Centers for Medicare & Medicaid Services

Internet Quality Improvement & Evaluation System (iQIES)

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

Version 4.1

June 23, 2026

Table of Contents

1. Introduction 1

1.1 Getting Started in S&C – Important Information to Know 1

1.2 iQIES Service Center 4

1.3 Roles and Permissions 5

2. Forms Overview 6

2.1 Access a Form 9

2.2 Add a Form 12

2.3 Edit a Form 14

2.4 Delete a Form 17

2.5 Link Form to Survey 19

2.6 Link Survey to Form 21

2.7 Save Form in Progress 23

2.8 Complete Form 24

2.9 Download a Form 25

Download the form from the Provider History page 25

Download the form from the Form page 25

2.10 Certification Event 26

3. CMS-29 28

4. CMS-286 30

5. CMS-359 39

6. CMS-360 42

7. CMS-377 44

8. CMS-381 46

9. CMS-417 51

10. CMS-437 53

11. CMS-437A 54

12. CMS-437B 55

13. CMS-576 56

14. CMS-643 59

15. CMS-671 61

16. CMS-724 66
17. CMS-726 71
18. CMS-1539 73
19. CMS-1572 77
20. CMS-1880 80
21. CMS-2802 81
22. CMS-3070G 84
23. CMS-3070H 91
24. CMS-3070I 96
25. CMS-3427 99
26. CMS-10455 110
27. Rural and Distance Verification 116
28. Rural and Distance Verification 119

List of Figures

Figure 1: Expandable Field 1
Figure 2: Notification Banner 2
Figure 3: Tool Tip Icon 3
Figure 4: Help Icon 5
Figure 5: HHA Provider Forms List 9
Figure 6: Actions for a Complete Form 10
Figure 7: Actions for an In Progress Form 11
Figure 8: Add Form 12
Figure 9: Save a Form 13
Figure 10: Form Last Updated By User Information 13
Figure 11: Hospice Provider Forms List 14
Figure 12: Edit a Form 15
Figure 13: Edit from Form Action Drop-Down 15
Figure 14: Edit a Form from Survey Record 16
Figure 15: Provider Forms List for CMS-643 17
Figure 16: Form Action Drop-Down 18
Figure 17: Delete a Form Pop Up Window 18
Figure 18: Provider Forms 19
Figure 19: Click Link Survey 19
Figure 20: Link Survey 20
Figure 21: Linked Survey 20
Figure 22: Provider Forms List for HHA 21
Figure 23: Form Action Drop-Down 21
Figure 24: Link Survey to Form Pop Up Window 22
Figure 25: Save Form 23

Figure 26: Last Updated By 23
Figure 27: Mark Form as Complete 24
Figure 28: Completed..... 24
Figure 29: Download Form From Provider History 25
Figure 30: Download Form From Form Page 25
Figure 31: Basic Information Page Certification Progress 26
Figure 32: CMS-29 Form 29
Figure 33: CMS-286, page 1 of 8 31
Figure 34: CMS-286 page 2 of 8 32
Figure 35: CMS-286 page 3 of 8 33
Figure 36: CMS-286 page 4 of 8 34
Figure 37: CMS-286 page 5 of 8 35
Figure 38: CMS-286 page 6 of 8 36
Figure 39: CMS-286 page 7 of 8 37
Figure 40: CMS-286 page 8 of 8 38
Figure 41: CMS-359 Form, page 1 of 2 40
Figure 42: CMS-359 Form, page 2 of 2 41
Figure 43: Resources..... 42
Figure 44: First Page of CMS-360 43
Figure 45: Ambulatory Surgical Center Request Form-377 45
Figure 46: CMS-381 (page 1 of 4)..... 47
Figure 47: CMS-381 (page 2 of 4)..... 48
Figure 48: CMS-381 (page 3 of 4)..... 49
Figure 49: CMS-381 (page 4 of 4)..... 50
Figure 50: CMS-417 Form 52
Figure 51: Form CMS-437 53
Figure 52: CMS-437A 54

Figure 53: CMS-437B........ 55
Figure 54: OPO Request for Designation as an OPO, page 1 of 2 57
Figure 55: OPO Request for Designation as an OPO, page 2 of 2 58
Figure 56: CMS-643 Form 60
Figure 57: CMS-671 (page 1 of 4)........ 62
Figure 58: CMS-671 (page 2 of 4)........ 63
Figure 59: CMS-671 (page 3 of 4)........ 64
Figure 60: CMS-671 (page 4 of 4)........ 65
Figure 61: CMS-724, part 1 of 4 67
Figure 62: CMS-724, part 2 of 4 68
Figure 63: CMS-724, part 3 of 4 69
Figure 64: CMS-724, part 4 of 4 70
Figure 65: CMS-726........ 72
Figure 66: CMS-1539 (page 1 of 3)........ 74
Figure 67: CMS-1539, (page 2 of 3)........ 75
Figure 68: CMS-1539, (page 3 of 3)........ 76
Figure 69: Form CMS-1572 (page 1 of 2)........ 78
Figure 70: Form CMS-1572 (page 2 of 2)........ 79
Figure 71: Request for Certification as Supplier of Portable X-Ray Services 80
Figure 72: CMS-2802, page 1 of 3 81
Figure 73: CMS-2802, page 2 of 3 82
Figure 74: CMS-2802, page 3 of 3 83
Figure 75: CMS-3070G (page 1 of 6)........ 85
Figure 76: CMS-3070G (page 2 of 6)........ 86
Figure 77: CMS-3070G (page 3 of 6)........ 87
Figure 78: CMS-3070G (page 4 of 6)........ 88
Figure 79: CMS-3070G (page 5 of 6)........ 89

Figure 80: CMS-3070G (page 6 of 6)........ 90
Figure 81: CMS-3070H (page 1 of 4)........ 92
Figure 82: CMS-3070H (page 2 of 4)........ 93
Figure 83: CMS-3070H (page 3 of 4)........ 94
Figure 84: CMS-3070H (page 4 of 4)........ 95
Figure 85: CMS-3070I (page 1 of 2)........ 97
Figure 86: CMS-3070I (page 2 of 2)........ 98
Figure 87: CMS-3427 (page 1 of 10)........ 100
Figure 88: CMS-3427 (page 2 of 10)........ 101
Figure 89: CMS-3427 (page 3 of 10)........ 102
Figure 90: CMS-3427 (page 4 of 10)........ 103
Figure 91: CMS-3427 (page 5 of 10)........ 104
Figure 92: CMS-3427 (page 6 of 10)........ 105
Figure 93: CMS-3427 (page 7 of 10)........ 106
Figure 94: CMS-3427 (page 8 of 10)........ 107
Figure 95: CMS-3427 (page 9 of 10)........ 108
Figure 96: CMS-3427 (page 10 of 10)........ 109
Figure 97: CMS-286, page 1 of 5........ 111
Figure 98: CMS-286, page 2 of 5........ 112
Figure 99: CMS-286, page 3 of 5........ 113
Figure 100: CMS-286, page 4 of 5........ 114
Figure 101: CMS-286, page 5 of 5........ 115
Figure 102: Psychiatric Residential Treatment Facility Form (Form Application PRTF), page 1 of 2........ 117
Figure 103: Psychiatric Residential Treatment Facility Form (Form Application PRTF), page 2 of 2........ 118
Figure 104: Rural and Distance Verification Form, Page 1 of 3........ 120

Figure 105: Rural and Distance Verification Form, Page 2 of 3........................... 121
Figure 106: Rural and Distance Verification Form, Page 3 of 3........................... 122

List of Tables

Table 1: Notification Banner Color Descriptions 2
Table 2: Forms in iQIES 6
Table 3: Forms That Must Be Uploaded to iQIES 7
Table 4: Provider Forms List Field Description 10
Table 5: Basic Information Page Certification Progress Callout Details 27

1. Introduction

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*.

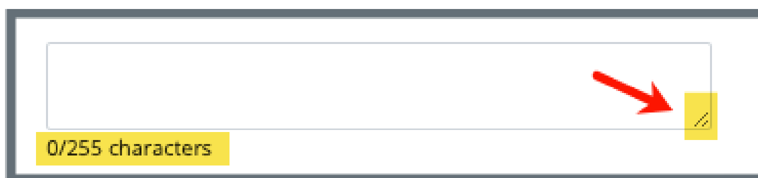

Figure 1: Expandable Field

- 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.

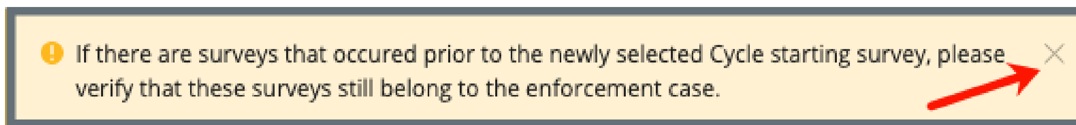

Figure 2: Notification Banner

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.*

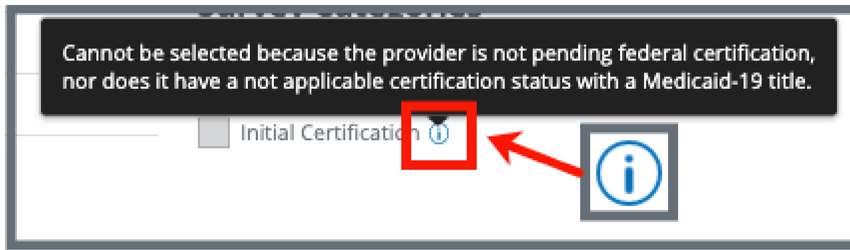

Figure 3: Tool Tip Icon

- 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.

Assistance Accessing iQIES:	Contact the iQIES Security Official (SO) for your organization
Technical Support:	Contact the iQIES Service Center: **Phone**: 888-477-7876 (select Option 1) **Email**: iQIES@cms.hhs.gov
CCSQ Support Central:	Create a new ticket or track an existing ticket: CCSQ Support Central.
Idea Portal:	Feedback for future iQIES software development: CCSQ Support Central. Click **Idea Portals** and select **iQIES Idea Portal**.
More information on iQIES:	Refer to the QIES Technical Support Office (QTSO) and the Quality, Safety, & Education Portal (QSEP). Logging in to HARP may be required before accessing some documentation in QTSO and QSEP. iQIES reference materials include: • Other volumes of the S&C User Manual • Links to Training Videos for providers • Assessment Management User Manual • Quick Reference Guides • Onboarding Guide • Managing User Information • Other helpful iQIES material 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

Important Note: This manual provides technical instruction on system functionality and does not replace CMS policy. Refer to official CMS guidance for policy requirements.

