
IV. LOCATION #4	NAME OF ORGANIZATION	EXTENSION IDENTIFICATION NUMBER
	ADDRESS	STATE/ZIP CODE

For additional extension sites, please attach Part VII addendum.

PART VII- LEGAL CONTACT INFORMATION

PRIMARY POINT OF CONTACT AT ORGANIZATION:

NAME: TITLE/POSITION:

EMAIL: TELEPHONE:

WHOEVER KNOWINGLY AND WILLINGLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWING AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THIS INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE, OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OF CONTRACT WITH THE STATE AGENCY OR THE SECRETARY AS APPROPRIATE.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE

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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 0938-0273. Expiration Date: July 31, 2027. The time required to complete this information collection is estimated to average 15 minutes 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. *******CMS Disclaimer***** 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_OPT@cms.hhs.gov**

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INSTRUCTIONS FOR THE COMPLETION OF THE REQUEST TO ESTABLISH ELIGIBILITY IN THE MEDICARE AND/OR MEDICAID PROGRAM TO PROVIDE OUTPATIENT PHYSICAL THERAPY AND/OR SPEECH PATHOLOGY SERVICES

INSTRUCTIONS FOR COMPLETING FORM CMS-381

General Instructions

- All new prospective organizations wishing to participate as an OPT/OSP provider in the Medicare program and existing Medicare-certified OPTs requesting extension location requests must complete Form CMS-381. Answer all questions as of the current date of the request. Part VII is required for all submissions.
- The requesting organization must identify the primary site and any extension locations for the facility.
- If your organization is uncertain about how to complete some of the fields, contact your State Survey Agency (SA).
- For multiple extension site requests, each extension site(s) must be listed in Part III of the form. If necessary, an additional document may be provided as long as the information in Part III is included for each extension site.
- If an organization is requesting multiple extension sites at the same time, the organization is not required to submit a CMS-855 for every location. One CMS-855 and this form will suffice. Follow the instructions below.

NOTE: If an organization has submitted a CMS-855 to the MAC and submits an additional request within 90 days, please note that processing delays could occur as the MAC will be required to complete the first requested change prior to starting the second request.

For Initial Enrollment:

- Please complete this form and include this form in the application submission of the CMS-855 to the Medicare Administrative Contractor (MAC). (Part I, A; Part II)
- If the organization is submitting an extension site request in addition to the initial enrollment and certification of the primary site location, please complete Part III in addition to Part I. A.
- The MAC will review for enrollment criteria and submit this form in addition to their recommendation for approval to the State Agency (SA) and Accrediting Organization (AO) (if applicable).
- You may also copy the SA or AO in your request to the MAC. Contact information may be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc.

For Existing Medicare-participating OPT/OSP:

- Please complete this form and include it with the CMS-855 application submission to the Medicare Administrative Contractor (MAC) for any changes following the guidance below.
- The MAC will review for enrollment criteria and submit this form in addition to their recommendation for approval to the State Agency (SA) and Accrediting Organization (AO) (if applicable).
- You may also copy the SA or AO in your request to the MAC. Contact information may be found at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc.
- **Request to add new Extension Site**: Please complete this form any time your OPT is requesting a new extension site or changing/removing an extension site. (Part I.A- Select "No" for initial request; Complete Part I.B through Part III)
- **Request to Close an Existing Extension Site or Update Address of an Existing Extension Site**: (Part I.A- Select "No" for initial request; Complete Part I.B through Part II and Part IV)
- **Request to Convert an Existing Extension Site to the Primary Site, or Primary Site to an Extension Site:** If your organization is relocating its primary site to an extension location, please complete (Part I.A- Select "No" for initial request; Complete Part I.B through Part II and Part V). It is recommended that organizations clearly identify whether the organization is making a change to a primary site and an extension site in a cover letter submitted to the MAC, SA and AO (if applicable). Extension sites have specific identifiers within the CMS Certification Number (CCN). In the event of conversions, the primary site CCN and extension site identifiers will need to be adjusted.
- **Completing the Request at Resurvey**: The SA Surveyor (non-deemed) will bring this form to any resurvey and either request that a facility representative complete, sign, date, and return it at the completion of the onsite visit, at which time the surveyor will review it for completeness and accuracy; or the surveyor may complete the form and have the facility representative review and sign it.

Additional Guidance - Detailed instructions or definitions are given below for questions other than those considered self-explanatory.

- **CMS CERTIFICATION NUMBER—**Leave blank on all initial certifications. On all recertifications, insert the facility's assigned six-digit provider number.
- **EXTENSION IDENTIFICATION NUMBER—**Leave blank on all initial certifications for extension locations. Insert extension identification numbers for all CMS-approved extension locations.
- **County—**Leave blank if not known.
- **Name of Accrediting Organization**- only insert if requesting deemed status or if already accredited. List of CMS-approved AOs may be found https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Prospective-Clients-.pdf
- **Type of Organization**:
  - **Hospital-** self explanatory
  - **Skilled Nursing Facility**- self explanatory
  - **Home Health Agency**- self explanatory
  - **Rehabilitation agency** is an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, it must provide physical therapy or speech pathology services, and a rehabilitation program which, in addition to physical therapy or speech pathology services, includes social or vocational adjustment services.
  - **Clinic** is a facility established primarily for providing outpatient physician's services. It must meet the following test of physician participation: (1) The medical services of the clinic are provided by a group of physicians, i.e., more than two, practicing medicine together, and (2) a physician is present in the clinic at all times to perform medical (rather than administrative) services.
  - **Public Health Agency** is an official agency established by a State or local government, the primary function of which is to maintain the health of the population served by performing environmental health services, preventive medical services, and, in certain cases, therapeutic services.
- **Qualified Staff (refer to § 485.705 Personnel qualifications).—**To determine full-time equivalents, add the total number of hours worked by the appropriate professionals in the week ending prior to the week of filing the request and divide by the number of hours in the standard work week. If the result is not a whole number, express it as a quarter fraction (e.g., .00, .25, .50, .75). Include only qualified physical therapists and qualified speech pathologists.
  - **A qualified physical therapist** is a person who is licensed as a physical therapist by the State in which practicing and (1) has graduated from a physical therapy curriculum approved by the American Physical Therapy Association or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education and Hospitals of the American Medical Association and the American Physical Therapy Association; or (2) prior to January 1, 1966: (a) was admitted to membership by the American Physical Therapy Association; or (b) was admitted to registration by the American Registry of Physical Therapists; or (c) has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or (3) has 2 years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or (4) was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring physicians; or (5) if trained outside the United States: (a) was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; (b) meets the requirements for membership in a member organization of the World Confederation for Physical Therapy; (c) has 1 year of experience under the supervision of an active member of the American Physical Therapy Association; and (d) has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.
  - **A qualified speech pathologist** is a person who is licensed, if applicable, by the State in which practicing: (1) is eligible for a certificate of clinical competence in speech pathology granted by the American Speech and Hearing Association under its requirements in effect on January 17, 1974; or (2) meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification.