



**Centers for Medicare & Medicaid Services**

# **Internet Quality Improvement & Evaluation System (iQIES)**

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## **Survey and Certification (S&C) Manage a Form User Manual**

**Version 3.0**

**March 3, 2026**

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# 1. Introduction

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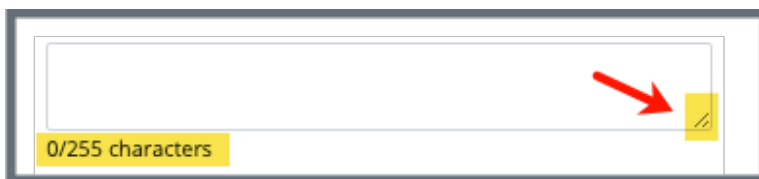
This S&C User Manual addresses forms and shows how to create and use CMS forms in iQIES.

For information on other modules, refer to [Reference & Manuals](#) on QTSO.

## 1.1 Getting Started in S&C – Important Information to Know

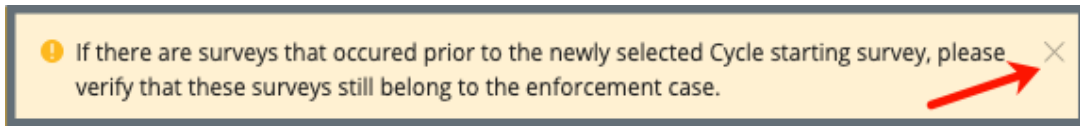
Below is important general information about iQIES.

- Log in to iQIES at <https://iqies.cms.gov/> with Health Care Quality Information Systems (HCQIS) Access Roles and Profile ([HARP](#)) login credentials. Refer to [iQIES Onboarding Guide](#) for further information, if necessary.
- All screenshots included in this manual contain only test data. Current screens in iQIES may be different from what is shown in screenshots below.
- Screenshots are dependent on user role and may not be an exact representation.
- Words highlighted in blue are clickable links.
- A red asterisk (\*) indicates a required field.
- Blank fields may have a limited number of characters allowed in that field. If so, the character limit is shown on the bottom left. The blank fields may also be expanded. Click the two 45° parallel lines and drag to the right to enlarge the box. See *Figure 1, Expandable Field*.



*Figure 1: Expandable Field*

- iQIES times out after 30 minutes of nonuse and reverts to the login page.
  - iQIES remains up and active as long as it is in use.
  - iQIES gives a five-minute warning before timing out.
  - The session resumes at the last accessed page after reauthentication.
  - Be sure to save data regularly. Pages that require saving are noted in this document, and have a **Save** button on the page.
- iQIES uses a smart search. Once three letters/digits are typed in the search bar, results are shown based on letters/digits entered. The more letters/digits entered, the narrower the search. If any of the results is the correct result, click the result to open.
- Review any notification banners. Some banners may have links to review further information; others may be a reminder of a task that must be completed. See *Figure 2, Notification Banner* and *Table 1, Notification Banner Color Descriptions*. These banners can be closed (X'd out) at any time.

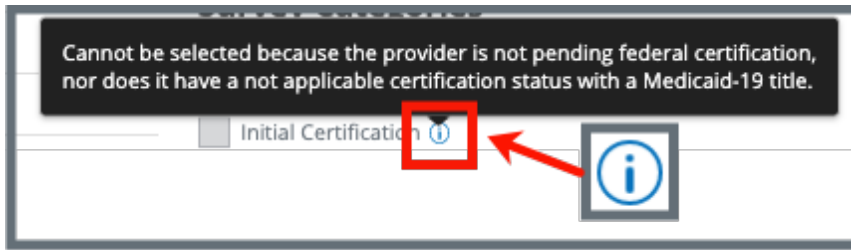


**Figure 2: Notification Banner**

**Table 1: Notification Banner Color Descriptions**

Notification Banner Color	Reason
Green	Action was successful
Blue	Informational only
Yellow	Warning. Review for information.
Red	Stop and review. The banner explains the actions must be taken.

- Review any Tool Tips for additional information to perform an action. Hover over the information icon to see the tip. Tool Tips are in iQIES to communicate information. Look for the information icon. See *Figure 3, Tool Tip Icon*.



*Figure 3: Tool Tip Icon*

- Below are the supported browsers for access to iQIES. Be sure to keep your browser updated.

[Chrome](#)

[Edge](#)

## 1.2 iQIES Service Center

The iQIES Service Center supports users working within the various iQIES components: S&C, Patient Assessment, and Reporting.

<b>Assistance Accessing iQIES:</b>	Contact the iQIES Security Official (SO) for your organization
<b>Technical Support:</b>	Contact the iQIES Service Center: <b>Phone:</b> 888-477-7876 (select Option 1) <b>Email:</b> <a href="mailto:iQIES@cms.hhs.gov">iQIES@cms.hhs.gov</a>
<b>CCSQ Support Central:</b>	Create a new ticket or track an existing ticket: <a href="#">CCSQ Support Central</a> .
<b>Idea Portal:</b>	Feedback for future iQIES software development: <a href="#">CCSQ Support Central</a> . Click <b>Idea Portals</b> and select <b>iQIES Idea Portal</b> .
<b>More information on iQIES:</b>	Refer to the <a href="#">QIES Technical Support Office (QTSO)</a> and the <a href="#">Quality, Safety, &amp; Education Portal (QSEP)</a> . Logging in to HARP may be required before accessing some documentation in QTSO and QSEP.  iQIES reference materials include: <ul style="list-style-type: none"><li>• Other volumes of the S&amp;C User Manual</li><li>• Links to Training Videos for providers</li><li>• Assessment Management User Manual</li><li>• Quick Reference Guides</li><li>• Onboarding Guide</li><li>• Managing User Information</li><li>• Other helpful iQIES material</li></ul> iQIES training materials on QSEP include S&C Foundation Series Videos

## 1.3 Roles and Permissions

iQIES roles allow users to access information pertinent to their area of work. The examples provided in this document pertain to S&C and require a State Agency or Centers for Medicare & Medicaid Services (CMS) role with the capability to view or edit this information.

Permissions are ultimately governed by HARP access privileges. Contact the SO for your organization or the iQIES Service Center for issues relating to access and permissions. Refer to the [iQIES User Roles Matrix](#) for detailed information on roles.

For additional help, refer to <https://iqies.cms.gov/iqies/help> or click the help icon in the top right corner of the screen, see *Figure 4, Help Icon*, for further information.



*Figure 4: Help Icon*

## 2. Forms Overview

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Users can access CMS forms for supported provider types in iQIES. Available forms include:

- [CMS-359](#), Comprehensive Outpatient Rehabilitation Facility Report for Certification to Participate in the Medicare Program
- [CMS-360](#), Comprehensive Outpatient Rehabilitation Facility Survey Report
- [CMS-377](#), Ambulatory Surgical Center Request Form
- [CMS-381](#), Outpatient Physical Therapy (OPT)/Speech Pathology Services (OSP) Application for Certification in the Medicare/Medicaid Program
- [CMS-417](#), Hospice Request for Certification in the Medicare Program Form
- [CMS-643](#), Hospice Survey and Deficiencies Report Form
- [CMS-671](#), Long-Term Care Facility Application for Medicare and Medicaid
- [CMS-1539](#), Medicare/Medicaid Certification and Transmittal
- [CMS-1572](#), Home Health Agency Survey Report Form
- CMS-3070G, Intermediate Care Facilities for Individuals With Intellectual Disabilities Survey Report
- [CMS-3427](#), End Stage Renal Disease Application and Survey and Certification Report

The following forms are used in iQIES but are available only as downloads from CMS:

- [CMS-576](#), Organ Procurement Request for Designation as an OPO
- [CMS-1880](#), Request for Certification as Supplier of Portable X-Ray Services,
- [CMS-3070H](#), Intermediate Care Facilities for Individuals With Intellectual Disabilities Deficiencies Report
- [CMS-3070I](#), Individual Observation Worksheet

The forms screens correspond as closely as possible to the CMS forms and instructions used in the field.

**Notes:**

- Completed forms cannot be edited or deleted.
- Provider-specific forms can be accessed from both the **Provider History** page and the survey record.
- Some form fields are derived from provider details. If changes to the form are needed, those changes may need to be made on the **Provider Basic Information** page.

## 2.1 Access a Form

**Purpose:** To access a form needed for a provider, survey, intake, or enforcement.

**Notes:**

- Forms are specific to provider type. Not all user roles have access to all forms.
- This example uses form CMS-1572 and the Home Health Agency (HHA) provider type.
- Certain forms are available for offline viewing and editing. Forms that are available for offline use are noted within this document. See the [Offline Job Aid](#) for further details on working offline.

2.1.1 Click the desired provider record. The **Provider History** page opens. For more information on searching for and accessing a provider, refer to the [Manage a Provider User Manual](#) on QTSO.

**Note:** Forms can also be accessed on the left menu of the survey record. For more information on searching for and accessing a survey record, refer to the [Manage a Survey User Manual](#) on QTSO.

Scroll down to view the **Provider Forms** list. Click **View All Forms** to view all forms associated with the provider, if desired. See *Figure 5, HHA Provider Forms List*. See *Table 2, Provider Forms List Field Description* for details on the columns shown.

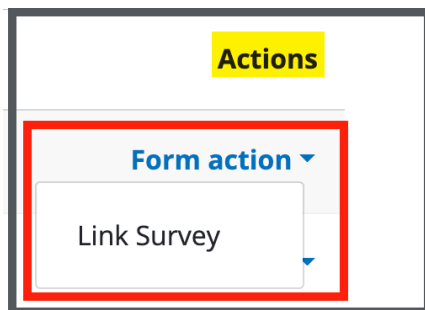
Form Name	Status	Related Survey(s)	Created Date	Last Updated	Track ID	Progress	Actions
CMS-1539	Complete	FA6CD-H1	02/02/2023	11/15/2023	FA6CD	0%	Form action
CMS-1572	In Progress	B04D2-H1	06/15/2023	06/15/2023	B04D2	0%	Form action
CMS-1539	In Progress	B04D2-H1	06/15/2023	06/15/2023	B04D2	0%	Form action

[View All Forms \(28\)](#)

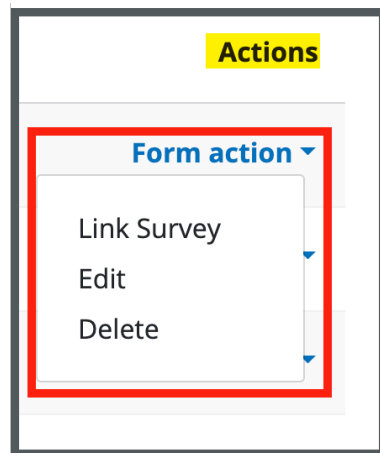
*Figure 5: HHA Provider Forms List*

*Table 2: Provider Forms List Field Description*

Column	Description
<b>Form Name</b>	Name of CMS form
<b>Status</b>	Either <b>Complete</b> or <b>In Progress</b>
<b>Related Survey(s)</b>	The survey(s) the form is linked to, if applicable
<b>Created Date</b>	The date the form was created
<b>Last Updated</b>	The date the form was last updated
<b>Track ID</b>	Click survey number under <b>Track ID</b> to see detailed information on certification status. <a href="#">See Certification Event</a> for further details.
<b>Actions</b>	<ul style="list-style-type: none"> <li>Form actions for a <b>Complete</b> form include <b>Link Survey</b>. A <b>Complete</b> form cannot be edited or deleted. See <i>Figure 6, Actions for a Complete Form</i>.</li> <li>Form actions for an <b>In Progress</b> form include <b>Link Survey, Edit, Delete</b>. See <i>Figure 7, Actions for an In Progress Form</i>.</li> </ul>



*Figure 6: Actions for a Complete Form*



*Figure 7: Actions for an In Progress Form*

- 2.1.2 Click the desired form under **Form Name**.
- If the form has a **Related Survey**, the Survey page opens.
  - If the form is not linked to a survey, the Form page opens.

## 2.2 Add a Form

**Purpose:** To add a form to a provider, survey, intake, or enforcement.

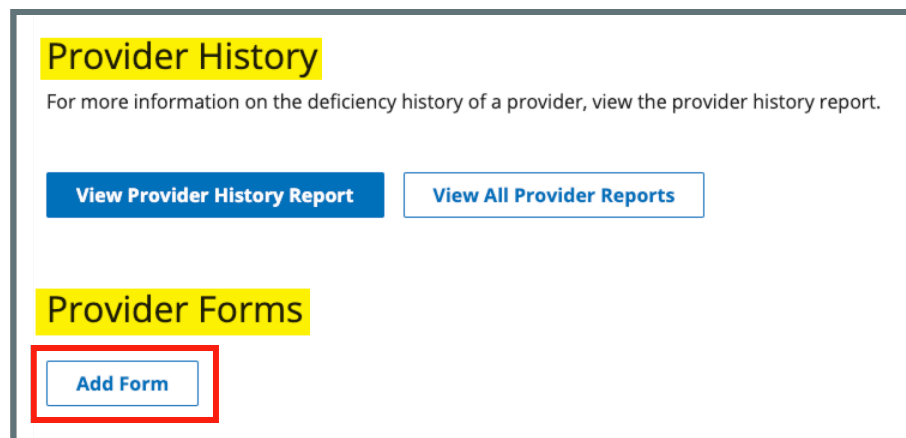
**Notes:**

- Forms are specific to provider type or user role.
- Forms can be added while working offline. Review the [Offline Job Aid](#) for further details on working offline.
- This example uses form CMS-377 and the Ambulatory Surgical Center (ASC) provider type.

2.2.1 Click the desired provider record. The **Provider History** page opens. For more information on searching for and accessing a provider, refer to the [Manage a Provider User Manual](#) on QTSO.

2.2.2 Scroll down to the **Provider Forms** section and click **Add Form**. The **New Form** page opens. See *Figure 8, Add Form*.

**Note:** Forms can also be added from the left menu of the survey record. For more information on searching for and accessing a survey, refer to the [Manage a Survey User Manual](#) on QTSO.



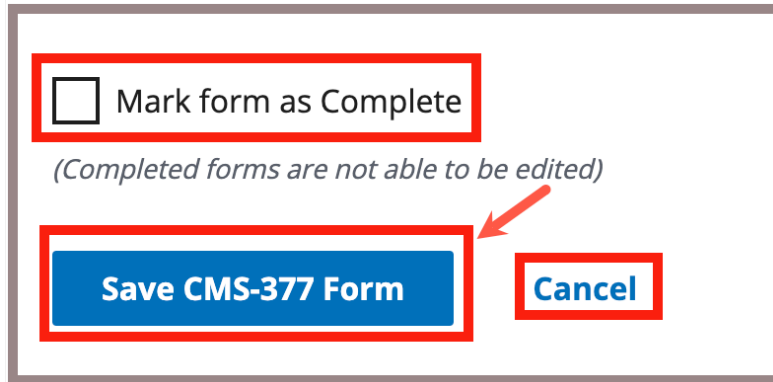
*Figure 8: Add Form*

2.2.3 Fill out the information.

2.2.4 Click **Mark form as Complete**, if desired.

**Note:** Completed forms cannot be edited or deleted.

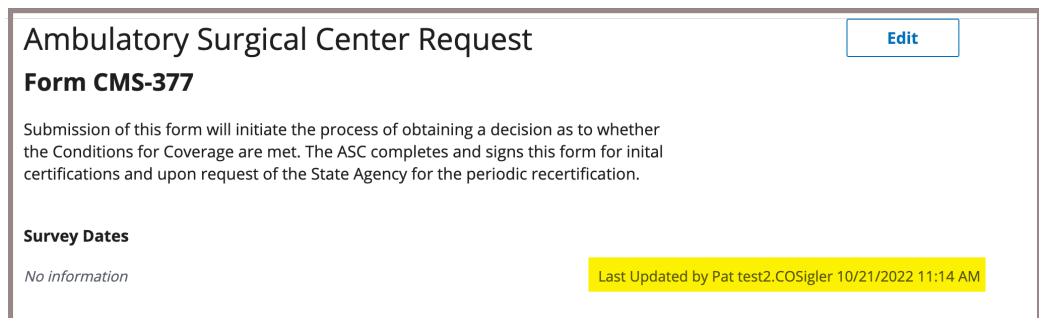
2.2.5 Click **Save** to save the form. Click **Cancel** to return to the **Provider History** page. See *Figure 9, Save a Form*.



*Figure 9: Save a Form*

**Notes:**

- Click **Save** at any time to save in progress work, even if required fields are not filled out.
- When **Save** is clicked for an in progress or completed form, a date and time stamp that captures **Last Updated by** or **Completed by** user information automatically generates. This information displays on the upper right corner of the form and in the **Provider Forms** table. See *Figure 10, Form Last Updated By User Information*.



*Figure 10: Form Last Updated By User Information*

## 2.3 Edit a Form

**Purpose:** To edit an in-progress form associated with a provider, survey, intake, or enforcement.

**Notes:**

- Only **In Progress** forms can be edited.
- Forms are specific to provider type or user role.
- Forms can be edited while working offline. Review the [Offline Job Aid](#) for further details on working offline.
- This example uses form CMS-417 and the hospice provider type.
  - 2.3.1 Click the desired provider record. The **Provider History** page opens. For more information on searching for and accessing a provider, refer to the [Manage a Provider User Manual](#) on QTSO.
  - 2.3.2 Scroll down to the **Provider Forms** section to view the **Provider Forms** list. See *Figure 11, Hospice Provider Forms List*.

Form Name	Status	Related Survey(s)	Created Date	Last Updated	Track ID	Actions
CMS-643	Complete	11108F-L1 11108F-H1	09/08/2022	09/09/2022	11108F 14%	Form action
CMS-1539	In Progress	11108F-L1 11108F-H1	01/12/2023	01/12/2023	11108F 14%	Form action
CMS-417	In Progress	No information	01/26/2023	01/27/2023	No information	Form action

[View All Forms \(4\)](#)

*Figure 11: Hospice Provider Forms List*

- 2.3.3 Click the desired form under the **Form Name** column. The form opens on a new page.

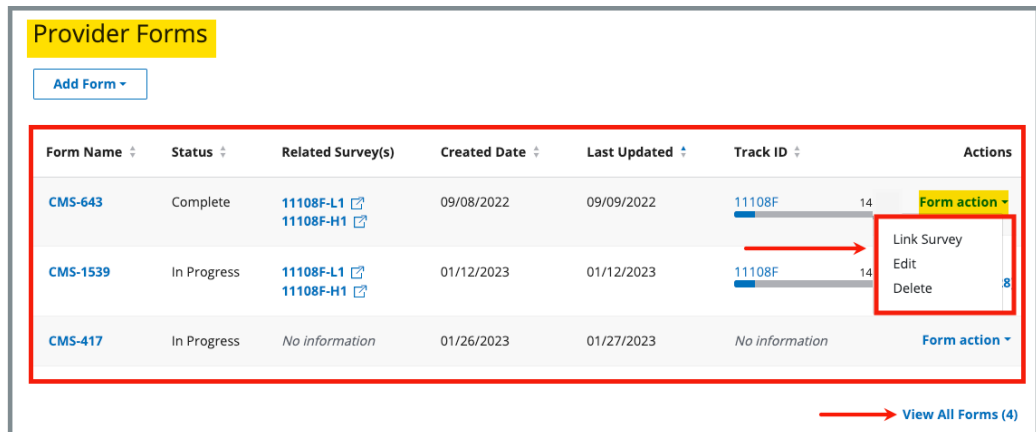
2.3.4 Click **Edit** to fill in the information as desired. Click **Return to Provider** to return to the **Provider History** page. See *Figure 12, Edit a Form*.



**Figure 12: Edit a Form**

**Notes:**

- Completed forms cannot be edited or deleted.
- An **In Progress** form can also be edited from the **Form action** drop-down in the **Provider Forms** table. See *Figure 13, Edit from Form Action Drop-Down*. Refer to [Access a Form](#) for more information, if needed.



**Figure 13: Edit from Form Action Drop-Down**

- If an **In Progress** form is linked to a survey, the form can also be edited from the left menu of the survey record. See *Figure 14, Edit a Form from Survey Record*. For more information on searching for and accessing a survey, refer to the [Manage a Survey User Manual](#) on QTSO.

*Figure 14: Edit a Form from Survey Record*

2.3.5 Click **Mark form as Complete**, if desired.

**Note:** Completed forms cannot be edited or deleted.

2.3.6 Click **Save** to save the form. Click **Cancel** to discard changes.

- Click **Save** at any time to save in progress work, even if required fields are not filled out.
- When **Save** is clicked for an in progress or completed form, a date and time stamp that captures **Last Updated by** or **Completed by** user information automatically generates. This information displays on the upper right corner of the form and in the **Provider Forms** table.

## 2.4 Delete a Form

**Purpose:** To delete an in-progress form for a provider, survey, intake, or enforcement.

**Notes:**

- Only **In Progress** forms can be deleted.
- **In Progress** forms can only be deleted from the **Provider Forms** list on the **Provider History** page. Refer to [Access a Form](#) for more information, if needed.
- Forms are specific to provider type or user role.
- Forms cannot be deleted while working offline.
- This example uses form CMS-643 and the Hospice provider type.

2.4.1 Click the desired provider record. The **Provider History** page opens. For more information on searching for and accessing a provider, refer to the [Manage a Provider User Manual](#) on QTSO.

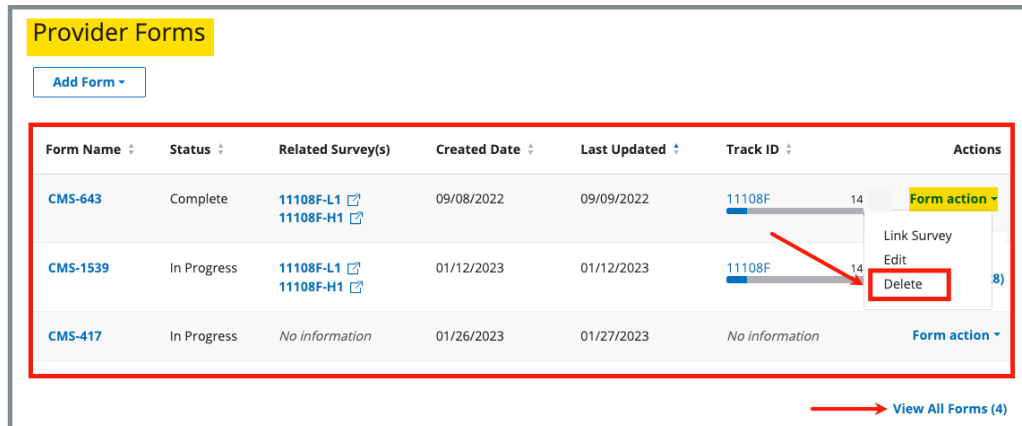
2.4.2 Scroll down to the **Provider Forms** section to view the **Provider Forms** list. See Figure 15, Provider Forms List for CMS-643.

Form Name	Status	Related Survey(s)	Created Date	Last Updated	Track ID	Actions
CMS-643	Complete	11108F-L1 11108F-H1	09/08/2022	09/09/2022	11108F 14%	Form action
CMS-1539	In Progress	11108F-L1 11108F-H1	01/12/2023	01/12/2023	11108F 14%	Form action
CMS-417	In Progress	No information	01/26/2023	01/27/2023	No information	Form action

View All Forms (4)

*Figure 15: Provider Forms List for CMS-643*

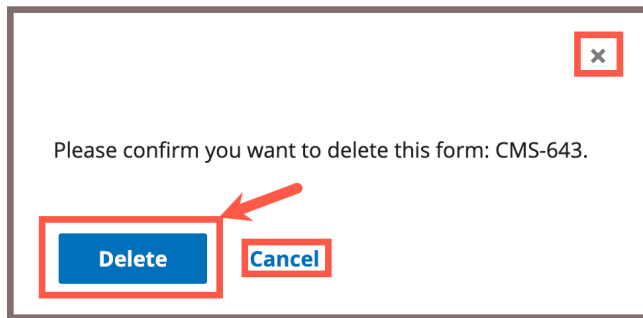
2.4.3 Locate the desired form and click the **Form action** drop-down from the **Actions** column. See *Figure 16, Form Action Drop-Down*.



*Figure 16: Form Action Drop-Down*

2.4.4 Click **Delete**. A window pops up. See *Figure 17, Delete a Form Pop Up Window*.

- a. Click **Delete** to delete the form.
- b. Click **Cancel** or the **X** in the upper right corner to return to the **Provider Forms** table.



*Figure 17: Delete a Form Pop Up Window*

## 2.5 Link Form to Survey

**Purpose:** To link a form to a survey record.

**Notes:**

- Both **In Progress** and **Complete** forms can be linked to a survey
- Forms cannot be linked while working offline.

2.5.1 Go to the **Provider History** page.

2.5.2 Locate the form in the **Provider Forms** list. See *Figure 18, Provider Forms*.

**Provider History**  
For more information on the deficiency history of a provider, view the provider history report.

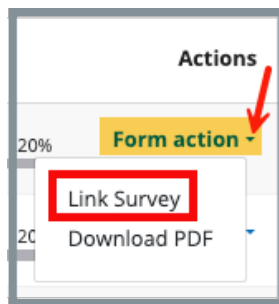
[View Provider History Report](#) [View All Provider Reports](#)

**Provider Forms**  
[Add Form -](#)

Form Name	Status	Related Survey(s)	Created Date	Last Updated	Track ID	Actions
CMS-1539	Complete	<a href="#">1A6456-H1</a>	05/23/2024	02/04/2026	<a href="#">1A6456</a> 20%	Form action
CMS-671	In Progress	<a href="#">1A6456-H1</a>	05/23/2024	11/08/2024	<a href="#">1A6456</a> 20%	Form action
CMS-1539	In Progress	No information	04/10/2024	04/10/2024	No information	Form action

*Figure 18: Provider Forms*

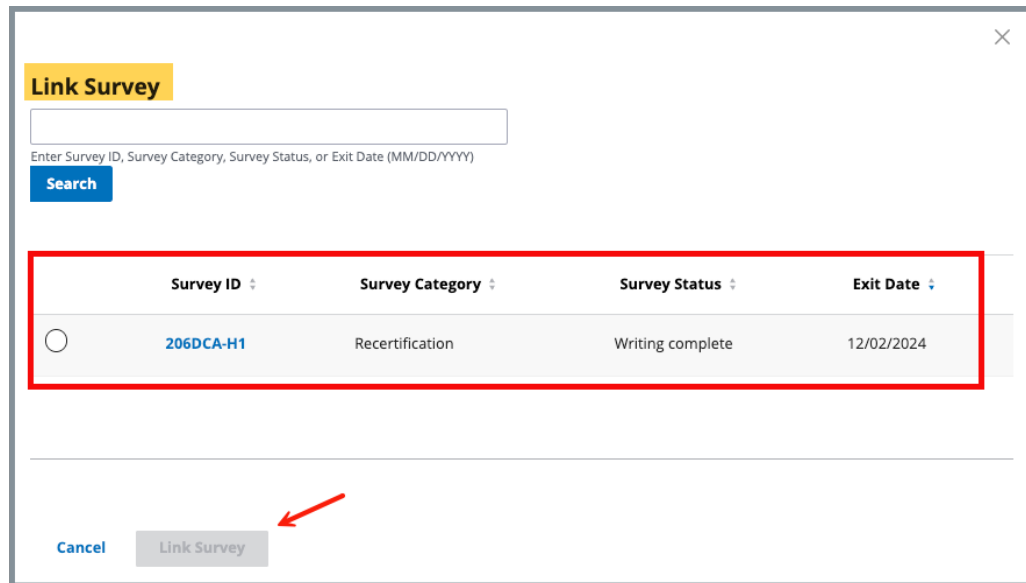
2.5.3 Select **Link Survey** from the **Form action** menu. See *Figure 19, Click Link Survey*. The **Link Survey to Form** pop-up window opens.



*Figure 19: Click Link Survey*

2.5.4 Search for the survey. See *Figure 20, Link Survey*.

**Note:** **Link Survey** is disabled until a selection is made.



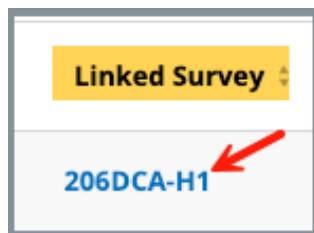
*Figure 20: Link Survey*

2.5.5 Select the appropriate survey.

2.5.6 Click **Link Survey**.

**Note:** Surveys cannot be unlinked once linked.

2.5.7 Verify the form appears under **Related Survey**. See *Figure 21, Linked Survey*.



*Figure 21: Linked Survey*

## 2.6 Link Survey to Form

**Purpose:** To link a survey to a form.

**Notes:**

- Both **In Progress** and **Complete** forms can be linked to a survey.
- Forms cannot be linked to surveys while working offline.
- Forms are specific to provider type or user role.
- This example uses form CMS-1572 and the HHA provider type.

2.6.1 Click the desired provider record. The **Provider History** page opens. For more information on searching for and accessing a provider, refer to the [Manage a Provider User Manual](#) on QTSO.

2.6.2 Scroll down to the **Provider Forms** section to view the **Provider Forms** list. See *Figure 22, Provider Forms List for HHA*.

Form Name	Status	Related Survey(s)	Created Date	Last Updated	Track ID	Actions
CMS-1539	Complete	<a href="#">FA6CD-H1</a>	02/02/2023	11/15/2023	<a href="#">FA6CD</a> 0%	Form action
CMS-1572	In Progress	<a href="#">B04D2-H1</a>	06/15/2023	06/15/2023	<a href="#">B04D2</a> 0%	Form action
CMS-1539	In Progress	<a href="#">B04D2-H1</a>	06/15/2023	06/15/2023	<a href="#">B04D2</a> 0%	Form action

[View All Forms \(28\)](#)

*Figure 22: Provider Forms List for HHA*

2.6.3 Locate the desired form and click the **Form action** drop-down from the **Actions** column. See *Figure 23, Form Action Drop-Down*.

Form Name	Status	Related Survey(s)	Created Date	Last Updated	Track ID	Actions
CMS-1539	Complete	<a href="#">FA6CD-H1</a>	02/02/2023	11/15/2023	<a href="#">FA6CD</a> 0%	Form action
CMS-1572	In Progress	<a href="#">B04D2-H1</a>	06/15/2023	06/15/2023	<a href="#">B04D2</a> 0%	Form action
CMS-1539	In Progress	<a href="#">B04D2-H1</a>	06/15/2023	06/15/2023	<a href="#">B04D2</a> 0%	Form action <ul style="list-style-type: none"> <li>Link Survey</li> <li>Edit</li> <li>Delete</li> </ul>

*Figure 23: Form Action Drop-Down*

2.6.4 Click **Link Survey**. The **Link Survey to Form** window pops up. See Figure 24, Link Survey to Form Pop Up Window.

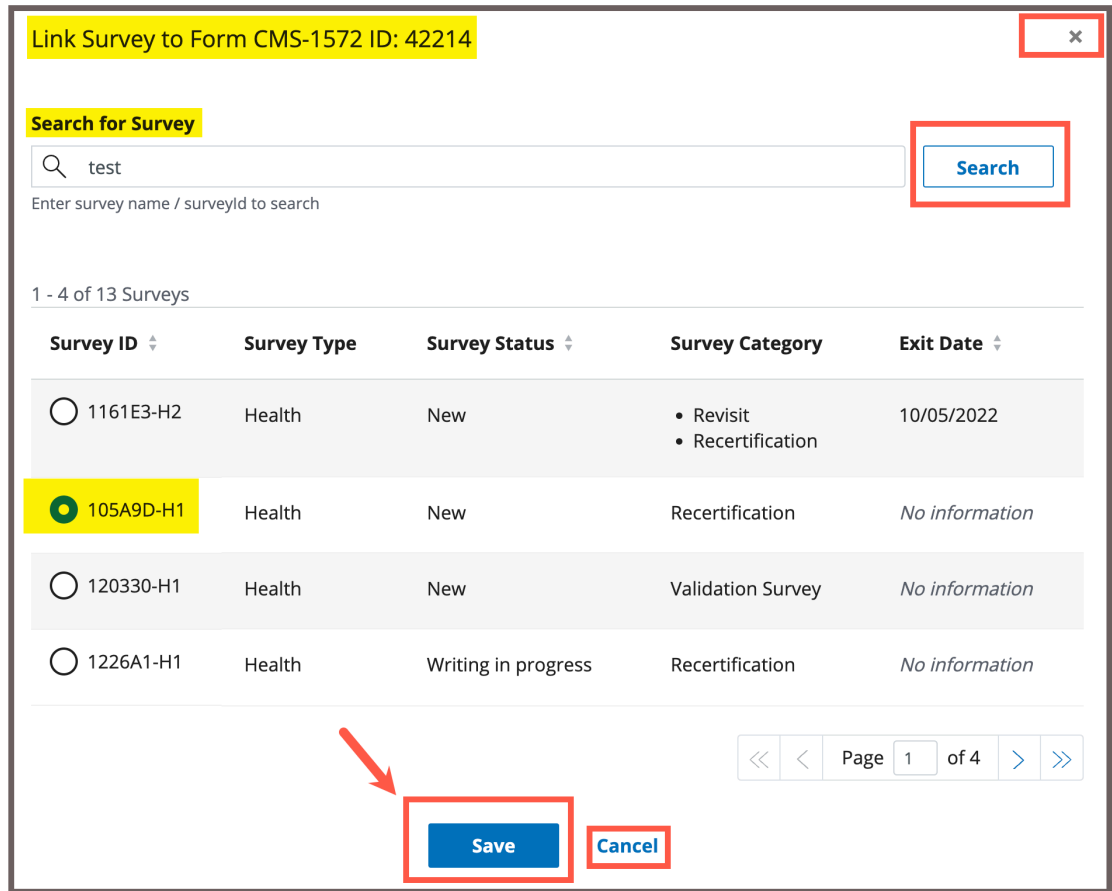


Figure 24: Link Survey to Form Pop Up Window

2.6.5 Enter the survey name or survey ID in the search bar. Click **Search**. A table of available surveys appears below the search bar.

2.6.6 Click the desired survey under the **Survey ID** column.

2.6.7 Click **Save** to link the form to the survey. Click **Cancel** or the **X** in the upper right corner to return to the **Provider Forms** table.

**Note:** The same form will be linked to all surveys in the group (i.e., if there are revisits).

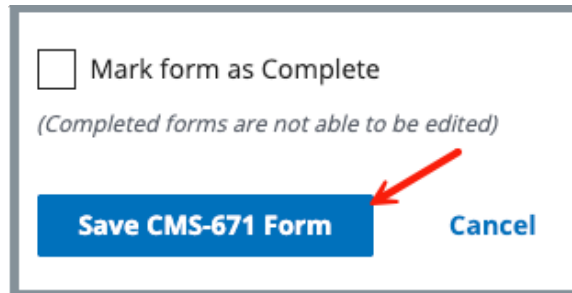
## 2.7 Save Form in Progress

**Purpose:** To save work on a form without marking it complete.

**Notes:**

- Forms can be saved at any time, even if required fields are not filled out.
- Saving a form does not submit or finalize the form.

2.7.1 Click **Save CMS- [Form Number] Form** at the bottom of the form to save a form while working on the form. The form saves. See *Figure 25, Save Form*.



*Figure 25: Save Form*

2.7.2 Verify **Last Updated By** is noted at the top of the page. See *Figure 26, Last Updated By*.



*Figure 26: Last Updated By*

**Notes:**

- Continue editing or exit the form as needed.
- The form remains in **In Progress** status and can be [edited](#), [deleted](#), [downloaded](#), or [linked to a survey](#).

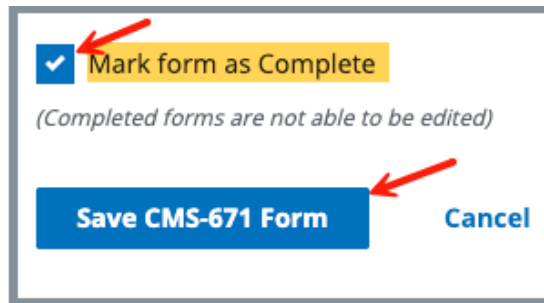
## 2.8 Complete Form

**Purpose:** To mark a form as complete and prevent further edits.

**Notes:**

- Completed forms cannot be edited or deleted.
- Completed forms can be downloaded and linked to a survey.
- A new form must be generated when new edits are needed on a completed form. Complete the information and reassociate it to the survey, if applicable.

2.8.1 Select **Mark form as Complete** at the bottom of the form. See *Figure 27, Mark Form as Complete*.



*Figure 27: Mark Form as Complete*

2.8.2 Click **Save**.

2.8.3 Verify the form status changes to **Completed** and is noted at the top of the page. See *Figure 28, Completed*.



*Figure 28: Completed*

## 2.9 Download a Form

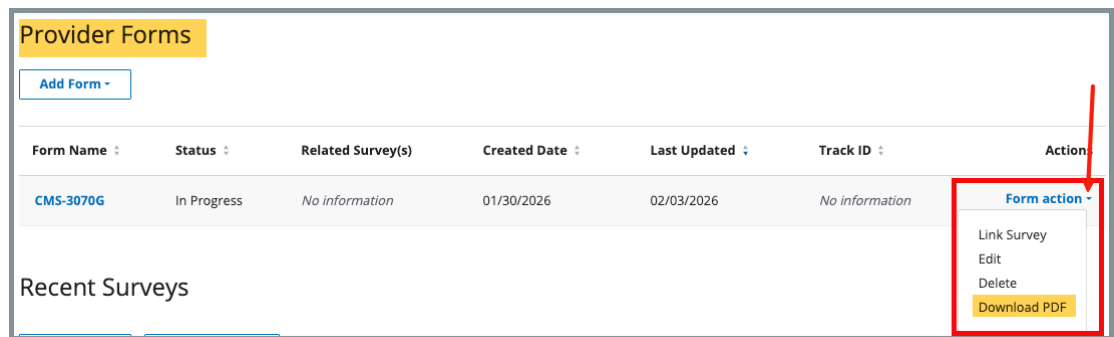
**Purpose:** To download a form as a PDF before or after completion.

**Note:** Forms can be downloaded both prior to completion and after completion.

### Download the form from the Provider History page

2.9.1 Go to the **Provider History** page.

2.9.2 Click **Download PDF** under **Form action** next to the desired form. See *Figure 29, Download Form From Provider History*. The form downloads to the user’s computer.



**Figure 29: Download Form From Provider History**

### Download the form from the Form page

2.9.3 Go to the form.

2.9.4 Click **Download PDF**. See *Figure 30, Download Form From Form Page*. The form downloads to the user’s computer.



**Figure 30: Download Form From Form Page**

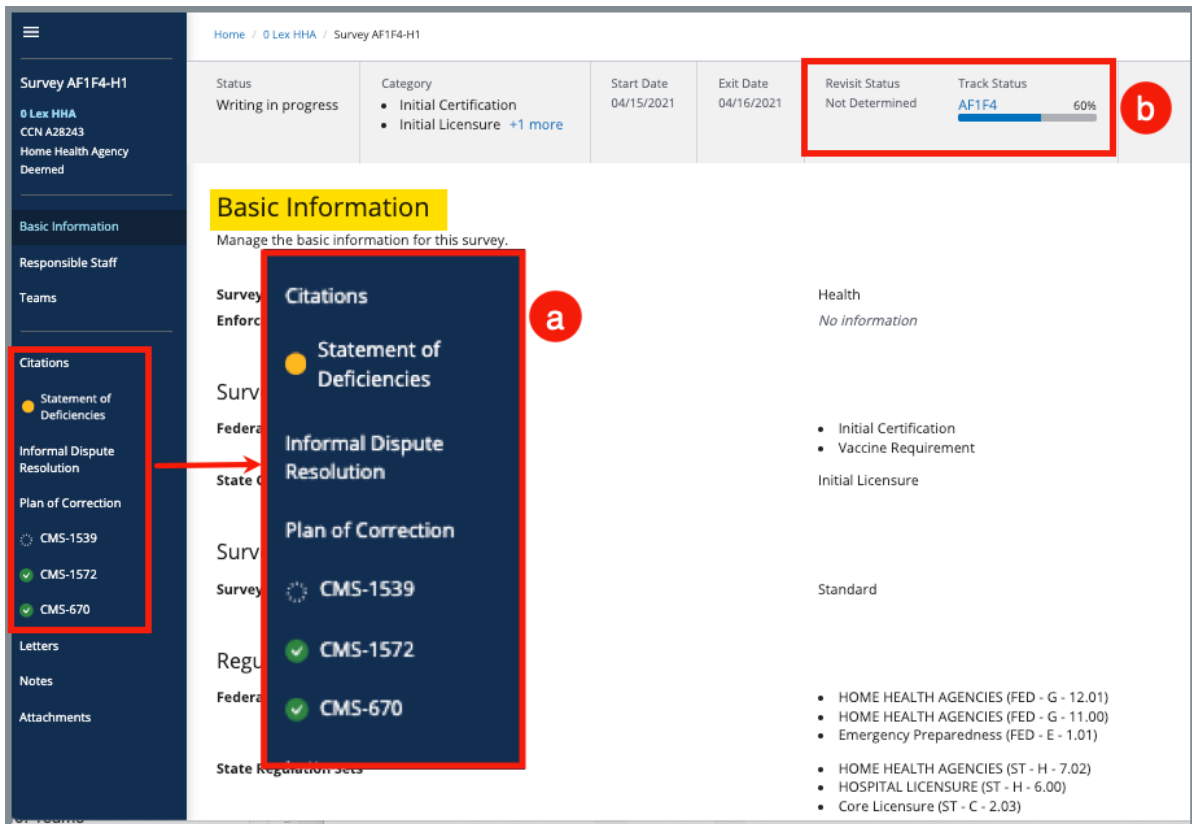
## 2.10 Certification Event

**Purpose:** To organize certification documents for provider certification.  
 Refer to [S&C User Manual: Manage a Survey](#) for further details.

**Notes:**

- It may be necessary to refresh the page to update track status when changes are made.
- View certification status under **Track Status** for each survey in Workload Management.

The form progress can be seen from the **Survey** or **Form Basic Information** page. See *Figure 31, Basic Information Page Certification Progress*, and *Table 2, Basic Information Page Certification Progress Callout Details*.



**Figure 31: Basic Information Page Certification Progress**

**Table 3: Basic Information Page Certification Progress Callout Details**

Callout	Action	
<b>a</b>	The left menu shows the status at a glance.	
	No fill	<b>Not Started:</b> Form or information hasn't been started
	Yellow fill	<b>In Progress:</b> Form or information has been started, but it is incomplete
	Green fill	<b>Complete:</b> Form or information is complete
<b>b</b>	The grey status bar shows the certification track status. Click survey number under <b>Track Status</b> to see detailed information on certification status.	

### 3. CMS-359

---

**Purpose:** To demonstrate how to use the Comprehensive Outpatient Rehabilitation Facility Report for Certification to Participate in the Medicare Program.

**Note:** This form is available for the CORF provider type only.

- 3.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.
- 3.2 Fill out the information. See *Figure 32, CMS-359 Form, page 1 of 2* and *Figure 33, CMS-359 Form, page 2 of 2*.
- 3.3 Complete the form. Review [Complete Form](#), if necessary.

## Comprehensive Outpatient Rehabilitation Facility Report for Certification to Participate in the Medicare Program

### Form 359

---

#### I. Identifying Information

**Name of Facility \***  
Siny Water Sports Rehab Facility ⓘ

**Medicare/Medicaid Provider Number (RD1)**  
684896 ⓘ

**Street Address \***  
123 Main St ⓘ

**City, County, and State \***  
FLEMING ISLAND, Miami-Dade, Florida ⓘ

**Zip Code \***  
32003 ⓘ

**Telephone Number (RD2) \***  
(800) 555-1212 ⓘ

**State/County (RD3)**  
Miami-Dade ⓘ

**State/Region (RD4)**  
36 - MIAMI ⓘ

---

#### II. Eligibility

**Request to Establish Eligibility to (RD5) \***  
Check all that apply

Medicare  
 Medicaid

**Related Provider Number (RD6)**  
684896 ⓘ

---

#### III. Type of Control

**Type of Control (RD7) \***  
(Only one category can be selected)

**Proprietary**  
For profit corporation

**Non-Profit Church**  
A church affiliated facility governed by a board of directors and financed by contributions and earnings

**Non-Profit Other than Church**  
A facility which is generally governed by a community-based board of directors and financed by contributions and earnings

**Government**  
A facility primarily administered by the State, county, city or other local unit of government

**Does your organization currently participate in Medicare as a provider or Outpatient Physical Therapy / Speech Pathology (e.g. Comprehensive Outpatient Rehabilitation Facility)? (RD8)**  
Check one

Yes  
 No

**If yes, list your Medicare Provider Number (RD9)**

Figure 32: CMS-359 Form, page 1 of 2

**IV. Type of Services Provided (RD10)** ⓘ

**Physical Therapy \*** ⓘ

Employees  
 Under Arrangement  
 Independent Contractor

**Physician Services \*** ⓘ

Employees  
 Under Arrangement  
 Independent Contractor

**Social Services \*** ⓘ

Employees  
 Under Arrangement  
 Independent Contractor

**Psychological Services \*** ⓘ

Employees  
 Under Arrangement  
 Independent Contractor

**Occupational Therapy**

Employees  
 Under Arrangement  
 Independent Contractor

**Respiratory Therapy**

Employees  
 Under Arrangement  
 Independent Contractor

**Speech Pathology**

Employees  
 Under Arrangement  
 Independent Contractor

**Orthotic / Prosthetic Services**

Employees  
 Under Arrangement  
 Independent Contractor

**Nurses**

Employees  
 Under Arrangement  
 Independent Contractor

---

**Signature**

Whoever knowingly and willfully makes, or causes to be made, a false statement or representation on this statement may be prosecuted under applicable Federal or State law. In addition, knowingly and willfully failing to fully, and accurately disclose this requested information 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.

**Title of Authorized Official**

**Date Signed**   
MM/DD/YYYY

Mark form as Complete  
Completed forms are not able to be edited

**Save CMS-359 Form**

Figure 33: CMS-359 Form, page 2 of 2

## 4. CMS-360

---

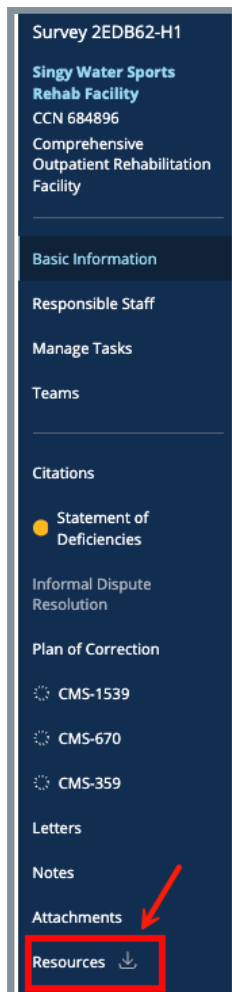
**Purpose:** To demonstrate how to use the Comprehensive Outpatient Rehabilitation Facility Survey Report.

**Notes:**

- The CMS-360 form is downloaded from iQIES.
- This form is available for the CORF provider type only.

4.1 Go to survey **Basic Information** page.

4.2 Click **Resources** on the left menu. See *Figure 34, Resources*. The CMS-360 form is automatically downloaded to the user's computer as a fillable PDF document.



*Figure 34: Resources*

- 4.3 Open the form. See *Figure 35, First Page of CMS-360.*
- 4.4 Fill out the information.

**Note:** This form shows only the first page of **Form CMS-360.**

Department of Health & Human Services Centers For Medicare & Medicaid Services		Form Approved OMB No. 0938-0267		
Comprehensive Outpatient Rehabilitation Facility Survey Report CMS-360				
Facility Name:		Facility CCN:		
Facility Street Address:		City:		
State:	Zip Code:	Telephone Number:		
Survey Start Date:	Survey End Date:	Type of Survey: <input type="checkbox"/> Initial Survey <input type="checkbox"/> Recertification Survey <input type="checkbox"/> Complaint <input type="checkbox"/> Other: (Specify):		
Code	Description	Yes	No	N/A
I-501	<b>§485.54 - Condition of Participation: Compliance with State and local laws.</b> The facility and all personnel who provide services must be in compliance with applicable State and local laws and regulations.	<input type="checkbox"/>	<input type="checkbox"/>	
I-502	<b>(a) Standard: Licensure of facility.</b> If State or local law provides for licensing, the facility must be currently licensed or approved as meeting the standards established for licensure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I-503	<b>(b) Standard: Licensure of Personnel.</b> Personnel that provide service must be licensed, certified, or registered in accordance with applicable State and local laws.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Form CMS-360 / OMB Approval Expires XX/XX/20XX				Page 1

**Figure 35: First Page of CMS-360**

## 5. CMS-377

---

**Purpose:** To demonstrate how to use the ASC request for initial certification or to update the certification information in the Medicare program.

**Note:** This form is available for the ASC provider type only.

- 5.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.
- 5.2 Fill out the information. See *Figure 36, Ambulatory Surgical Center Request Form CMS-377*.
- 5.3 Complete the form. Review [Complete Form](#), if necessary.

[Return to Provider](#)

### Ambulatory Surgical Center Request Form CMS-377

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions for Coverage are met. The ASC completes and signs this form for initial certifications and upon request of the State Agency for the periodic recertification.

**Survey Dates**  
*No information*

**Type of Control**

**Type of Control (AS5) \***

Proprietary  
 Non-Profit  
 Government

---

**Ancillary Services (AS6)**

**Laboratory \***

1 - Provided Directly by The Facility  
 2 - Provided Through an Outside Source  
 3 - Combination  
 4 - Not Provided

**Radiology \***

1 - Provided Directly by The Facility  
 2 - Provided Through an Outside Source  
 3 - Combination  
 4 - Not Provided

**Pharmaceutical Services \***

1 - Provided Directly by The Facility  
 2 - Provided Through an Outside Source  
 3 - Combination  
 4 - Not Provided

---

**Surgical Specialties**

**Surgical Specialties (AS7) \***

Select all categories of surgery offered by the ASC.

Dental  
 Endoscopy  
 Ear/Nose/Throat  
 Ob/Gyn  
 Ophthalmologic  
 Orthopedic  
 Pain  
 Plastic/Reconstructive  
 Podiatry  
 Other (Specify)

Include only broad categories, not subspecialties.

---

**Facility Characteristics**

**Number of Operating Rooms (AS8) \*** 
**Number of Procedure Rooms (AS8) \***

**Date Center Began Providing Services (AS9) \***   
MM/DD/YYYY

---

**Authorized Official Information**

**Name of Authorized Official \*** 
**Title of Authorized Official \***

Mark form as Complete  
(Completed forms are not able to be edited)

Figure 36: Ambulatory Surgical Center Request Form-377

## 6. CMS-381

---

**Purpose:** To demonstrate how to use the Outpatient Physical Therapy (OPT)/Speech Pathology Services (OSP) Application for Certification in the Medicare/Medicaid Program

**Note:** This form is available for OPT/SLP provider type only.

- 6.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.
- 6.2 Fill out the information. See *Figure 37, CMS-381 (page 1 of 4)*, *Figure 38, CMS-381 (page 2 of 4)*, *Figure 39, CMS-381 (page 3 of 4)*, *Figure 40, CMS-381 (page 4 of 4)*.
- 6.3 Complete the form. Review [Complete Form](#), if necessary.

**Note:** Parts III, IV, and V responses are not submitted on this form. Click **Extension Locations** on the left menu and fill out the information. Information is automatically included in the CMS-381 form. The form cannot be marked as complete without this information.

**Outpatient Physical Therapy (OPT)/Speech Pathology Services (OSP) Application for Certification in the Medicare/Medicaid Program**

**Form 381** ←

**Part I: Request Information**

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

**Initial Request**  
Check one

Yes  
 No

**Request to Establish Eligibility In**  
Check all that apply

Medicare  
 Medicaid

**County**  
Miami-Dade [ⓘ](#)

**State**  
Florida [ⓘ](#)

**Seeking Deemed Status**  
Check one

Yes  
 No

**Name of Accrediting Organization**  
Select one ▼

B. If this request is to establish a new extension file, please complete the following and proceed to part II: [ⓘ](#)

**CMS Certification Number of Primary Site**  
686973 [ⓘ](#)

**Extension Site Request**  
Check one

Yes  
 No

**Name of Accrediting Organization (If Deemed)**  
No information [ⓘ](#)

**Figure 37: CMS-381 (page 1 of 4)**

## Part II: Primary Site Where the OPT/OSP Services are Provided

**Identifying Information**

**Legal Name of Organization \***  
 Singy Motion Commotion PT ⓘ

**Doing Business As (DBA) Name of Organization**  
 Singy Motion Commotion PT ⓘ

**Street Address \***  
 123 Main St ⓘ

**City, County, and State \***  
 MIAMI, Miami-Dade, Florida ⓘ

**Zip Code \***  
 33101 ⓘ

**Telephone Number (include area code) \***  
 (800) 555-1212 ⓘ

**Services Provided \***  
 Check all that apply

Physical Therapy

Speech Pathology

Occupational Therapy

**Type of Organization**  
 Check one

Hospital

Skilled Nursing Facility

Home Health Agency

Rehabilitation

Public Clinic

Private Clinic

Public Health Agency

**Figure 38: CMS-381 (page 2 of 4)**

**Type of Control**  
Check one

Voluntary Non-Profit Other than Church  
 Voluntary Non-Profit Church  
 State Government  
 Local Government  
 Combination Government and Voluntary  
 Proprietary

**Hours of Operation**  
Check one

Full-time  
 Part-time

**Qualified Staff**

**Physical Therapists**

On Staff	By Arrangement	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Speech Pathologists**

On Staff	By Arrangement	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Occupational Therapists**

On Staff	By Arrangement	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>

Figure 39: CMS-381 (page 3 of 4)

Part III: New Extension Site Request Where the OPT/OSP Services are Provided

Extension Site Information should be entered in the [Extension Locations](#) area

---

Part IV: Existing or Closures for Extension Sites ⓘ

Extension Site Information should be entered in the [Extension Locations](#) area

---

Part V: Request to Change Existing Extension Site to Primary Site ⓘ

Extension Site Information should be entered in the [Extension Locations](#) area

---

Part VI: Existing Extension Sites

No information

---

Part VII: Legal Contact Information ⓘ

**Name \*** ⓘ  
No information

**Title/Position \*** ⓘ  
No information

**Email**  
No information

**Telephone**  
No information

---

Whoever knowingly and willfully makes, or causes to be made, a false statement or representation on this statement may be prosecuted under applicable Federal or State law. In addition, knowingly and willfully failing to fully, and accurately disclose this requested information 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.

**Title**

**Date**   
MM/DD/YYYY

---

Mark form as Complete  
Completed forms are not able to be edited

**Save CMS-381 Form** **Cancel**

**Respond to parts III, IV, and V in the Extension Locations area of iQIES.**

Figure 40: CMS-381 (page 4 of 4)

## 7. CMS-417

---

**Purpose:** To demonstrate how to use the Hospice Request for Certification in the Medicare Program.

**Note:** This form is available for the hospice provider type only.

- 7.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.
- 7.2 Fill out the information. See *Figure 41, CMS-417 Form*.
- 7.3 Complete the form. Review [Complete Form](#), if necessary.

**Hospice Request for Certification in the Medicare Program Form CMS-417**

**Initial Certification \***  
10/04/2022 - 10/05/2022

**Related Certification Number PH6**  
 Find Facility

**Type of Hospice PH7 \***  
Select one

**For Hospitals Only**  
Select one

**Type of Control PH8 \***  
Select one

**Services Provided PH9**

	Services *	Contractee	Address	Medicare Certification/Supplier Number
1. Core - Physician Services	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>			
2. Core - Nursing Services	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>			
3. Core - Medical Social Services	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>			
4. Core - Counseling Services	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>			
5. Physical Therapy	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. Occupational Therapy	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7. Speech-Language Pathology	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8. Hospice Aide	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9. Homemaker	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10. Medical Supplies	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11. Short Term Inpatient Care	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>	<input type="text"/>	<input type="text"/>	<input type="text"/>
12. Other	<span style="border: 1px solid #ccc; padding: 2px;">Select one</span>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Acute/Respite PH10**  
Select one

**Number of Employees/Volunteers Full-time Equivalent**

Type	Employees *	Volunteers *
<b>Physicians PH11</b>	<input type="text"/>	<input type="text"/>
<b>Registered Professional Nurses PH12</b>	<input type="text"/>	<input type="text"/>
<b>Licensed Practical Nurses/Licensed Vocational Nurses PH13</b>	<input type="text"/>	<input type="text"/>
<b>Medical Social Workers PH14</b>	<input type="text"/>	<input type="text"/>
<b>Homemakers PH15</b>	<input type="text"/>	<input type="text"/>
<b>Hospice Aide PH16</b>	<input type="text"/>	<input type="text"/>
<b>Counselors PH17</b>	<input type="text"/>	<input type="text"/>
<b>Others PH18</b>	<input type="text"/>	<input type="text"/>

**Authorized Official Information**

**Name of Authorized Official \***  **Title of Authorized Official \***

Mark form as Complete  
(Completed forms are not able to be edited)  
Save CMS-417 Form Cancel

**Figure 41: CMS-417 Form**

## 8. CMS-576

---

**Purpose:** To demonstrate how to use the Organ Procurement Request for Designation as an OPO.

**Notes:**

- This form is available for OPO provider type only.
- This worksheet is used to initiate the process for designation or recertification under §1138 of the Social Security Act. It ensures OPOs comply with Medicare and Medicaid conditions for coverage, including reporting requirements to CMS.
- This form is not generated in iQIES. Users must download the form from CMS, complete it, and upload it to iQIES. See *Figure 42, OPO Request for Designation as an OPO, page 1 of 2* and *Figure 43, OPO Request for Designation as an OPO, page 2 of 2*.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		Form Approved OMB No. 0938-0512	
<b>ORGAN PROCUREMENT ORGANIZATION (OPO) REQUEST FOR DESIGNATION AS AN OPO UNDER §1138 OF THE SOCIAL SECURITY ACT</b> <i>(READ INSTRUCTIONS AND INFORMATION COLLECTION STATEMENT ON COVER SHEET PRIOR TO COMPLETION)</i>			
<b>CMS REGIONAL OFFICE USE ONLY</b>			
MEDICARE NUMBER		MEDICARE HOSPITAL NUMBER	DHHS REGIONAL OFFICE
DATE OF SA RECEIPT	DATE OF RO RECEIPT	STATE/REG.	STATE/COUNTY CODE
RELATED PROVIDER NUMBER	STATE/COUNTY CODE	STATE/REGION CODE	FY ENDING DATE
			MEDICARE PROVIDER NUMBER
<b>I. IDENTIFYING INFORMATION</b>	NAME OF FACILITY		STREET ADDRESS
	CITY, COUNTY AND STATE		ZIP CODE
			TELEPHONE NO. <i>(Include Area Code)</i>
	NAME OF CHIEF EXECUTIVE		
	<b>SERVICE AREA (Attach separate sheet if necessary)</b>		
	A. LIST COUNTRIES SERVED <i>(or State if the service includes the entire State)</i>		
	B. GEOGRAPHIC BOUNDARIES		
C. TOTAL POPULATION			
D. LIST ALL ACUTE CARE HOSPITALS WITH AN OPERATING ROOM AND THE EQUIPMENT AND PERSONNEL TO RETRIEVE ORGAN			
<b>II. TYPE OF CONTROL</b> <i>(Check all the apply)</i>	<input type="checkbox"/> INDEPENDENT	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> CORPORATION
	<input type="checkbox"/> HOSPITAL-BASED	<input type="checkbox"/> PROFIT	<input type="checkbox"/> NONPROFIT UNDER §501
		<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> STATE GOVERNMENT
		<input type="checkbox"/> FEDERAL GOVERNMENT	
<b>III. ADMINISTRATION AND STAFFING</b>	<b>BOARD OF DIRECTORS AND ADVISORY BOARD (Give names and title of members who represent the following)</b>		
	1. HOSPITAL'S ADMINISTRATOR	5. TISSUE BANKS	
	2. INTENSIVE CARE OR EMERGENCY ROOM PERSONNEL	6. ORGAN PROCUREMENT SPECIALIST	
	3. DIRECTOR	7. VOLUNTARY HEALTH ASSOCIATIONS	
	4. DONATION COORDINATOR		

Form CMS-576 (01/93)

1

Figure 42: OPO Request for Designation as an OPO, page 1 of 2

<b>III. ADMINISTRATION AND STAFFING (continued)</b>	8. PHYSICIAN WITH KNOWLEDGE, EXPERIENCE, OR SKILL IN THE FIELD OF HUMAN HISTOCOMPATIBILITY OR AN INDIVIDUAL WITH A DOCTORATE DEGREE IN BIOLOGICAL SCIENCE OR WHO HAS KNOWLEDGE, EXPERIENCE, OR SKILLS IN THE FIELD OF HUMAN HISTOCOMPATIBILITY		
	9. TRANSPLANT SURGEONS <i>(from each transplant hospital with an agreement in the service area)</i>		
	10. MEMBERS WHO REPRESENT THE PUBLIC RESIDING IN THE AREA		
	11. NEUROSURGEON OR ANOTHER PHYSICIAN WITH KNOWLEDGE OR SKILLS IN THE FIELD OF NEUROLOGY		
<b>IV. NARRATIVE</b>	<b>ANSWER THE FOLLOWING QUESTIONS AND ATTACH SUPPORTING DOCUMENTATION.</b>		
	1. Attach documentation of working relationship that exists with facilities of the service area for harvesting organs. Specify percentage of hospitals in the service area that you have a working relationship with and specify bed capacity of associated hospitals.		
	2. Specify allocation plan for donated organs among transplant patients.		
	3. Discuss arrangements for tissue typing donated organs.		
	4. Discuss and document your accounting procedures and give name and address of accounting firm.		
	5. Submit quantifiable data showing service area, population and number of potential donors per year.		
	6. Document your affiliation with tissue banks for the retrieval, processing, preservation, storage and distribution of tissues to assure that all usable tissues from potential donors are obtained.		
	7. Discuss and document your procedures for testing for HIV reactivity to prevent the acquisition of organs infected with the etiologic agent for acquired immune deficiency syndrome.		
	8. Document your arrangements to coordinate activities with transplant centers in your service area.		
	9. Discuss and document your procedures for ensuring the confidentiality of patient records.		
	10. Discuss and document your activities relating to professional education concerning organ procurement.		
	11. Document your assistance with hospitals in establishing and implementing protocols for making routine inquiries about organ donations by potential donors.		
	12. Discuss and document your procedures for allocating organs equitably among transplant patients consistent with OPTN criteria as approved by the Secretary.		
<b>V. PERFORMANCE</b>	<b>PROCUREMENT ACTIVITY (the activity is for the 2 calendar years prior to the year of designation):</b>		
	NOTE: THIS INFORMATION MUST BE SUBMITTED 15 DAYS FOLLOWING THE END OF EACH CALENDAR YEAR.		
		FIRST CALENDAR YEAR	SECOND CALENDAR YEAR
	DATE OF CALENDAR YEAR	MM/DD/YY	MM/DD/YY
	NUMBER OF ACTUAL DONORS		
	NUMBER OF KIDNEYS TRANSPLANTED		
	NUMBER OF KIDNEYS RECOVERED		
NUMBER OF EXTRARENAL ORGANS RECOVERED			
NUMBER OF EXTRARENAL ORGANS TRANSPLANTED			
AVERAGE NUMBER OF ORGANS PROCURED PER DONOR			
<small>WHOEVER KNOWINGLY OR WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, 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.</small>			
SIGNATURE OF AUTHORIZED OFFICIAL <i>(Sign in ink)</i>		DATE	
Form CMS-576 (01/93)		2	

Figure 43: OPO Request for Designation as an OPO, page 2 of 2

## 9. CMS-643

---

**Purpose:** To demonstrate how to use the Hospice Survey and Deficiencies Report.

**Note:** This form is available for the hospice provider type only.

- 9.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.
- 9.2 Fill out the information. See *Figure 44, CMS-643 Form*.
- 9.3 Complete the form. Review [Complete Form](#), if necessary.

**Hospice Survey and Deficiencies Report  
Form CMS-643**

**Initial Certification \***  
10/04/2022 - 10/05/2022

1. Was this hospice surveyed for compliance with 42 CFR 418.110? L50 \*

Yes  
 No

2. If this hospice provides inpatient care directly, is the inpatient care provided on the premises? L51 \*

Yes  
 No

3. Has a waiver of core nursing services been granted? L52 \*

Yes  
 No

4. If "Yes" to question number 3, please indicate date. L53

MM/DD/YYYY

5. Indicate type of setting(s) in which the hospice provides routine home care. L54 \*

Type of setting(s) in which the hospice provides routine home care

Private Residence  
 SNF  
 NF  
 Other. If selected, please specify below.

**Specify other type of home care**

6. Number of hospice patients residing in a SNF, NF or other residential facility who receive routine home care from the hospice. L55 \*

7. Number of hospice patients admitted during recent 12 month period. L56 \*

8. Number of records reviewed during survey. L57 \*

9. Number of home visits conducted to patients in a private residence. L58 \*

10. Number of home visits conducted to patients in residential facilities. L59 \*

11. Does this hospice operate under the same certification number at more than one location? L60 \*

Yes  
 No

12. If "Yes" enter number of locations. L61

13. Does this hospice operate as part of another entity that participates in the Medicare program? L62 \*

Yes  
 No

14. If "Yes" enter the Medicare certification number of the entity. L63

**Authorized Official Information**

**Name of Authorized Official \***  **Title of Authorized Official \***

Mark form as Complete  
(Completed forms are not able to be edited)

**Figure 44: CMS-643 Form**

## 10. CMS-671

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**Purpose:** Form CMS-671 is the long-term care facility application for Medicare and Medicaid.

**Notes:**

- The CMS-671 form is available for the Nursing Home provider type only.
  - The CMS-671 form contains fields that were on the now decommissioned CMS-672 form.
- 10.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.
  - 10.2 Fill out the information. See *Figure 45, CMS-671 (page 1 of 4)*, *Figure 46, CMS-671 (page 2 of 4)*, *Figure 47, CMS-671 (page 3 of 4)*, *Figure 48, CMS-671 (page 4 of 4)*.
  - 10.3 Complete the form. Review [Complete Form](#), if necessary.

**Long-Term Care Facility Application for Medicare and Medicaid Form 671**

Survey Team Will Complete

Standard Survey

**1. From**  **2. To**   
MM/DD/YYYY MM/DD/YYYY

Extended Survey

**3. From**  **4. To**   
MM/DD/YYYY MM/DD/YYYY

---

General Instructions

**This form is to be completed by the Facility.** For the purpose of this form, "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

**5. Name of Facility \***  
 0 Lex Nursing Ctr ⓘ

**6. Provider Number**  
 106299 ⓘ

**7. Fiscal Year Ending**  
  
MM/DD/YYYY

**8. Address \***  
 3525 W 42nd ⓘ  
 Miami, FL 20202

**Figure 45: CMS-671 (page 1 of 4)**

**9. Telephone Number \***  
No information ⓘ

**10. State/County Code**  
No information ⓘ

**11. State/Region Code**  
65 - MARYLAND ⓘ

**12. Medicare \***  
 ⓘ

**13. Medicaid \***  
 ⓘ

**14. Other \***  
 ⓘ

**15. Total Residents \***  
0 ⓘ

**16. Program Participation \***  
SNF/NF - Medicare/Medicaid ⓘ

**17. Is this facility hospital based? \***  
 Yes ⓘ  
 No ⓘ

If yes, indicate Hospital Provider Number  
 ⓘ

**18. Ownership \***  
Select one ▼ ⓘ

Figure 46: CMS-671 (page 2 of 4)

**19. Owned or leased by Multi-Facility Organization \***

Yes  
 No ⓘ

Name of Multi-Facility Organization

ⓘ

Dedicated Special Care Units: (show number of beds for all that apply) ⓘ

<b>20. AIDS</b>	<b>21. Alzheimer's Disease</b>	<b>22. Dialysis</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>23. Disabled Children/Young Adults</b>	<b>24. Head Trauma</b>	<b>25. Hospice</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>26. Huntington's Disease</b>	<b>27. Ventilator/Respiratory Care</b>	<b>28. Other Specialized Rehabilitation</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**29. Does the facility currently have an organized residents' group? \***

Yes  
 No ⓘ

**30. Does the facility currently have an organized group of family members of residents? \***

Yes  
 No ⓘ

**31. Does the facility conduct experimental research? \***

Yes  
 No ⓘ

**32. Is the facility part of a continuing care retirement community (CCRC)? \***

Yes  
 No ⓘ

Figure 47: CMS-671 (page 3 of 4)

**32. Is the facility part of a continuing care retirement community (CCRC)? \***

Yes  
 No ⓘ

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks. ⓘ

**Waiver of seven day RN requirement:**

**33. Date**  **34. Hours waived per week**   
MM/DD/YYYY

**Waiver of 24 hr licensed nursing requirement:**

**35. Date**  **36. Hours waived per week**   
MM/DD/YYYY

**37. Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? \***

Yes ⓘ  
 No ⓘ

**38. Name of Person Completing Form \***  **Time \***

**Signature**  **Date \***   
MM/DD/YYYY

---

**To Be Completed By Survey Team**

**39. Was ombudsman office notified prior to survey? \***

Yes  
 No

**40. Was ombudsman present during any portion of the survey? \***

Yes  
 No

**41. Medication Error Rate % \***

ⓘ

---

Mark form as Complete  
(Completed forms are not able to be edited)

Figure 48: CMS-671 (page 4 of 4)

## 11. CMS-1539

---

**Purpose:** Form CMS-1539 and the state agency certification file constitute the primary record of the determination to approve a provider or supplier. Form CMS-1539 processes updates to a provider's information in the national data system.

**Notes:**

- This form is available for most provider types for both Health (Initial, Recertification, Complaint) and LSC (Initial, Recertification, Complaint) survey types.
  - The form can be viewed in both Health and LSC surveys.
- 11.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.
  - 11.2 Fill out the information. See *Figure 49, CMS-1539 (page 1 of 3)*, *Figure 50, CMS-1539 (page 2 of 3)*, *Figure 51, CMS-1539 (page 3 of 3)*.
  - 11.3 Complete the form. Review [Complete Form](#), if necessary.

## Medicare/Medicaid Certification and Transmittal Form 1539

Part 1: To Be Completed by the State Survey Agency or Survey Operations Group

**1. Medicare/Medicaid Provider No.**  
*No information* ⓘ

**2. State Vendor or Medicaid No.**  
*No information* ⓘ

**3. Name and Address of Facility \***  
 House of the Rising Sun  
 1 Main St ⓘ  
 Anytown, VA 24501

**4. Type of Action \***  
 Select one ▼

**5. Effective Date for Change of Ownership**  
 [Greyed out field]  
 MM/DD/YYYY

**6. Date of Survey**  
*No information* ⓘ

**7. Provider/Supplier Category \***  
 HHA ⓘ

**8. Accreditation Status**  
 Unaccredited ⓘ

**9. Fiscal Year Ending Date**  
 Month: Select one ▼      Day: Select one ▼

**10. The Facility is Certified as \***  
 In Compliance with Program Requirements  
 Not in Compliance with Program Requirements

**Figure 49: CMS-1539 (page 1 of 3)**

Compliance Based On

Acceptable POC

And/or approved waivers of the following requirements

Technical Personnel

24 HR RN

7-Day RN (Rural SNF)

Life Safety Code

Scope of Service Limited

Medical Director

Patient Room

Beds per Room

**11. LTC Period of Certification** ⓘ

From (a): *No information*

To (b): *No information*

**12. Total Facility Beds**

*No information* ⓘ

**13. Total Certified Beds**

*No information* ⓘ

**14. LTC Certified Bed Breakdown**

Medicare: *No information* ⓘ

Medicare/Medicaid: *No information* ⓘ

Medicaid: *No information* ⓘ

ICF/IID: *No information* ⓘ

**16. State Survey Agency Remarks \***

If applicable show LTC Cancellation Date  
0/50000 characters

**17. Surveyor Signature \*** **Date \***

04/30/2023

MM/DD/YYYY

**18. State Survey Agency Approval \*** **Date \***

04/30/2023

MM/DD/YYYY

**Figure 50: CMS-1539, (page 2 of 3)**

**Part 2: To Be Completed by the CMS Survey and Operations Group Location or State Agency**

**19. Determination of Eligibility \***

Facility is eligible to participate

Facility is not eligible to participate

**20. Initial Survey Determination**

Survey #1

Survey #2

Survey #3 (Final Attempt)

**22. Effective Date**  
No information ⓘ

**23. LTC Agreement Beginning Date**  
No information ⓘ

**24. LTC Agreement Ending Date**  
No information ⓘ

**25. LTC Extension Date**  
No information ⓘ

**26. Termination Action**  
No information ⓘ

**27. Alternative Sanctions**

Suspension of Admission: No information ⓘ

Rescind Suspension Date: No information ⓘ

**28. Termination Date**  
No information ⓘ

**29. MAC ID Number**

**30. Remarks**

0/50000 characters

**31. CMS Location or MAC Receipt of 1539 \***

MM/DD/YYYY

**32. Determination of Approval Date \***

MM/DD/YYYY

**33. Initial Certification Determination Remarks**

0/50000 characters

Mark form as Complete  
(Completed forms are not able to be edited)

**Figure 51: CMS-1539, (page 3 of 3)**

## 12. CMS-1572

---

**Purpose:** To demonstrate how to use the Home Health Agency Survey Report.

**Note:** This form is available for the HHA provider type only.

- 12.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.
- 12.2 Fill out the information. See *Figure 52, Form CMS-1572 (page 1 of 2)* and *Figure 53, Form CMS-1572 (page 2 of 2)*.
- 12.3 Complete the form. Review [Complete Form](#), if necessary.

**Home Health Agency Survey Report**  
**Form 1572 (OMB NO. 0938-0355)**

**Part 1: To Be Completed by Facility Staff**

**1. Name of Facility \***  
 Sigler Test Provider ⓘ

**2. Provider Number \***  
 148408 ⓘ

**3. Street Address \***  
 123 Main Street ⓘ  
 666  
 Chicago, IL 60051  
 Abc

**4. Telephone Number \***  
 (800) 588-2300 ⓘ

**5. Name of Administrator \***

First Name *	MI	Last Name *	ⓘ
9/15 Jay	No information	Test	

**6. Administrator Qualifications \***  
 RN ⓘ

**7. Type of Control \***  
 Select one

**8. Has there been a change of ownership of the facility since last survey? \***  
 Yes  
 No

**9. Is this home health agency co-located with a separately Medicare-certified Hospice? \***  
 Yes  
 No

If yes, provide the hospice Medicare provider number  
6 alphanumeric characters

**10. Does this home health agency operate any branches locations? \***  
 Yes ⓘ

If yes, how many branches locations?  
 21 ⓘ

All Branch Locations ⓘ

Branch Number	Branch Name	Branch Mailing Address
Branch #1	This branch better not show on that one form	123, Miami 11111
Branch #2	IS THIS BRANCH SHOWING IN THAT COMPLETED FORM?	123, main 11111
Branch #3	10/21 Branch	1234, Orlando 11111
Branch #4	10/19 New Branch from SA	123, Main 11111
Branch #5	9/19 Test Branch	123, Main 11111
Branch #6	Demo Me!	123, orlando 11111
Branch #7	Demo Branch second attempt	123, Main, Orlando 11111
Branch #8	SAGU Created branch 8/2	987 Main, HI, Orlando 11111
Branch #9	CMSGU generated branch 8/2	123 Main, Orlando 11111
Branch #10	Bug 113 Branch	1234, Orlando 11111
Branch #11	6/29 New Branch 2	123, chicago 60051
Branch #12	6/29 New Branch 1	123, chicago 60051
Branch #13	CMSGU Adding an Approved Branch	123, Chicago 60051
Branch #14	Test Create Approved Branch	123, Chicago 60051
Branch #15	New Branch from Form CMS-1572	1, new york 12345
Branch #16	Branch Created from Form CMS-1572	1, hello 60651
Branch #17	Test Branch	234, asdfasfadsafd 60477
Branch #18	SAGU Added branch to certified provider	123, Chicago 60654
Branch #19	CMSGU added branch to certified Provider	123 Main Street, Chicago 60654
Branch #20	That Branch	125 Main Street, Chicago 60051 7
Branch #21	This Branch	124 Main Street, Chicago 60051

**Figure 52: Form CMS-1572 (page 1 of 2)**

**11. Services Provided \***  
 Select each type of care services provided and indicate how this service is provided.

<p><b>Skilled Nursing *</b>  <input type="text" value="Select one"/></p> <p><b>Physical Therapy *</b>  <input type="text" value="Select one"/></p> <p><b>Occupational Therapy *</b>  <input type="text" value="Select one"/></p> <p><b>Speech Therapy *</b>  <input type="text" value="Select one"/></p> <p><b>Social Worker *</b>  <input type="text" value="Select one"/></p>	<p><b>Home Health Aide *</b>  <input type="text" value="Select one"/></p> <p><b>Pharmaceutical Services *</b>  <input type="text" value="Select one"/></p> <p><b>Infusion Services *</b>  <input type="text" value="Select one"/></p> <p><b>Laboratory Services *</b>  <input type="text" value="Select one"/></p> <p><b>Outpatient Therapy Services *</b>  <input type="text" value="Select one"/></p>
---	---

**12. Staffing**  
 List full-time equivalents (not hours)

Staff Member	Direct Hire Staff *	Staff Under Arrangement *
Registered Nurse	<input type="text"/>	<input type="text"/>
Licensed Practical Nurse	<input type="text"/>	<input type="text"/>
Physical Therapist	<input type="text"/>	<input type="text"/>
Physical Therapist Assistant	<input type="text"/>	<input type="text"/>
Occupational Therapist	<input type="text"/>	<input type="text"/>
Occupational Therapist Assistant	<input type="text"/>	<input type="text"/>
Speech-Language Pathologist	<input type="text"/>	<input type="text"/>
Social Worker	<input type="text"/>	<input type="text"/>
Social Work Assistant	<input type="text"/>	<input type="text"/>
Home Health Aide	<input type="text"/>	<input type="text"/>

**Name of Person Completing Form \***  **Title of Person Completing Form \***  **Date Form Completed \***   
MM/DD/YYYY

**Part 2: Surveyor to Complete**

**13. Type of Survey \***  
 Recertification: *No information* ⓘ

**14. Survey Data \***

Total Number of Home Visits

Number of Records Reviewed, No Home Visits

Mark form as Complete  
(Completed forms are not able to be edited)

Figure 53: Form CMS-1572 (page 2 of 2)

# 13. CMS-1880

**Purpose:** To demonstrate how to use the Request for Certification as Supplier of Portable X-Ray Services.

**Notes:**

- This form is available for Portable X-Ray provider type only.
- This worksheet ensures providers meet federal health and safety standards, allows for surveying by state agencies, and acts as a screening tool for participation in Medicare and Medicaid programs.
- This form is not generated in iQIES. Users must download the form from CMS, complete it, and upload it to iQIES. See *Figure 54, Request for Certification as Supplier of Portable X-Ray Services*.

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

FORM APPROVED  
OMB No. 0938-0027

**REQUEST FOR CERTIFICATION AS SUPPLIER OF PORTABLE X-RAY SERVICES  
UNDER THE MEDICARE/MEDICAID PROGRAM**

*(Please read the following instructions before completing this form)*

Submission of this form will initiate the process of obtaining a decision as to whether the conditions of coverage are met. Do not delay returning the form even though certain information is not now available. Assistance in completing the form is available from the State agency.

Answer all questions as of the current date. Return the original and first two copies to the State agency in the envelope provided, 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 below for questions other than those considered self-explanatory.

**Medicare/Medicaid Provider Number** — Leave blank on all initial certifications. On all recertifications, insert the supplier's assigned six-digit provider number.

**State/County Code and State Region** — Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.

**Question II** — The director is the owner or person having administrative control and responsibility for the operation of portable X-ray equipment. If more than one degree is held, check the highest degree; e.g., director holds both an M.D. and an M.P.H., check *physician*; director holds Ph.D. and M.S., check *Ph.D.* Check block 1 if a physician is licensed to practice medicine and osteopathy.

**Question IV** — Include only those persons regularly employed. Do not include director. Count each technologist only once; e.g., technologist holds a B.S. degree in radiologic technology and is also a graduate of a 24-month approved school, place his full-time equivalents in block A. To determine full-time equivalents, divide the total number of hours worked by all employees in each classification in the week prior to the week of filing the request by the number of hours in the standard work week. If the result for each classification is not a whole number, express it as a quarter fraction; e.g., .00, .25, .50, or .75.

**Completion of the Request at Resurvey** — At the time of resurvey, the surveyor will bring this form 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. In either case, the surveyor will initial after the facility representative's signature.

REQUEST TO ESTABLISH ELIGIBILITY IN <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> BOTH (S20)		MEDICARE/MEDICAID PROVIDER NUMBER (S1)	STATE/COUNTY (S2)	STATE REGION (S3)
<b>I. Identifying Information</b>	NAME OF SUPPLIER		STREET ADDRESS	
	CITY, COUNTY, AND STATE		ZIP CODE	TELEPHONE NUMBER (including area code) (S6)
<b>II. Qualifications of Director</b> (Check one) (S7)	<input type="checkbox"/> 1. PHYSICIAN	<input type="checkbox"/> 3. M.S./M.A.	<input type="checkbox"/> 5. OTHER	
	<input type="checkbox"/> 2. PH.D./SC.D.	<input type="checkbox"/> 4. B.S./B.A.		
<b>III. Type of Ownership or Control</b> (Check one) (S14)	<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> CORPORATION			
	<input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> OTHER THAN PRIVATE (Specify) _____			
<b>IV. Number of Technologists</b> (Full time equivalents)	(a) BS/BA IN RADIOLOGIC TECHNOLOGY (S15)	(b) ASSOCIATE DEGREE RADIOLOGIC TECHNOLOGY (S16)	(c) GRADUATE OF 24 MO. APPROVED SCHOOL OF RADIOLOGIC TECHNOLOGY (S17)	(d) ALL OTHER (Specify) (S18)

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 0938-0027. 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, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

I certify that this application is true, correct, and complete. I agree, if approval is granted, to render portable X-ray services in conformity with Federal, State, and local laws relating to safety standards. I further understand that a violation of such laws will constitute grounds for withdrawal of approval under the regulations.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE
----------------------------------	-------	------

Form CMS-1880 (10-90)

*Figure 54: Request for Certification as Supplier of Portable X-Ray Services*

## 14. CMS-3070G

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**Purpose:** To demonstrate how to use the Intermediate Care Facilities for Individuals With Intellectual Disabilities Survey Report.

**Note:** This form is available for ICF/IID provider type only.

- 14.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.
- 14.2 Fill out the information. See *Figure 55, CMS-3070G (page 1 of 6)*, *Figure 56, CMS-3070G (page 2 of 6)*, *Figure 57, CMS-3070G (page 3 of 6)*, *Figure 58, CMS-3070G (page 4 of 6)*, *Figure 59, CMS-3070G (page 5 of 6)*, *Figure 60, CMS-3070G (page 6 of 6)*.
- 14.3 Complete the form. Review [Complete Form](#), if necessary.

**Intermediate Care Facilities For Individuals With Intellectual Disabilities Survey Report**  
**Form 3070G** ←

**1. Name of Facility \***  
 Singy Residential Center ⓘ

**2. Street Address \***  
 123 Main St ⓘ

**3. City \***  
 FLEMING ISLAND ⓘ

**4. State \***  
 Florida ⓘ

**5. Zip Code \***  
 32003 ⓘ

**6. Medicaid Provider Number**  
 10G130 ⓘ

**7. Name of CEO**

**8. Telephone No. \***  
 (800) 555-1212 ⓘ

**9. State/Region Code \***  
 36 - MIAMI ⓘ

**10. State/County Code \***  
 Miami-Dade ⓘ

**11. Dates of Survey (mm/dd/yyyy)**

<b>Begin</b>	<b>End</b>
No information ⓘ	No information ⓘ

**12. Type of Ownership or Control \***

- Private (non-profit)
- Private (proprietary)
- State
- City/Town
- County
- City/County
- Other (specify):

Figure 55: CMS-3070G (page 1 of 6)

**13. Is this ICF/IID a distinct part of a Hospital, SNF or NF? \***

Yes

No

**14. If "Yes" to block 13, indicate either:**

A. Hospital Provider Number

B. SNF Provider Number

C. NF Provider Number

**15. Survey Team Composition**

Survey Team Composition	Disciplines * ⓘ	Qualify as QIDP * ⓘ
A. Administrator	<input type="text"/>	<input type="text"/>
B. Nurse	<input type="text"/>	<input type="text"/>
C. Dietitian	<input type="text"/>	<input type="text"/>
D. Pharmacist	<input type="text"/>	<input type="text"/>
E. Records Administrator	<input type="text"/>	<input type="text"/>
F. Social Worker	<input type="text"/>	<input type="text"/>
G. LSC Specialist	<input type="text"/>	<input type="text"/>
H. Laboratorian	<input type="text"/>	<input type="text"/>
I. Sanitarian	<input type="text"/>	<input type="text"/>
J. Therapist	<input type="text"/>	<input type="text"/>
K. Physician	<input type="text"/>	<input type="text"/>
L. Psychologist	<input type="text"/>	<input type="text"/>
M. Other (specify)	<input type="text"/>	<input type="text"/>
N. Total number of Surveyors onsite	0	N/A
O. Total number of QIDP Surveyors onsite	N/A	0

Figure 56: CMS-3070G (page 2 of 6)

**16. Facility Data**

**A. Is this ICF/IID a residential unit within a larger organization in the State that provides residential services to individuals with intellectual disabilities? \***

Yes

No (If "No", proceed to Item C.)

**B. If "Yes", indicate name and address of larger organization.**

**Name:**

**Address:**

**City:**

**State:**

▼

**Zip Code:**

**Name of CEO:**

**Total Number of Beds:**

*No information*

**Total Number of Clients:**

*(including ICF/IID clients directly served)*

**C. Total Number of ICF/IID Clients: \***

**D. Is this ICF/IID community-based? \***

Yes

No

**E. Total number of ICF/IID beds under this Provider No: \***

0 ⓘ

**F. Total number of discrete living units under this Provider No: \***

**G. Age range of clients served:**

**from \***

**to \***

**H. Total number of off-campus day program sites used by ICF/IID clients: \***

Figure 57: CMS-3070G (page 3 of 6)

**17. Staffing: List the full time equivalents who function in this capacity:**  
List the full time equivalents who function in this capacity:

**A. Direct Care Personnel \***  
(483.430(d)(3))

**B. Registered Nurse \***  
(483.480(d)(3))

**C. Licensed Voc./Practical Nurse \***  
(483.480(d)(2))

**D. Total Personnel \***  
(List the Full Time Equivalent for all employees)

**18. Off-Campus Day Programs:**

**A. How many clients in the sample attend off-campus day programs? \***

**B. In how many off-campus day program sites was an observation done by the Surveyor? \***

Figure 58: CMS-3070G (page 4 of 6)

**19. Individual Characteristics**  
(NOTE: The total number in Items B-L (Col./a)) may exceed the facility's population because some clients have multiple disabilities)

**A. AGE AND SEX**

(1) Age	(2) Sex		
under 22 (a) *	Male *		
<input type="text"/>	<input type="text"/>		
22-45 (b) *	Female *		
<input type="text"/>	<input type="text"/>		
46-65 (c) *	Total: *		
<input type="text"/>	0		
66+ (d) *			
<input type="text"/>			
Total: *			
0			

**B. DISABILITIES**

(1) Intellectual Disability	(2) Autism *	(3) Cerebral Palsy *	(4) Epilepsy
Mild *	<input type="text"/>	<input type="text"/>	Controlled *
<input type="text"/>			<input type="text"/>
Moderate *			Uncontrolled *
<input type="text"/>			<input type="text"/>
Severe *			Total: *
<input type="text"/>			0
Profound *			
<input type="text"/>			
Total: *			
0			

**C. OTHER DISABILITIES**

(1) Non-ambulatory	(2) Speech/Language Impairment *	(3) Hearing Impairment	(4) Visual Impairment
Mobile *	<input type="text"/>	Hard of Hearing *	Impaired *
<input type="text"/>		<input type="text"/>	<input type="text"/>
Non-Mobile *		Deaf *	Blind *
<input type="text"/>		<input type="text"/>	<input type="text"/>
Total: *		Total: *	Total: *
0		0	0

**D. MEDICAL CARE PLAN \***

**E. DRUGS TO CONTROL BEHAVIOR \***

**F. PHYSICAL RESTRAINTS \***

**G. TIME-OUT ROOMS \***

Figure 59: CMS-3070G (page 5 of 6)

**H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI \***

**I. NUMBER OF ATTENDING OFF-CAMPUS DAY PROGRAMS \***

**J. NUMBER OF COURT ORDERED ADMISSIONS \***

**K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT \***

**L. OTHER (specify)**  
(1)    
(2)    
(3)

**M. ALLEGATIONS OF ABUSE AND NEGLECT**  
No. of allegations of abuse investigated (a) \*  
  
No. of allegations of neglect investigated (b) \*  
  
Total: \*  
0

**N. NUMBER OF DEATHS**  
No. of deaths related to unusual incidents (a) \*  
  
No. of deaths related to restraints (b) \*  
  
No. of deaths for any reason (c) \*  
  
Total: \*  
0

---

Mark form as Complete  
(Completed forms are not able to be edited)

Figure 60: CMS-3070G (page 6 of 6)

## 15. CMS-3070H

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**Purpose:** To demonstrate how to use the Intermediate Care Facilities for Individuals With Intellectual Disabilities Deficiencies Report.

**Notes:**

- This form is available for ICF/IID provider type only.
- This worksheet is used by state survey agencies to document compliance with Medicare/Medicaid regulations.
- This form is not generated in iQIES. Users must download the form from CMS, complete it, and upload it to iQIES. See *Figure 61, CMS-3070H (page 1 of 4)*, *Figure 62, CMS-3070H (page 2 of 4)*, *Figure 63, CMS-3070H (page 3 of 4)*, *Figure 64, CMS-3070H (page 4 of 4)*

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

Form Approved  
OMB NO. 0938-0082

**INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES  
DEFICIENCIES REPORT**

Name of Facility

DEFICIENCIES		COMMENTS
1. DATA TAG NO.	2. CoP/STND NO.	

FORM CMS-3070H (03/13)

Figure 61: CMS-3070H (page 1 of 4)





<p>DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</p>	<p>Form Approved OMB NO. 0938-0062</p>
<b>INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES DEFICIENCIES REPORT</b>	
<p>Evaluate each of the requirements identified in the ICF/IID Interpretive Guidelines, (Appendix "J" to the SOM). For each identified deficiency:</p> <ul style="list-style-type: none"><li>A. In the first column, identify the data tag number.</li><li>B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter "CoP" below the regulatory citation.</li><li>C. In column three, describe deficient facility practice and supporting findings.</li><li>D. Draw horizontal lines to separate identified tag numbers.</li><li>E. If more space is needed, photocopy FIRST page (front and back).</li><li>F. Each surveyor must sign the certifying statement on the last page.</li><li>G. If there are more surveyors to sign the last page, than are lines available on which to sign, photocopy the last page, and add the additional signatures.</li></ul>	
<p><small>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 0938-0062. The time required to complete this information collection is estimated to average 3 hours 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.</small></p>	
<p>FORM CMS-3070H (03/13)</p>	
<p>4</p>	

**Figure 64: CMS-3070H (page 4 of 4)**

## 16. CMS-3070I

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**Purpose:** To demonstrate how to use the Individual Observation Worksheet.

**Notes:**

- This form is available for ICF/IID provider type only.
- This worksheet is used by state survey agencies to document, evaluate, and report on the compliance of Intermediate Care Facilities for Individuals with Intellectual Disabilities with CMS Conditions of Participation.
- This form is not generated in iQIES. Users must download the form from CMS, complete it, and upload it to iQIES. See *Figure 65, CMS-3070I (page 1 of 2)*, *Figure 66, CMS-3070I (page 2 of 2)*,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0062	
<b>INDIVIDUAL OBSERVATION WORKSHEET</b>			
Name of Facility		Date	
Location/Start		Location/Start	
Time/Start		Time/Finish	
Surveyor		Client Codes	
COLUMN 1 — TIME	COLUMN 2 — OBSERVATION		
Form CMS-3070I (10/95)			

Figure 65: CMS-3070I (page 1 of 2)

COLUMN 1 — TIME	COLUMN 2 — OBSERVATION

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 0938-0062. The time required to complete this information collection is estimated to average 3 hours per response, including the time to review instructions, searching 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.

Form CMS-3070I (10/95)

Figure 66: CMS-3070I (page 2 of 2)

## 17. CMS-3427

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**Purpose:** Form CMS-3427 is the End Stage Renal Disease Application and Survey and Certification Report.

**Notes:**

- The CMS-3427 form is available for the End Stage Renal Disease (ESRD) provider type only.
- Information on this form may be shown within iQIES. For example, ownership (question 16) is reflected on the Operating and Ownership page.

17.1 Access and add the form from the **Provider History** page. Review [Access a Form](#) and [Add a Form](#), if necessary.

17.2 Fill out the information. See *Figure 67, CMS-3427 (page 1 of 10)*, *Figure 68, CMS-3427 (page 2 of 10)*, *Figure 69, CMS-3427 (page 3 of 10)*, *Figure 70, CMS-3427 (page 4 of 10)*, *Figure 71, CMS-3427 (page 5 of 10)*, *Figure 72, CMS-3427 (page 6 of 10)*, *Figure 73, CMS-3427 (page 7 of 10)*, *Figure 74, CMS-3427 (page 8 of 10)*, *Figure 75, CMS-3427 (page 9 of 10)*, *Figure 76, CMS-3427 (page 10 of 10)*.

17.3 Complete the form. Review [Complete Form](#), if necessary.

**End Stage Renal Disease Application and Survey and Certification Report  
Form 3427**

**Part I - Application - To Be Completed By Facility**

**1. Type of Application/Notification: (V1) \*** ⓘ ← Information icons show additional details

(Check all that apply; if "Other," specify in "Remarks" section [Item33])

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

**2. Name of Dialysis Facility \***  
Kidney Beans Connection ⓘ

**3. CCN**  
*No information* ⓘ

**4. Street Address \***  
123 Main St ⓘ

**5. NPI**  
*No information* ⓘ

**6. City \***  
FORT LAUDERDALE ⓘ

**7. County \***  
Broward ⓘ

**Figure 67: CMS-3427 (page 1 of 10)**

**8. Fiscal Year End Date \***

Month  Day

**9. State \***  
Florida ⓘ

**10. ZIP Code \***  
33311 ⓘ

**11. Administrator's Email Address**  
No information ⓘ

**12. Telephone No. \***  
(800) 555-1212 ⓘ

**13. Facsimile No.**  
No information ⓘ

**14. Medicare Enrollment (CMS 855A) completed? \***

Yes  
 No  
 NA

**15. Dialysis Facility Administrator Name:**  
No information ⓘ

**Business Address:**  
No information ⓘ

**City:**  
No information ⓘ

**State:**  
No information ⓘ

**ZIP Code:**  
No information ⓘ

**Telephone No:**  
No information ⓘ

Figure 68: CMS-3427 (page 2 of 10)

**16. Ownership (V2) \***

For Profit

Not for Profit

Public

**17. Is this dialysis facility independent (i.e., not owned or managed by a hospital)? (V3) \* ⓘ**

Yes

No

Is this dialysis facility owned and managed by a hospital and on the hospital campus (i.e., hospital-based)? (V4)

Yes

No

Is this dialysis facility owned and managed by a hospital and located off the hospital campus (i.e., satellite)? (V5)

Yes

No

**18. Is this dialysis facility located in a SNF/NF (LTC): (V6) \* ⓘ**

(Check one)

Yes

No

If SNF/NF owned and managed by a hospital:

Hospital name: (V7)

CCN: (V8)

If Yes,

SNF/NF name: (V9)

CCN: (V10)

**Figure 69: CMS-3427 (page 3 of 10)**

**19. Is this dialysis facility owned &/or managed by a multi-facility organization? (V11) \***

No  
 Yes, Owned  
 Yes, Managed

If Yes, name of multi-facility organization: (V12)

Multi-facility organization's address:

**20. Current modalities/services for dialysis facilities requesting recertification only: (V13) ⓘ**

(Check all that apply)

1. In-center Hemodialysis (HD)  
 2. In-center Peritoneal Dialysis (PD)  
 3. In-center Nocturnal HD  
 4. Home HD Training & Support  
 5. HD in LTC  
 6. Home PD Training & Support  
 7. PD in LTC  
 8. Dialyzer Reuse

**21. New modalities/services being requested: (V14) \* ⓘ**

(Check all that apply; must have 1 permanent patient for any modality requested)

1. In-center HD  
 2. In-center PD  
 3. In-center Nocturnal HD  
 4. Home HD Training & Support  
 5. HD in LTC  
 6. Home PD Training & Support  
 7. PD in LTC  
 8. Dialyzer Reuse  
 9. N/A

**NOTE:** For dialysis in more than 1 LTC facility, record this same information in the "Remarks" (item 33) section or attach list

Figure 70: CMS-3427 (page 4 of 10)

**22. Does the dialysis facility have any dialysis (PD/HD) patients physically receiving dialysis within long-term care (LTC) facilities? \*** ⓘ

(Check one)

Yes

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

**Number of dialysis residents by modality receiving dialysis within this LTC facility: (V19)**

1. HD

2. PD

*Figure 71: CMS-3427 (page 5 of 10)*

**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 currently approved in-center dialysis stations: (V26) \* ⓘ**

**Are onsite home training room(s) provided? (V27) \***

Yes  
 N/A

**25. Additional in-center stations requested: (V28) ⓘ**  
 or  None

**26. How is isolation provided? (V29) \***

Room  
 Area (existing 2/9/2009 only)  
 CMS Waiver/Agreement (Attach copy)

Figure 72: CMS-3427 (page 6 of 10)

**27. If applicable, number of hemodialysis stations designated for isolation: (V30)**

**28. Days/times for in-center shifts or operating hours if home only: (V31) ⓘ**  
 (Check all days that apply and complete time field in 24-hour clock format)

1st in-center shift starts or home only facility opens:	Last in-center shift ends or home only facility closes:
<b>M:</b>	<b>M:</b>
<input type="text"/>	<input type="text"/>
<b>T:</b>	<b>T:</b>
<input type="text"/>	<input type="text"/>
<b>W:</b>	<b>W:</b>
<input type="text"/>	<input type="text"/>
<b>Th:</b>	<b>Th:</b>
<input type="text"/>	<input type="text"/>
<b>F:</b>	<b>F:</b>
<input type="text"/>	<input type="text"/>
<b>Sat:</b>	<b>Sat:</b>
<input type="text"/>	<input type="text"/>
<b>Sun:</b>	<b>Sun:</b>
<input type="text"/>	<input type="text"/>

**29. Dialyzer reprocessing: (V32) \* ⓘ**

Onsite  
 Centralized/Offsite  
 N/A

Figure 73: CMS-3427 (page 7 of 10)

**30. Staff (List full-time equivalents): \*** ⓘ

**Registered Nurse: (V33) \***

**Certified Patient Care Technician: (V34) \***

**LPN/LVN: (V35) \***

**Technical Staff (water, machine): (V36) \***

**Registered Dietician: (V37) \***

**Masters Social Worker: (V38) \***

**Others: (V39) \***

**31. State license number (if applicable): (V40)**  
*No information* ⓘ

**32. Certificate of Need required? (V41) \*** ⓘ

Yes

No

NA

**33. Remarks:** ⓘ

(Copy if more and attach additional pages if needed)

0/50000 characters

Figure 74: CMS-3427 (page 8 of 10)

**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:

<b>Signature of Administrator/Medical Director</b>	<b>Title *</b>	<b>Date *</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>
		MM/DD/YYYY

---

**Part II 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 recommended approval of the CMS-855A by the applicable MAC. Complete the Statement of Deficiencies (CMS Form 2567). Complete the CMS-1539 entering recommended action(s). All required information must be entered and uploaded in order for the survey to be counted in the state workload.

**35. Medicare Enrollment (CMS 855A recommended for approval by the Medicare Administrative Contractor)? (V42) \***

Yes  
 No

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

**36. Type of Survey: (V43) \***

- 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: (V44) \***

35 - LAUDERHILL [📍](#)

**38. State County Code: (V45) \***

Broward [📍](#)

*Figure 75: CMS-3427 (page 9 of 10)*

**39. Network Number: (V46) \***  
07 - FLORIDA ⓘ

**My signature below indicates that I have reviewed this form and it is complete.**

**40. Survey Team Leader (sign)**

**41. Name/Number (print) \***

**42. Professional Discipline (print) \***

**43. Survey Exit Date**  
No information ⓘ

---

Mark form as Complete  
*(Completed forms are not able to be edited)*

Figure 76: CMS-3427 (page 10 of 10)