Note: Forms are required to close surveys and achieve 100% certification track status.

Users can access CMS forms for supported provider types in iQIES. Refer to *Table 2, Forms in iQIES,* for forms found within iQIES and to *Table 3, Forms That Must Be Uploaded to iQIES,* for forms that must be downloaded from CMS, completed and then uploaded to iQIES.

Table 2: Forms in iQIES

CMS Form No	Form Title
CMS-29	Verification of Clinic Data - Rural Health Clinic Program
CMS-286	Hospital/Critical Access Hospital (CAH) Database Worksheet
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-724	Medicare/Medicaid Psychiatric Hospital Survey Data

CMS Form No	Form Title
CMS-726	CMS Death Record Review Data Sheet
CMS-1539	Medicare/Medicaid Certification and Transmittal
CMS-1572	Home Health Agency Survey Report Form
CMS-2802	Authorization for State Agency Hospital Validation Survey
CMS-3070G	Intermediate Care Facilities for Individuals With Intellectual Disabilities Survey Report
CMS-3427	End Stage Renal Disease Application and Survey and Certification Report
CMS-10455	Report of a Hospital Death Associated with Restraint or Seclusion
Form Application PRTF	Psychiatric Residential Treatment Facility Form Application PRTF
Rural and Distance Verification	Rural and Distance Verification

Table 3: Forms That Must Be Uploaded to iQIES

CMS Form No	Form Title
CMS 437	Psychiatric Unit Criteria Worksheet
CMS 437A	Rehabilitation Unit Criteria Worksheet
CMS 437B	Rehabilitation Unit Criteria Worksheet

CMS Form No	Form Title
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 4, Provider Forms List Field Description* for details on the columns shown.

Provider Forms

Add Form

Form Name	Status	Related Survey(s)	Created Date	Last Updated	Track ID	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 4: Provider Forms List Field Description

Column	Description
Form Name	Name of CMS form
Status	Either **Complete** or **In Progress**
Related Survey(s)	The survey(s) the form is linked to, if applicable
Created Date	The date the form was created
Last Updated	The date the form was last updated
Track ID	Click survey number under **Track ID** to see detailed information on certification status. See Certification Event for further details.
Actions	• Form actions for a **Complete** form include **Link Survey**. A **Complete** form cannot be edited or deleted. See *Figure 6, Actions for a Complete Form.* • Form actions for an **In Progress** form include **Link Survey**, **Edit**, **Delete**. See *Figure 7, Actions for an In Progress Form*.

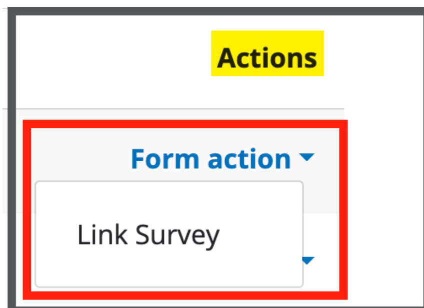

Figure 6: Actions for a Complete Form

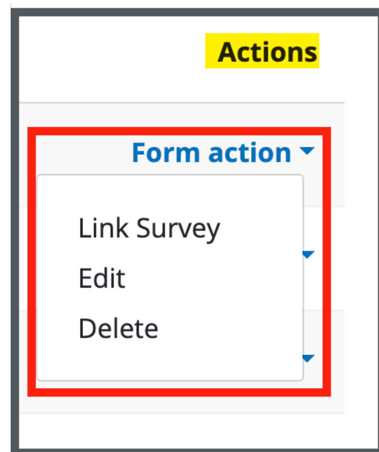

Figure 7: Actions for an In Progress Form

2.1.2 Click the desired form under **Form Name**.

a. If the form has a **Related Survey**, the Survey page opens.

b. 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.

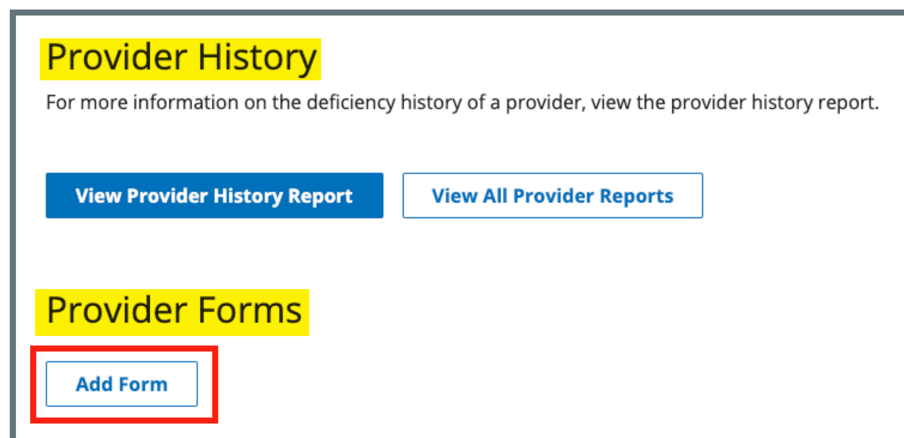

Figure 8: Add Form

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*.

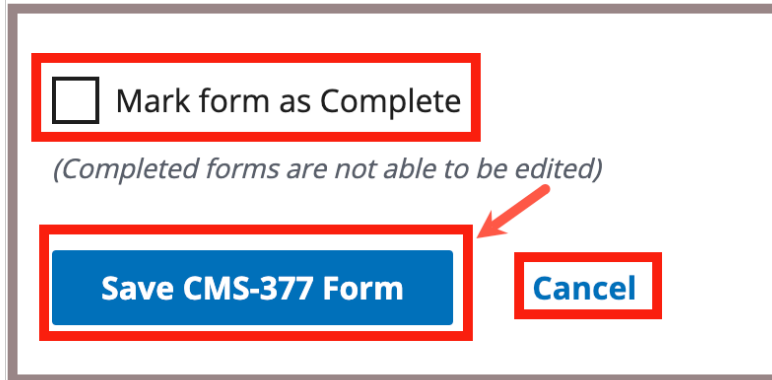

Figure 9: Save a Form

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.*

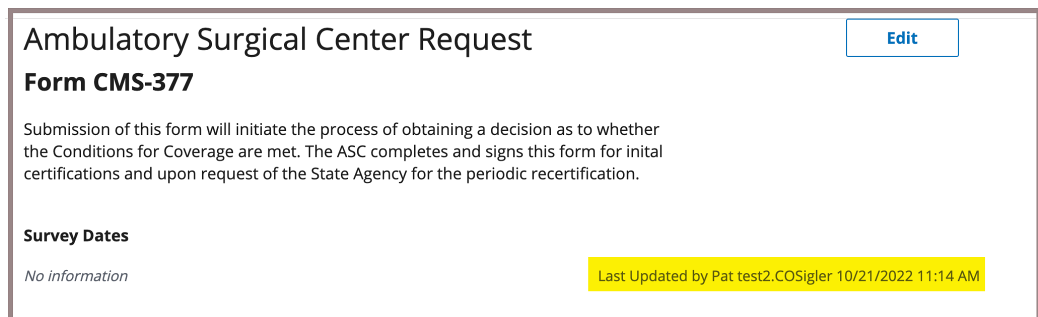

Figure 10: Form Last Updated By User Information

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*.

Provider Forms

Add Form

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.

Provider Forms

Add Form

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	Link Survey Edit Delete
CMS-417	In Progress	No information	01/26/2023	01/27/2023	No information	Form action

View All Forms (4)

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.

Provider Forms

Add Form

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*.

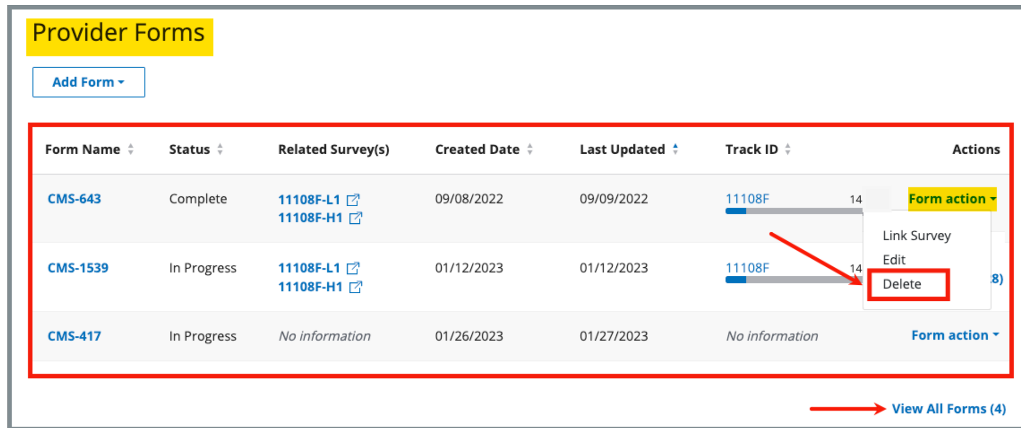

Figure 16: Form Action Drop-Down

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.

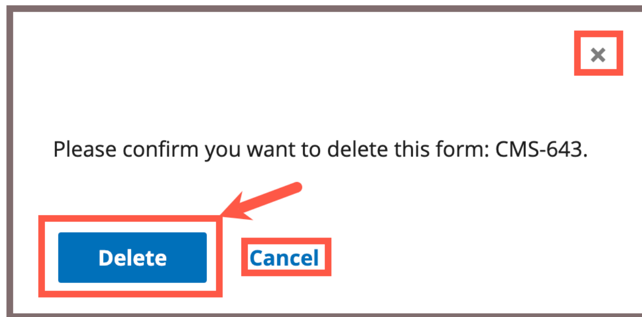

Figure 17: Delete a Form Pop Up Window

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	1A6456-H1	05/23/2024	02/04/2026	1A6456 20%	Form action
CMS-671	In Progress	1A6456-H1	05/23/2024	11/08/2024	1A6456 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.

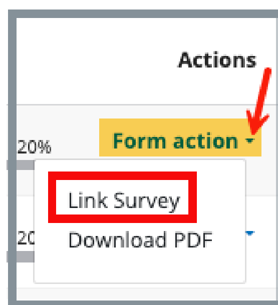

Figure 19: Click Link Survey

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

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

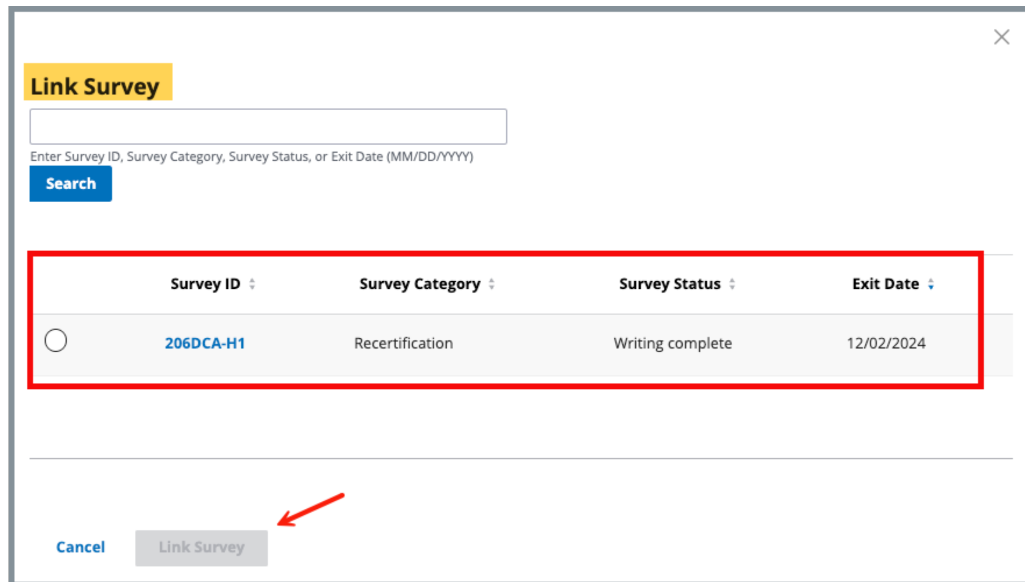

Figure 20: Link Survey

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.*

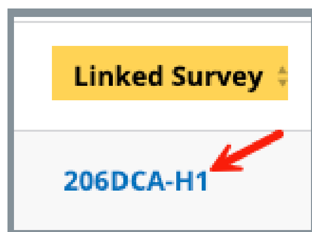

Figure 21: Linked Survey

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*.

Provider Forms

Add Form

Form Name	Status	Related Survey(s)	Created Date	Last Updated	Track ID		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 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	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

Link Survey
Edit
Delete

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.

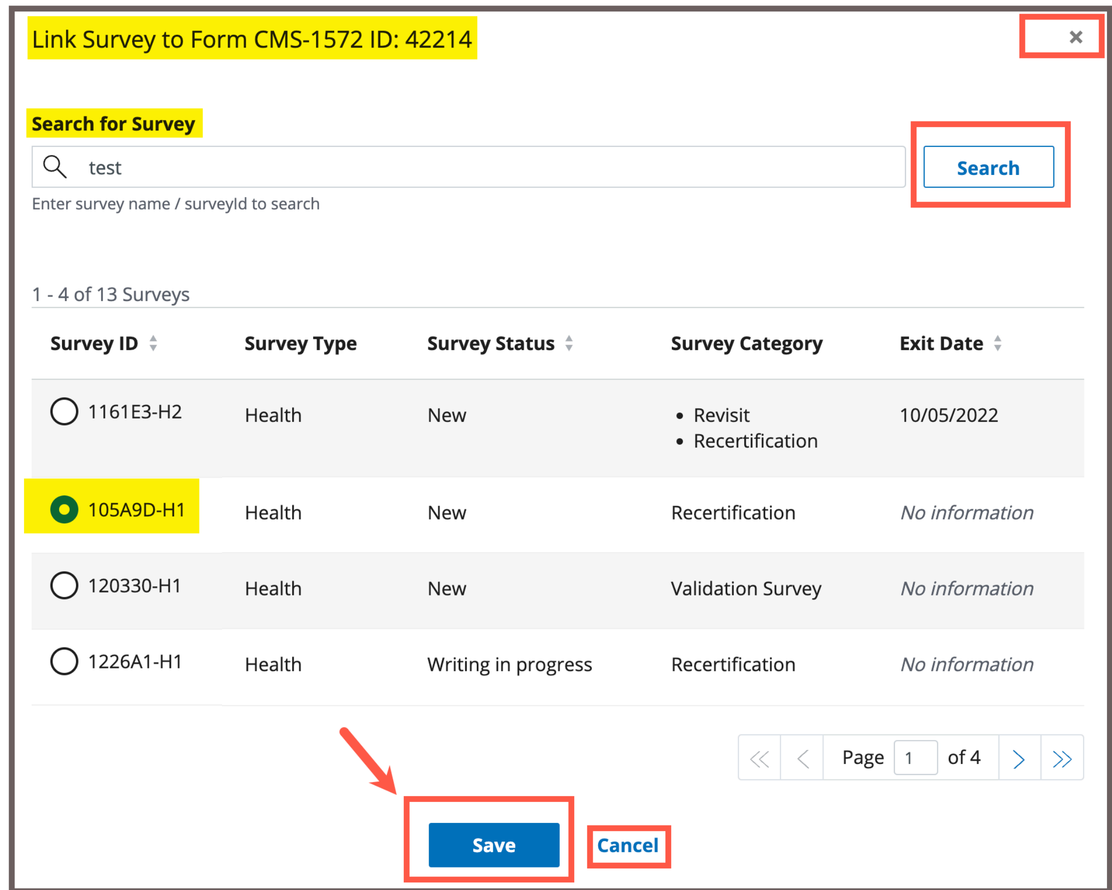

Figure 24: Link Survey to Form Pop Up Window

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.*

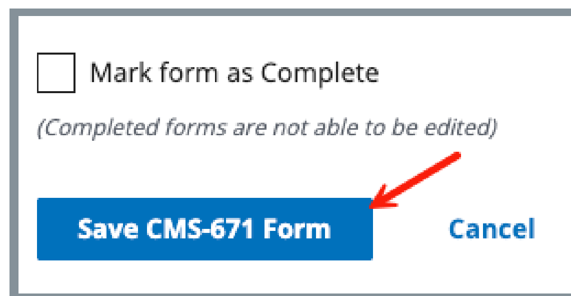

Figure 25: Save Form

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

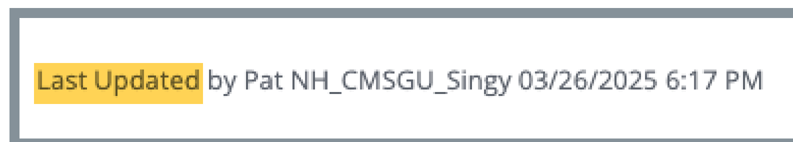

Figure 26: Last Updated By

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.*

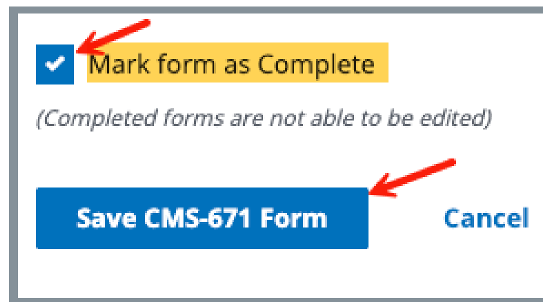

Figure 27: Mark Form as Complete

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: Not all forms can be downloaded both prior to completion and after completion.

- CMS-671 can be downloaded only when marked as complete.
- CMS-29, CMS-286, CMS-377, CMS-417, CMS-643, CMS-724, CMS-1572, CMS-2980, CMS-10455, Form Application PRTF, Rural and Distance Verification cannot be downloaded as a PDF.

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.

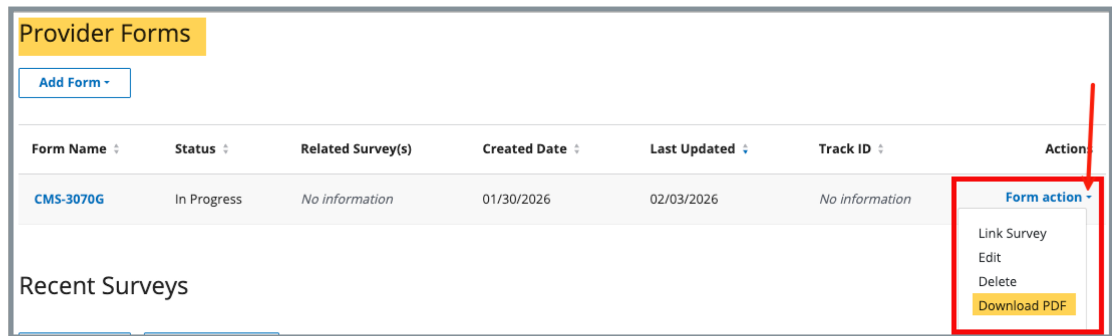

Figure 29: Download Form From Provider History

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*.

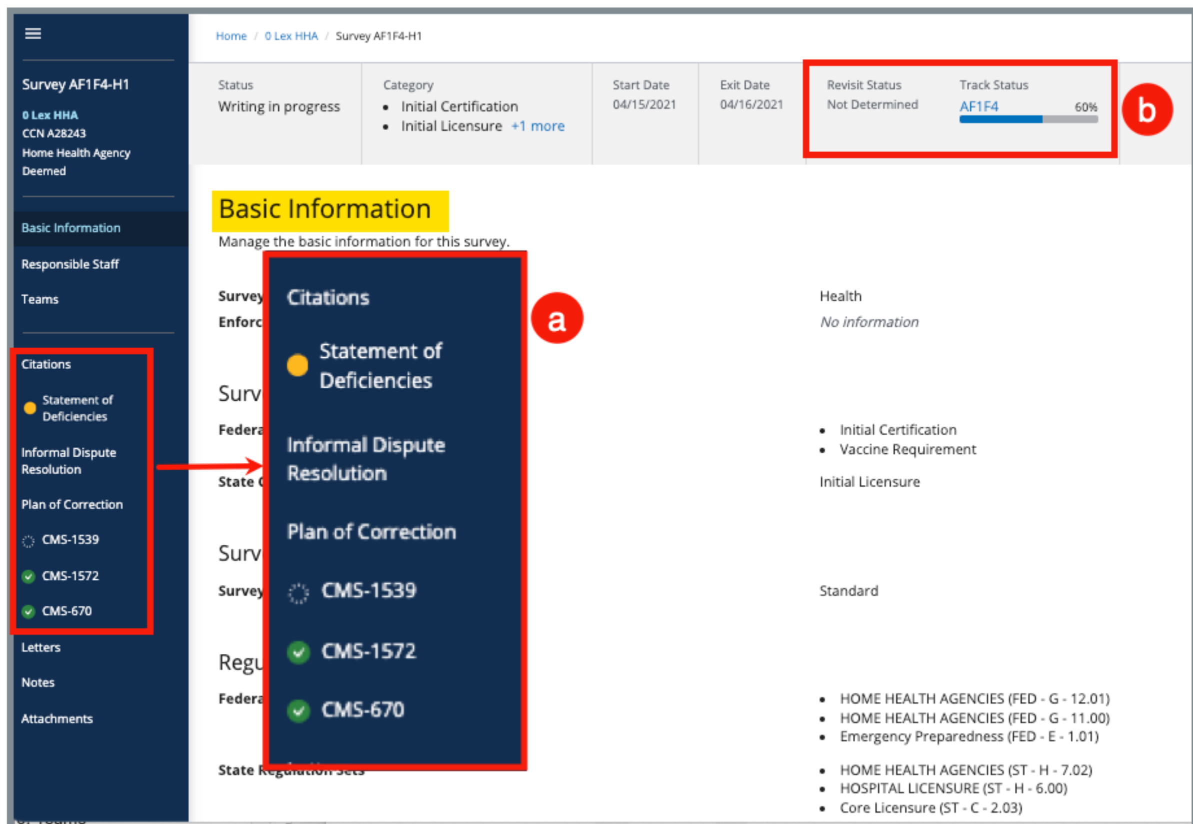

Figure 31: Basic Information Page Certification Progress

Table 5: Basic Information Page Certification Progress Callout Details

<table>
<tr><th>Callout</th><th colspan="2">Action</th></tr>
<tr><td rowspan="4">a</td><td colspan="2">The left menu shows the status at a glance.</td></tr>
<tr><td>No fill</td><td>Not Started: Form or information hasn’t been started</td></tr>
<tr><td>Yellow fill</td><td>In Progress: Form or information has been started, but it is incomplete</td></tr>
<tr><td>Green fill</td><td>Complete: Form or information is complete</td></tr>
<tr><td>b</td><td colspan="2">The grey status bar shows the certification track status. Click survey number under Track Status to see detailed information on certification status.</td></tr>
</table>

3. CMS-29

Purpose: To demonstrate how to use the Verification of Clinic Data - Rural Health Clinic Program.

Notes:

- This form is available for the RHC provider type only.
- This form is used to initiate or update Medicare certification for RHCs

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-29 Form.*

Notes:

- Click **+Add another Clinic Owner** or **+Add Another Medical Direction** to add additional clinic owners or medical directions. These buttons are disabled until one clinic owner or medical direction is added.
- **Clinic Personnel: Full-Time Equivalent** allows values with two digits to the right of the decimal (for example, 1.22 or 1.50).

3.3 Complete the form. Review Complete Form, if necessary.

CMS-29 Form

Figure 32: CMS-29 Form

4. CMS-286

Purpose: To demonstrate how to use the Hospital/Critical Access Hospital (CAH) Database Worksheet.

Notes:

- This form is available for the Hospital provider type only.
- This form is used to gather, update, and certify critical structural data for Medicare participation.

4.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

4.2 Fill out the information. See *Figure 33, CMS-286 page 1 of 8, Figure 34, CMS-286 page 2 of 8, Figure 35, CMS-286 page 3 of 8, Figure 36, CMS-286 page 4 of 8, Figure 37, CMS-286 page 5 of 8, Figure 38, CMS-286 page 6 of 8, Figure 39, CMS-286 page 7 of 8,* and *Figure 40, CMS-286 page 8 of 8,*

4.3 Complete the form. Review Complete Form, if necessary.

HOSPITAL/CAH DATABASE WORKSHEET
Exhibit 286

Worksheet completed by the SA surveyor to gather data of worksheet, not to be given to provider to fill out.

Date of Worksheet Update (MM/DD/YYYY)
05/07/2026

CMS Certification Number (CCN)
103305

Medicaid Provider Number
No information

National Provider Identification Number(s) (NPI)
No information

Fiscal Year Ending Date (MMDD)
Month Day
Select one Select one

Name and Address of Facility
Singy Hospital for Kids
123 Main St
Fleming Island, FL 32003

Telephone Number (M2)
(800) 555-1212

Fax Number (M3)
No information

CEO Telephone Number

Email Address
No information

Website Address
No information

Figure 33: CMS-286, page 1 of 8

Accreditation Status
CIHQ

Effective Date of Accreditation (M4)
2026-04-09

Renewal Date of Accreditation (M5)
2029-04-09

Multiple Accreditation Status
No

Other Accreditations
No information

State/County Code (M6)
FL - Miami-Dade

State Region Code (M7)
35 - LAUDERHILL

Type of Program Participation (M8)
Medicare

CLIA ID Numbers (M9)

Add CLIA ID

Medicare CAH Status or Type of Medicare Hospital (M10)
Pediatric

Affiliation With Medical School (M11)
Select one

Resident Programs (M12)
Select...

Ownership Type (M13)
Select one

Average Daily Census (M14)

Figure 34: CMS-286 page 2 of 8

Number of Staffed Beds (M15)

Chain/Health System Involvement (M16)

Select one

Name of System (M17)

Corporate Headquarters City (M18)

Corporate Headquarters State (M19)

Select one

Number of State Licensed Beds

No information

Number of Operating Rooms

No information

Separately Licensed

No information

Number of Endoscopy Rooms

No information

Separately Licensed

No information

Number of Cardiac Catheterization Rooms

No information

Separately Licensed

No information

Has Nurse Bed Override

Yes

No

Figure 35: CMS-286 page 3 of 8

Number of Employees Salaried by Hospital/CAH

(Use Full Time Equivalents FTE)

(M20) Physicians (Salaried only)

(M21) Physicians - Residents

(M22) Physician Assistants (PA)

(M23) Nurses - CRNA

(M24) Nurses - Practitioners

(M25) Nurses - Registered

(M26) Nurses - LPN

(M27) Dieticians

(M28) Medical Social Workers

(M29) Medical Lab Technicians

(M30) Medical Technologists (Lab)

(M31) Nuclear Medicine Technicians

(M32) Occupational Therapists

(M33) Pharmacists (registered)

(M34) Physical Therapists

(M35) Psychologists

(M36) Radiology Technicians (Diagnostic)

(M37) Respiratory Therapists

(M38) Speech Therapists

(M39) All Others

Figure 36: CMS-286 page 4 of 8

Medicare Payment - Related Categories for a Hospital or a CAH (select all that apply) (M40):

CAH Categories

- [ ] 01 - CAH Psychiatric DPU
- [ ] 02 - CAH Rehabilitation DPU
- [ ] 03 - CAH Swing Beds

Hospital Categories

- [ ] 07 - Hospital PPS Excluded Psych Unit
- [ ] 08 - Hospital PPS Excluded Rehab Unit
- [ ] 09 - Hospital Swing Beds
- [ ] 10 - Medicare Dependent Hospital
- [ ] 11 - Regional Referral Center
- [ ] 12 - Sole Community Hospital

Services Provided by the Facility (M41)

02 Alcohol and/or Drug Services
Select one

03 Anesthesia Service
Select one

04 Audiology
Select one

06 Burn Care Unit
Select one

07 Cardiac Catheterization Laboratory
Select one

08 Cardiac-Thoracic Surgery
Select one

09 Chemotherapy Services
Select one

38 Organ Transplant Services (Not Medicare Certified)
Select one

39 Orthopedic Surgery
Select one

40 Outpatient Services
Select one

41 Pediatric Services
Select one

42 Pharmacy
Select one

43 Physical Therapy Services
Select one

44 Positron Emission Tomography Scan
Select one

Figure 37: CMS-286 page 5 of 8

10 Chiropractic Service

Select one

11 CT Scanner

Select one

12 Dental Services

Select one

13 Dietetic Service

Select one

14 Emergency Department (Dedicated)

Select one

16 Extracorporeal Shock Wave Lithotripter

Select one

17 Gerontological Specialty Services

Select one

20 ICU - Cardiac (Non-Surgical)

Select one

21 ICU - Medical Surgical

Select one

22 ICU - Neonatal

Select one

23 ICU - Pediatric

Select one

45 Post-Operative Recovery Rooms

Select one

46 Psychiatric Services - Emergency

Select one

47 Psychiatric - Child/Adolescent

Select one

48 Psychiatric - Forensic

Select one

49 Psychiatric - Geriatric

Select one

50 Psychiatric - Adult Inpatient

Select one

51 Psychiatric - Outpatient

Select one

52 Radiology Services - Diagnostic

Select one

53 Radiology Services - Therapeutic

Select one

54 Reconstructive Surgery

Select one

55 Respiratory Care Services

Select one

Figure 38: CMS-286 page 6 of 8

24 ICU - Surgical

Select one

26 Laboratory-Clinical

Select one

28 Magnetic Resonance Imaging (MRI)

Select one

29 Neonatal Nursery

Select one

30 Neurosurgical Services

Select one

31 Nuclear Medicine Services

Select one

32 Obstetric Service

Select one

33 Occupational Therapy Services

Select one

34 Operating Rooms

Select one

35 Ophthalmic Surgery

Select one

36 Optometric Services

Select one

56 Rehab Services - Inpatient

Select one

58 Rehab - Outpatient

Select one

59 Renal Dialysis (Acute Inpatient)

Select one

60 Social Services

Select one

61 Speech Pathology Services

Select one

62 Surgical Services - Inpatient

Select one

63 Surgical Services - Outpatient

Select one

64 Trauma Center Designated

Select one

65 Transplant Center (Medicare Certified)

Select one

66 Urgent Care Center Services

Select one

Figure 39: CMS-286 page 7 of 8

Sprinkler Status, Main Campus (M42)

Select one

Total number of provider-based off-site locations under the same CCN (M43): 0

(01) Inpatient Remote Location	0	**(07) Satellite of IPPS Excluded Psych Unit**	0
(02) Offsite Outpatient Surgery	0	**(08) Satellite of Long Term Care Hospital**	0
(03) Offsite Urgent Care Center	0	**(09) Satellite of Cancer Hospital**	0
(04) Satellite of Rehabilitation Hospital	0	**(10) Satellite of Children's Hospital**	0
(05) Satellite of Psychiatric Hospital	0	**(11) Offsite Emergency Department**	0
(06) Satellite of IPPS Excluded Rehab Unit	0	**(20) Other Provider-Based Offsite Facility/Department**	0

Total number of affiliated providers/suppliers under the same CCN (M44): 1

(01) Ambulance Service	0	**(06) Hospice**	0
(02) Ambulatory Surgery Center	0	**(07) Organ Procurement Organization**	0
(03) End Stage Renal Disease	0	**(08) Psychiatric Residential Treatment Facility**	0
(04) Federally Qualified Health Center	0	**(09) Rural Health Clinic**	1
(05) Home Health Agency	0	**(10) Skilled Nursing Facility**	0

(M45) Co-location Status: Is there another hospital, or a satellite location of another hospital, that occupies space in a building used by the hospital described in this worksheet?

No

PROVIDER - BASED OFF - SITE LOCATION CONTINUATION WORKSHEET

No information

AFFILIATED PROVIDER/SUPPLIER CONTINUATION WORKSHEET

ENTRY # 1
Name: Singy's Outback RHC **CCN:** 683828
Type of Provider/Supplier: (09) Rural Health Clinic

☐ Mark form as Complete

(Completed forms are not able to be edited)

Save CMS-286 Form **Cancel**

Figure 40: CMS-286 page 8 of 8

5. 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.

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 41, CMS-359 Form, page 1 of 2* and *Figure 42, CMS-359 Form, page 2 of 2*.

5.3 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 *

Singy 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

- [x] 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 41: 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   Cancel

Figure 42: CMS-359 Form, page 2 of 2

6. 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.

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

6.2 Click **Resources** on the left menu. See *Figure 43, Resources.* The CMS-360 form is automatically downloaded to the user's computer as a fillable PDF document.

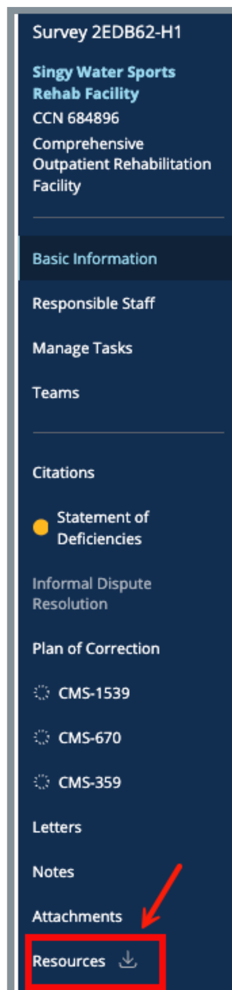

Figure 43: Resources

6.3 Open the form. See *Figure 44, First Page of CMS-360*.

6.4 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: ☐ Initial Survey ☐ Recertification Survey ☐ Complaint ☐ Other: (Specify):

Code	Description	Yes	No	N/A	
I-501	**§485.54 - Condition of Participation: Compliance with State and local laws.** The facility and all personnel who provide services must be in compliance with applicable State and local laws and regulations.	☐	☐		
I-502	**(a) Standard: Licensure of facility.** If State or local law provides for licensing, the facility must be currently licensed or approved as meeting the standards established for licensure.	☐	☐	☐	
I-503	**(b) Standard: Licensure of Personnel.** Personnel that provide service must be licensed, certified, or registered in accordance with applicable St ate and local laws.	☐	☐	☐	

Form CMS-360 / OMB Approval Expires XX/XX/20XX Page 1

Figure 44: First Page of CMS-360

7. 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.

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 45, Ambulatory Surgical Center Request Form CMS-377*.

7.3 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 inital 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 Specialities

Surgical Specialities (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 subspecialities.

Some other surgical speciality

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)

Save CMS-377 Form Cancel

Figure 45: Ambulatory Surgical Center Request Form-377

8. CMS-381

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

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

8.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

8.2 Fill out the information. See *Figure 46, CMS-381 (page 1 of 4), Figure 47, CMS-381 (page 2 of 4), Figure 48, CMS-381 (page 3 of 4), Figure 49, CMS-381 (page 4 of 4)*.

8.3 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 46: 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 47: 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

Speech Pathologists

On Staff	By Arrangement	Total

Occupational Therapists

On Staff	By Arrangement	Total

Figure 48: 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

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

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

Figure 49: CMS-381 (page 4 of 4)

9. 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.

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 50, CMS-417 Form*.

9.3 Complete the form. Review Complete Form, if necessary.

Figure 50: CMS-417 Form

10. CMS-437

Purpose: To demonstrate how to use Rehabilitation Unit Criteria Worksheet.

Notes:

- This form is available for the Hospital provider type only.
- This worksheet is used to attest that they meet Medicare requirements for exemption from the Inpatient Prospective Payment System (IPPS).
- This form is not generated in iQIES. Users must download the form from CMS, complete it, and upload it to iQIES. See *Figure 51, CMS-437.*

  Note: This form shows only the first page of **Form CMS-437**.

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

Form Approved
OMB No. 0938-0358

PSYCHIATRIC UNIT CRITERIA WORK SHEET

RELATED MEDICARE PROVIDER NUMBER	ROOM NUMBERS IN THE UNIT	FACILITY NAME AND ADDRESS *(CITY, STATE, ZIP CODE)*
NUMBER OF BEDS IN THE UNIT	SURVEY DATE	
REQUEST FOR EXCLUSION FOR COST REPORTING PERIOD ___ / ___ / _____ to ___ / ___ / _____ MM DD YYYY MM DD YYYY		
VERIFIED BY		

ALL CRITERIA MUST BE MET FOR EXCLUSION FROM MEDICARE'S HOSPITAL PROSPECTIVE PAYMENT SYSTEM (PPS)

TAG	REGULATION	GUIDANCE	YES	NO	EXPLANATORY STATEMENT
	§412.25 Excluded Hospital Units: Common Requirements				
A1105	(a) Basis for exclusion. In order to be excluded from the prospective payment system, a psychiatric unit must meet the requirements under §412.25(a) and (b) which include:				
A1106	(1) Be part of an institution that (i) Has in effect an agreement to participate as a hospital; (ii) Is not excluded in its entirety from the prospective payment systems; and (iii) Has enough beds that are not excluded from the prospective payment systems to permit the provision of adequate cost information, as required by §413.24(c)	Has the state agency (SA) verified with the CMS Regional Office (RO) that the hospital has a current agreement to participate in the Medicare program and to ensure that the hospital is not already excluded in its entirety from PPS, such as a psychiatric hospital?			
A1107	(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.	Are the same admission criteria being applied to all patients?			
A1108	(3) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.	Are the psychiatric unit medical records separate from other hospital records? Are the records readily available for review?			
A1109	(4) Have policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.	Does the hospital have a policy ensuring prompt transfer of information to the unit?			
A1110	(5) Meet applicable State licensure laws.	Has the unit verified current active licensure of its professional staff? Does the unit meet any special licensing requirements of the state?			

Form CMS-437 (04/06) 1

Figure 51: Form CMS-437

11. CMS-437A

Purpose: To demonstrate how to use Rehabilitation Unit Criteria Worksheet.

Notes:

- This form is available for the Hospital provider type only.
- This worksheet is used to document compliance with Medicare requirements to qualify for exemption from the IPPS.
- This form is not generated in iQIES. Users must download the form from CMS, complete it, and upload it to iQIES. See *Figure 52, CMS-437A.*

  Note: This form shows only the first page of **Form CMS-437A**.

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

FORM APPROVED
OMB NO. 0938-0986

REHABILITATION UNIT CRITERIA WORK SHEET
CMS-437A

RELATED MEDICARE PROVIDER NUMBER	ROOM NUMBERS IN THE UNIT	FACILITY NAME AND ADDRESS (City, State, Zip Code)
NUMBER OF BEDS IN THE UNIT	SURVEY DATE	
REQUEST FOR EXCLUSION FOR COST REPORTING PERIOD __/__/__ to __/__/__ MM DD YYYY MM DD YYYY		VERIFIED BY

ALL CRITERIA UNDER SUBPART B OF PART 412 OF THE REGULATIONS MUST BE MET FOR EXCLUSION FROM MEDICARE'S ACUTE CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM OR FROM THE PAYMENT SYSTEM USED TO PAY CRITICAL ACCESS HOSPITALS.

TAG	REGULATION	GUIDANCE	THE HOSPITAL REPRESENTATIVE WHO COMPLETES THIS ENTIRE FORM	YES	NO	N/A
		• Verification of hospital attestations may be done by CMS surveyors or MACs as applicable.	The hospital representative is expected to answer all questions accurately. The representative should verify the answers with the director of rehabilitation, physician, medical records office, or any applicable department to ensure correct responses to this form. A "yes" response means the hospital is in compliance with the applicable regulation.			
	§412.25 Excluded hospital units: Common requirements.					
	(a) Basis for exclusion. In order to be excluded from the prospective payment systems specified in §412.1(a)(1), a rehabilitation unit must meet the following requirements in addition to the all criteria under Subpart B of Part 412 of the regulations:		In the case of § 412.25 and § 412.29, as related to IRF units, the term hospital includes Critical Access Hospitals.			

Figure 52: CMS-437A

12. CMS-437B

Purpose: To demonstrate how to use Rehabilitation Hospital Criteria Worksheet.

Notes:

- This form is available for the Hospital provider type only.
- This worksheet is used to attest that the Medicare's regulatory requirements for IPPS (Inpatient Prospective Payment System) exclusion are met.
- This form is not generated in iQIES. Users must download the form from CMS, complete it, and upload it to iQIES. See *Figure 53, CMS-437B.*

  Note: This form shows only the first page of **Form CMS-437B**.

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

FORM APPROVED
OMB NO. 0938-0986

**REHABILITATION HOSPITAL CRITERIA WORK SHEET
CMS-437B**

RELATED MEDICARE PROVIDER NUMBER	ROOM NUMBERS IN THE HOSPITAL	FACILITY NAME AND ADDRESS (City, State, Zip Code)
NUMBER OF BEDS IN THE HOSPITAL	SURVEY DATE	
REQUEST FOR EXCLUSION FOR COST REPORTING PERIOD	/ / to / / MM DD YYYY MM DD YYYY	VERIFIED BY

ALL CRITERIA UNDER SUBPART B OF PART 412 OF THE REGULATIONS MUST BE MET FOR EXCLUSION FROM MEDICARE'S ACUTE CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM

TAG	REGULATION	GUIDANCE	THE HOSPITAL REPRESENTATIVE WHO COMPLETES THIS ENTIRE FORM	YES	NO	N/A
		Verification of hospital attestations may be done by CMS surveyors or MACs as applicable.	The hospital representative is expected to answer all questions truthfully. The representative should verify the answers with the Director of Rehabilitation physician, medical records office, or any applicable department to ensure correct responses to this form, A "yes" response means the hospital is in compliance with the applicable regulation.			
	§412.23 Excluded hospital units: Classifications.					
	(b) Rehabilitation hospitals. A rehabilitation hospital must meet the requirements specified in §412.29 of this subpart to be excluded from the prospective payment systems specified in §412.1(a)(1) of this subpart and to be paid under the prospective payment system specified in §412.1(a)(3) of this subpart and in subpart P of this part.					

Figure 53: CMS-437B

13. 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 54, OPO Request for Designation as an OPO, page 1 of 2* and *Figure 55, 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

ORGAN PROCUREMENT ORGANIZATION (OPO) REQUEST FOR DESIGNATION AS AN OPO UNDER §1138 OF THE SOCIAL SECURITY ACT

(READ INSTRUCTIONS AND INFORMATION COLLECTION STATEMENT ON COVER SHEET PRIOR TO COMPLETION)

CMS REGIONAL OFFICE USE ONLY

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

I. IDENTIFYING INFORMATION

NAME OF FACILITY	STREET ADDRESS	
CITY, COUNTY AND STATE	ZIP CODE	TELEPHONE NO. *(Include Area Code)*
NAME OF CHIEF EXECUTIVE		

SERVICE AREA (Attach separate sheet if necessary)

A. LIST COUNTRIES SERVED *(or State if the service includes the entire State)*

B. GEOGRAPHIC BOUNDARIES

C. TOTAL POPULATION

D. LIST ALL ACUTE CARE HOSPITALS WITH AN OPERATING ROOM AND THE EQUIPMENT AND PERSONNEL TO RETRIEVE ORGAN

II. TYPE OF CONTROL (Check all the apply)

☐ INDEPENDENT ☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP ☐ STATE GOVERNMENT
☐ HOSPITAL-BASED ☐ PROFIT ☐ NONPROFIT UNDER §501 ☐ FEDERAL GOVERNMENT

III. ADMINISTRATION AND STAFFING

BOARD OF DIRECTORS AND ADVISORY BOARD (Give names and title of members who represent the following)

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

III. ADMINISTRATION AND STAFFING (continued)	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 *(from each transplant hospital with an agreement in the service area)*
	10. MEMBERS WHO REPRESENT THE PUBLIC RESIDING IN THE AREA
	11. NEUROSURGEON OR ANOTHER PHYSICIAN WITH KNOWLEDGE OR SKILLS IN THE FIELD OF NEUROLOGY

IV. NARRATIVE

ANSWER THE FOLLOWING QUESTIONS AND ATTACH SUPPORTING DOCUMENTATION.

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 inquires 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.

V. PERFORMANCE

PROCUREMENT ACTIVITY (the activity is for the 2 calendar years prior to the year of designation):
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		

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.

SIGNATURE OF AUTHORIZED OFFICIAL *(Sign in ink)*	DATE

Form CMS-576 (01/93) 2

Figure 55: OPO Request for Designation as an OPO, page 2 of 2

14. 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.

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 56, CMS-643 Form*.

14.3 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

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)

Save CMS-643 Form Cancel

Figure 56: CMS-643 Form

15. CMS-671

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.

15.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

15.2 Fill out the information. See *Figure 57, CMS-671 (page 1 of 4), Figure 58, CMS-671 (page 2 of 4), Figure 59, CMS-671 (page 3 of 4), Figure 60, CMS-671 (page 4 of 4)*.

15.3 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

MM/DD/YYYY

2. To

MM/DD/YYYY

Extended Survey

3. From

MM/DD/YYYY

4. To

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 57: 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 58: 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)

20. AIDS

21. Alzheimer's Disease

22. Dialysis

23. Disabled Children/Young Adults

24. Head Trauma

25. Hospice

26. Huntington's Disease

27. Ventilator/Respiratory Care

28. Other Specialized Rehabilitation

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 59: 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)

Save CMS-671 Form   Cancel

Figure 60: CMS-671 (page 4 of 4)

16. CMS-724

Purpose: To demonstrate how to use the Medicare/Medicaid Psychiatric Hospital Survey Data.

Notes:

- This form is available for the Hospital provider type only.
- This form is used to collect specialized data on psychiatric hospitals to support program evaluation, survey activities, and maintain accurate provider databases

16.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

16.2 Fill out the information. See *Figure 61, CMS-724, part 1 of 4, Figure 62, CMS-724, part 2 of 4, Figure 63, CMS-724, part 3 of 4,* and *Figure 64, CMS-724, part 4 of 4*.

16.3 Complete the form. Review Complete Form, if necessary.

Medicare/Medicaid Psychiatric Hospital Survey Data

Exhibit 724

Section I: to be completed by hospital

Name and Address of Facility

Singy Hospital for Kids
123 Main St
Fleming Island, FL 32003

Hospital Provider Number (CCN)

103305

Total Number of Beds

0

Total Number of Certified Beds

0

Does the Hospital Operate a Forensic Unit?

- ◯ Yes
- ◯ No

Figure 61: CMS-724, part 1 of 4

For the past year:

from (month) (year)

April 2025

A. Total Number of Admissions to Certified Areas

B. Age Range of Patients

Min Max

C. Medicare/Medicaid Billings

	Billed	Collected
Medicare/Part A		
Medicare/Part B		
Medicaid		

D. Does the hospital operate a separate MEDICAID ONLY-Residential Treatment Program for Psychiatric patients under the age of 22?

- Yes
- No

Current Hospital Statistics (on days of survey) [certified beds only]

Name of Ward	Bed Capacity	Patient Census

Add Ward

Figure 62: CMS-724, part 2 of 4

Section II: to be completed by the survey team

Dates of Survey (beginning)

No information

Dates of Survey (ending)

No information

Type of Survey

No information

Team Composition

- ☐ Administrator
- ☐ Nurse
- ☐ Dietician
- ☐ Pharmacist
- ☐ Social Worker
- ☐ LSC Specialist
- ☐ Sanitarian
- ☐ Physician
- ☐ Psychologist
- ☐ Other

Figure 63: CMS-724, part 3 of 4

Total Number of Surveyors on Site

SA

RO

Consultant

CO

Certification of Findings

I certify that I have reviewed each Condition of Participation and Related Standards for Psychiatric Hospitals, and unless indicated on the CMS-2567, the Facility was found to be in compliance with the Conditions and/or Standards

Signature Title Date

Add Signature

Mark form as Complete

(Completed forms are not able to be edited)

Save CMS-724 Form Cancel

Figure 64: CMS-724, part 4 of 4

17. CMS-726

Purpose: To demonstrate how to use the Death Record Review Data Sheet.

Notes:

- This form is available for the PRTF provider type only.
- This form can also be accessed from the left menu on the survey.

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 65, CMS-726.*

17.3 Complete the form. Review Complete Form, if necessary.

CMS Death Record Review Data Sheet
Form CMS-726

Patient Record Number *

Date of Admission *
MM/DD/YYYY

Date of Birth *
MM/DD/YYYY

Date of Death *
MM/DD/YYYY

Psychiatric Diagnosis

Physical Diagnosis

Cause of Death
0/50000 characters

Autopsy
(Review autopsy report if available)
0/50000 characters

Mortality Board Review
(Please note conclusions and recommendations)
0/50000 characters

Was proper treatment provided?
(Describe below any deficiencies found)
0/50000 characters

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

Save CMS-726 Form   Cancel

Figure 65: CMS-726

18. 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.

18.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

18.2 Fill out the information. See *Figure 66, CMS-1539 (page 1 of 3), Figure 67, CMS-1539 (page 2 of 3), Figure 68, CMS-1539 (page 3 of 3).*

18.3 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

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 66: 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 67: 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)

Save CMS-1539 Form | Cancel

Figure 68: CMS-1539, (page 3 of 3)

19. 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.

19.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

19.2 Fill out the information. See *Figure 69, Form CMS-1572 (page 1 of 2) and Figure 70, Form CMS-1572 (page 2 of 2)*.

19.3 Complete the form. Review Complete Form, if necessary.

Home Health Agency Survey Report
Form 1572 (OMB N0. 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 alpha/numeric 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, asdfasfdsafd 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 69: Form CMS-1572 (page 1 of 2)

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

Skilled Nursing * — Select one	Home Health Aide * — Select one
Physical Therapy * — Select one	Pharmaceutical Services * — Select one
Occupational Therapy * — Select one	Infusion Services * — Select one
Speech Therapy * — Select one	Laboratory Services * — Select one
Social Worker * — Select one	Outpatient Therapy Services * — Select one

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

Staff Member	Direct Hire Staff *	Staff Under Arrangement *
Registered Nurse		
Licensed Practical Nurse		
Physical Therapist		
Physical Therapist Assistant		
Occupational Therapist		
Occupational Therapist Assistant		
Speech-Language Pathologist		
Social Worker		
Social Work Assistant		
Home Health Aide		

Name of Person Completing Form * | Title of Person Completing Form * | Date Form Completed * 12/06/2022 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)

Save CMS-1572 Form   Cancel   Top

Figure 70: Form CMS-1572 (page 2 of 2)

20. 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 71, 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 ☐ MEDICARE ☐ MEDICAID ☐ BOTH (S22)	MEDICARE/MEDICAID PROVIDER NUMBER (S1)	STATE/COUNTY (S2)	STATE REGION (S3)

I. Identifying Information	NAME OF SUPPLIER	STREET ADDRESS	
	CITY, COUNTY, AND STATE	ZIP CODE	TELEPHONE NUMBER *(Including area code)* (S6)

II. Qualifications of Director *(Check one)* (S7)	☐ 1. PHYSICIAN	☐ 3. M.S./M.A.	☐ 5. OTHER
	☐ 2. PH.D/SC.D.	☐ 4. B.S./B.A.	

III. Type of Ownership or Control *(Check one)* (S14)	☐ INDIVIDUAL	☐ CORPORATION
	☐ PARTNERSHIP	☐ OTHER THAN PRIVATE *(Specify)* ____________

IV. Number of Technologists *(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 (S20)

Form CMS-1880 (10-80)

Figure 71: Request for Certification as Supplier of Portable X-Ray Services

21. CMS-2802

Purpose: This form is used to authorize State Agencies to survey hospitals.

Note: This form is available for the Hospital provider type only

21.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

21.2 Fill out the information. See *Figure 72, CMS-2802, page 1 of 3, Figure 73, CMS-2802, page 2 of 3,* and *Figure 74, CMS-2802, page 3 of 3* .

21.3 Complete the form. Review Complete Form, if necessary.

AUTHORIZATION FOR STATE AGENCY HOSPITAL VALIDATION SURVEY

Form 2802

Validation Survey Worksheet - CMS-2802

Name and Address of State Agency

State Agency Name

Address 1

Address 2

City

State

Select one

ZIP Code

Name and Address of Hospital *

Singy Hospital for Kids

123 Main St
Fleming Island, FL 32003

CMS Certification Number (CCN)

103305

This Hospital is currently deemed by (None or More than 1 may be checked)

- [ ] TJC
- [ ] DNV
- [ ] AOA/HFAP
- [ ] None

Figure 72: CMS-2802, page 1 of 3

Check A or B; Do NOT Check Both

☐ **A)** This validation survey is based on a sample selection. Check 1 OR 2. Do NOT Check both.

☐ **1)** Please conduct a full validation survey following the protocols and procedures for a medicare certification survey within 60 calendar days of accreditation survey end date.

Accreditation Organization

Center for Improvement in Healthcare Quality (CIHQ)

The scheduled end date of the accreditation survey is:

If applicable, check one or more of the following:

☐ This is an initial accreditation survey for this currently participating, non-deemed facility.

☐ This is an initial accreditation survey for this AO; Hospital is currently deemed.

☐ **2)** This is a mid-cycle validation survey. Please conduct a full validation survey following the protocols and procedures for a medicare certification survey.

SA Must complete all validation packet documents listed in Exhibit 63 for any Full Validation Survey

☐ **B)** This validation survey is based on allegations of significant deficiencies which could affect the health and safety of patients. Check **ONE** of the following:

☐ Potential IJ - Initiate Survey within 2 working days; OR

☐ Initiate Survey within 45 Calendar days

SA must NOT notify the facility or AO in advance of the survey

Figure 73: CMS-2802, page 2 of 3

Areas to be Surveyed (For Sample Validation Surveys, Check ALL; For Allegation Surveys, Check ALL applicable conditions, and, if applicable, the Life Safety Code Standard):

- [ ] 482.11 Federal, State and Local Laws
- [ ] 482.12 Governing Body
- [ ] 482.13 Patient's Rights
- [ ] 482.21 Quality Assessment and Performance Improvement
- [ ] 482.22 Medical Staff
- [ ] 482.23 Nursing Services
- [ ] 482.24 Medical Record Services
- [ ] 482.25 Pharmaceutical Services
- [ ] 482.26 Radiologic Services
- [ ] 482.27 Laboratory Services
- [ ] 482.28 Food and Dietetic Services
- [ ] 482.30 Utilization Review
- [ ] 482.41 Physical Environment
- [ ] 482.41(b) Life Safety Code
- [ ] 482.42 Infection Control
- [ ] 482.43 Discharge Planning
- [ ] 482.45 Organ, Tissue, & Eye Procurement
- [ ] 482.51 Surgical Services
- [ ] 482.52 Anesthesia Services
- [ ] 482.53 Nuclear Medicine Services
- [ ] 482.54 Outpatient Services
- [ ] 482.55 Emergency Services
- [ ] 482.56 Rehabilitation Services
- [ ] 482.57 Respiratory Care Services

Signature of Regional Representative

Region

ARIZONA LAB Updated again

Date of Signature

- [ ] Mark form as Complete

(Completed forms are not able to be edited)

Save CMS-2802 Form Cancel

Figure 74: CMS-2802, page 3 of 3

22. CMS-3070G

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.

22.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

22.2 Fill out the information. See *Figure 75, CMS-3070G (page 1 of 6), Figure 76, CMS-3070G (page 2 of 6), Figure 77, CMS-3070G (page 3 of 6), Figure 78, CMS-3070G (page 4 of 6), Figure 79, CMS-3070G (page 5 of 6), Figure 80, CMS-3070G (page 6 of 6).*

22.3 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)

Begin	End
No information	No information

12. Type of Ownership or Control *

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

Figure 75: 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		
B. Nurse		
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker		
G. LSC Specialist		
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify)		
N. Total number of Surveyors onsite	0	N/A
O. Total number of QIDP Surveyors onsite	N/A	0

Figure 76: 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:

Select one

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 77: 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 78: 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

under 22 (a) *

22-45 (b) *

46-65 (c) *

66+ (d) *

Total: *
0

(2) Sex

Male *

Female *

Total: *
0

B. DISABILITIES

(1) Intellectual Disability

Mild *

Moderate *

Severe *

Profound *

Total: *
0

(2) Autism *

(3) Cerebral Palsy *

(4) Epilepsy

Controlled *

Uncontrolled *

Total: *
0

C. OTHER DISABILITIES

(1) Non-ambulatory

Mobile *

Non-Mobile *

Total: *
0

(2) Speech/Language Impairment *

(3) Hearing Impairment

Hard of Hearing *

Deaf *

Total: *
0

(4) Visual Impairment

Impaired *

Blind *

Total: *
0

D. MEDICAL CARE PLAN *

E. DRUGS TO CONTROL BEHAVIOR *

F. PHYSICAL RESTRAINTS *

G. TIME-OUT ROOMS *

Figure 79: 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)

Save CMS-3070G Form Cancel

Figure 80: CMS-3070G (page 6 of 6)

23. CMS-3070H

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 81, CMS-3070H (page 1 of 4), Figure 82, CMS-3070H (page 2 of 4), Figure 83, CMS-3070H (page 3 of 4), Figure 84, CMS-3070H (page 4 of 4)*

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

Form Approved
OMB NO. 0938-0062

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 81: CMS-3070H (page 1 of 4)

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

Form Approved
OMB NO. 0938-0062

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

FORM CMS-3070H (03/13) 2

Figure 82: CMS-3070H (page 2 of 4)

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

Form Approved
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES DEFICIENCIES REPORT

FOR INITIAL OR ANNUAL RECERTIFICATION SURVEY

I certify that I have reviewed the following requirements and conditions for: (a) Full Survey _____, (b) Extended Survey _____, or (c) Fundamental Survey _______, and unless indicated on this form, the facility was found to be in compliance with the Standards and the Conditions of Participation.

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

FOR FOLLOW-UP SURVEY

For the purpose of this onsite visit, I certify that I have reviewed each Condition of Participation and related Standard(s) found not to be in compliance during the survey on _____________, and unless indicated on this form, the facility was found to be in compliance with the Standards and/or the Conditions of Participation.

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

FORM CMS-3070H (03/13) 3

Figure 83: CMS-3070H (page 3 of 4)

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

Form Approved
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES DEFICIENCIES REPORT

Evaluate each of the requirements identified in the ICF/IID Interpretive Guidelines, (Appendix "J" to the SOM). For each identified deficiency:

A. In the first column, identify the data tag number.

B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter "CoP" below the regulatory citation.

C. In column three, describe deficient facility practice and supporting findings.

D. Draw horizontal lines to separate identified tag numbers.

E. If more space is needed, photocopy FIRST page (front and back).

F. Each surveyor must sign the certifying statement on the last page.

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.

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.

FORM CMS-3070H (03/13) 4

Figure 84: CMS-3070H (page 4 of 4)

24. CMS-3070I

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 85, CMS-3070I (page 1 of 2), Figure 86, CMS-3070I (page 2 of 2),*

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

FORM APPROVED
OMB NO. 0938-0062

INDIVIDUAL OBSERVATION WORKSHEET

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 85: 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 86: CMS-3070I (page 2 of 2)

25. CMS-3427

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.

25.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

25.2 Fill out the information. See *Figure 87, CMS-3427 (page 1 of 10), Figure 88, CMS-3427 (page 2 of 10), Figure 89, CMS-3427 (page 3 of 10), Figure 90, CMS-3427 (page 4 of 10), Figure 91, CMS-3427 (page 5 of 10), Figure 92, CMS-3427 (page 6 of 10), Figure 93, CMS-3427 (page 7 of 10), Figure 94, CMS-3427 (page 8 of 10), Figure 95, CMS-3427 (page 9 of 10), Figure 96, CMS-3427 (page 10 of 10)*.

25.3 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

Information icons show additional details

1. Type of Application/Notification: (V1) *

(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 87: CMS-3427 (page 1 of 10)

8. Fiscal Year End Date *

Month: Select one
Day: Select one

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 88: 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 89: 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 90: 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 91: 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 92: 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:
M: -- : --	M: -- : --
T: -- : --	T: -- : --
W: -- : --	W: -- : --
Th: -- : --	Th: -- : --
F: -- : --	F: -- : --
Sat: -- : --	Sat: -- : --
Sun: -- : --	Sun: -- : --

29. Dialyzer reprocessing: (V32) *

- Onsite
- Centralized/Offsite
- N/A

Figure 93: 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 94: 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:

Signature of Administrator/Medical Director

Title *

Date *

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 95: 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)

Save CMS-3427 Form Cancel

Figure 96: CMS-3427 (page 10 of 10)

26. CMS-10455

Purpose: To demonstrate how to use the Report of a Hospital Death Associated with Restraint or Seclusion form.

Note:

- This form is available for the Hospital provider type only.
- This form is used to report a patient death associated with the use of restraints or seclusion
- This form cannot be edited once submitted.
- This form can be accessed from the intake.

26.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

26.2 Fill out the information. See *Figure 97, CMS-286, page 1 of 5, Figure 98, CMS-286, page 2 of 5, Figure 99, CMS-286, page 3 of 5, Figure 100, CMS-286, page 4 of 5,* and *Figure 101, CMS-286, page 5 of 5*.

26.3 Complete the form. Review Complete Form, if necessary.

REPORT OF A HOSPITAL DEATH ASSOCIATED WITH RESTRAINT OR SECLUSION
Form 10455

A. Hospital Information:

Name and Address of Hospital *
Singy Hospital for Kids
123 Main St
Fleming Island, FL 32003

CMS Certification Number (CCN)
103305

Person Filing Report

Title

Filer Phone Number

Figure 97: CMS-286, page 1 of 5

B. Patient Information:

Patient Name

Patient Date of Birth

MM/DD/YYYY

Primary Diagnoses

Primary Diagnoses of the Patient

Medical Record Number

Date of Admission

MM/DD/YYYY

Date of Death

MM/DD/YYYY

Time of Death

--:-- --

HH:MM

Condition of Patient Leading to Death

Mortality Review

Select one

Date of Report Submission

MM/DD/YYYY

Time of Report Submission

--:-- --

HH:MM

Report Documented in Patient Record

○ Yes

○ No

Figure 98: CMS-286, page 2 of 5

C. Restraint Information (Part 1):

Restraint Information Time Check

- ◯ While in Restraint, Seclusion, or Both
- ◯ Within 24 Hours of Removal of Restraint, Seclusion, or Both
- ◯ Within 1 week (7 days), where the use of Restraint, Seclusion, or Both is reasonable to assume contributed to the patient's death

Restraint Types That Apply

- ☐ Physical Restraint
- ☐ Seclusion
- ☐ Drug Used As A Restraint

Physical Restraint Types That Apply

- ☐ Side Rails
- ☐ Forced Medication Holds
- ☐ Enclosed Beds
- ☐ 2-Point Soft Wrist
- ☐ Therapeutic Holds
- ☐ Vest Restraints
- ☐ 2-Point Hard Wrist
- ☐ Take Downs
- ☐ Elbow Immobilizers
- ☐ 4-Point Soft Restraints
- ☐ Other Physical Holds
- ☐ Law Enforcement Restraints
- ☐ 4-Point Hard Restraints

Figure 99: CMS-286, page 3 of 5

D. Restraint Information (Part 2):

Reasons for Restraint/Seclusion

Circumstances Surrounding Death

Restraint or Seclusion Details

Date of Restraint/Seclusion

MM/DD/YYYY

Time of Restraint/Seclusion

--:-- --

HH:MM

Date of Last Monitored/Assessed

MM/DD/YYYY

Time of Last Monitored/Assessed

--:-- --

HH:MM

Total Time Restraint/Seclusion Applied

Drugs Used as Restraint

For drug(s) used as a restraint: • List the drug name, drug dose, and time drug was administered (for ALL doses)

Restraint/Seclusion Used for Intervention

- Yes
- No

Figure 100: CMS-286, page 4 of 5

E. CMS Regional Office to Complete this Section:

Select "Yes" or "No" to indicate if a survey was authorized

- Yes
- No

If a survey was authorized based on reported information, document the date that the State Agency (SA) was notified.

MM/DD/YYYY

Also provide the Intake ID

If a survey was not authorized, provide a rationale for this decision.

(i.e. explain in the text box why a survey was not indicated based on specific diagnosis, circumstances, restraint/seclusion, etc. after a full review of reported events).

Select "Yes" or "No" to indicate if the hospital/CAH has had a survey in the past two years based on any Patient Rights findings pertaining to previous reports of patient death(s) associated with restraint and/or seclusion, and if so, was there a Condition-level or Immediate Jeopardy (IJ) finding.

- Yes
- No

If yes, list in the text box the deficiencies cited on those Form CMS-2657s

For hospitals/CAHs accredited by an Accreditation Organization (AO), also document in the text box, the date the AO was notified of IJ finding(s).

MM/DD/YYYY

If a survey was authorized and the P&A was notified, document the date of the P&A notification in the text box.

MM/DD/YYYY

Mark form as Complete

(Completed forms are not able to be edited)

Save CMS-10455 Form   Cancel

Figure 101: CMS-286, page 5 of 5

27. Form Application PRTF (Psychiatric Residential Treatment Facility Form)

Purpose: To demonstrate how to use the Form Application PRTF, also known as the Psychiatric Residential Treatment Facility form.

Notes:

- This form is available for the PRTF provider type only.
- This form is used to apply for admission to a PRTF.
- This form can be a standalone and does not have to be linked to a survey.

27.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

27.2 Fill out the information. See *Figure 102, Psychiatric Residential Treatment Facility Form (Form Application PRTF), Page 1 of 2,* and *Figure 103, Psychiatric Residential Treatment Facility Form (Form Application PRTF), Page 2 of 2*.

Note: There are two links on the Rural and Distance Verification form. The **Provider Look Up** and the **Add-Campus Provider-Based** Location. The pop-up window and the fields are shown on the forms (pages 2 and 3) below. These do not show unless the button is clicked.

27.3 Complete the form. Review Complete Form, if necessary.

Psychiatric Residential Treatment Facility

Form Application PRTF

1. Type of Control *

Select one

Attestation

2. Date Attestation Received by State Medicaid Agency *

MM/DD/YYYY

3. Date Attestation Signed by PRTF Director *

MM/DD/YYYY

Residents

4. Number of Medicaid residents in the facility

5. Number of residents whose benefits are paid by another state

States from which the facility has received payments for the psych under 21 benefits

6. States from which the facility has received payment to the psych under 21 benefit

Select...

Select one or more

Acknowledgments

7. Facility Certifies that it meets Part 483, Subpart G *

- Yes
- No

8. Acknowledgment of State Survey Agency's right to conduct an on-site survey *

- Yes
- No

9. Acknowledgment that new attestation of compliance is required for director change *

- Yes
- No

Figure 102: Psychiatric Residential Treatment Facility Form (Form Application PRTF), page 1 of 2

Director's Name

First *

M.I.

Last *

State Medicaid Agency

11. Contact Name

12. Contact Telephone No.

State Survey Agency

13. Remarks

0/50000 characters

Mark form as Complete

(Completed forms are not able to be edited)

Save Application PRTF Form

Cancel

Figure 103: Psychiatric Residential Treatment Facility Form (Form Application PRTF), page 2 of 2

28. Rural and Distance Verification

Purpose: To demonstrate how to use the Rural and Distance Verification form.

Notes:

- This form is available for the Hospital provider type only.
- This form is used to verify that a facility meets specific location-based criteria for Medicare certification or recertification.

28.1 Access and add the form from the **Provider History** page. Review Access a Form and Add a Form, if necessary.

28.2 Fill out the information. See *Figure 104, Rural and Distance Verification Form, Page 1 of 3, Figure 105, Rural and Distance Verification Form, Page 2 of 3,* and *Figure 106, Rural and Distance Verification Form, Page 3 of 3*.

Note: There are two links on the Rural and Distance Verification form. The **Provider Look Up** and the **Add-Campus Provider-Based** Location. The pop-up window and the fields are shown on the forms (pages 2 and 3) below. These do not show unless the button is clicked.

28.3 Complete the form. Review Complete Form, if necessary.

Edit CAH RAD Form

Date of Review *

MM/DD/YYYY

CCN:

103305

Date of Initial Certification:

04/09/2026

CAH Name:

Singy Hospital for Kids

Address:

123 Main St
Fleming Island, FL 32003
Miami-Dade

Administrator:

N/A

Last Survey Date:

No information

If deemed: Accrediting Organization (AO):

Center for Improvement in Healthcare Quality (CIHQ)

Figure 104: Rural and Distance Verification Form, Page 1 of 3

Rural Status: (All CAH's must meet this requirement)

Does the Office of Management and Budget (OMB) Metropolitan Statistical Area (MSA) List adopted by the CMS indicate that the county is designated as rural?

Yes

No

If no, does the Innovation and Financial Management (IFM) confirm alternative rural status?

Date IFM Confirmed Rural Status:

MM/DD/YYYY

Distance from other CAHs or Hospitals

Necessary Provider (NP) Designation prior to **January 1, 2006:**

Source:

If the CAH is **not a designated NP**, evaluate the distance to all nearby CAHs/Hospitals using the 2021 geocoding spreadsheet and enter the information in the table below. The **main campus** of all **Non-NP CAHs** must be > 35 miles from another CAH or Hospital or, be eligible for the lesser distance standard due to the secondary road criteria under §485.610(c).

To apply the secondary roads criterion, measure the total driving distance between the CAH and each hospital or other CAH located within a 35-mile drive, and subtract the portion of that drive in which primary roads are available.

If the result is more than 15 miles for each drive to a hospital or other CAH, the 15- mile criterion is met. **[Psych, LTCH, Rehabilitation, Children's, IHS, Cancer hospitals are not considered an acute care hospital and should not be included in the location analysis.]**

Distance Analysis Table

Provider Look Up | Add Distance Manually

Select Surrounding Hospital

Search for Provider

FL | Provider or DBA | Search

Search

There are no providers for this search.

Submit | Cancel

Figure 105: Rural and Distance Verification Form, Page 2 of 3

Surrounding Hospital's Name	CCN	Hospital's Address	Distance from non-NP CAH Under Evaluation	Does the 15 miles standard apply via Secondary Roads or Mountainous Terrain?	Actions
No distances added yet. Click "Add Distance Manually" or "Provider Look Up" to begin.					

REGARDLESS of the CAH's NP DESIGNATION evaluate the distance of each off-campus provider-based location created or acquired after January 1, 2008, from other surrounding CAHs or Hospitals

Add Off-Campus Provider-Based Location

Address of each Off-Campus Provider-Based location created/acquired after 1/1/2008 of the CAH under evaluation (regardless of NP designation)	Surrounding Hospital's or CAH's CCN & Address from geocoding spreadsheet	Distance from off-campus location	Actions
No off-campus provider-based locations added yet. Click "Add Off-Campus Provider-Based Location" to begin.			

Save Critical Access Hospital - Rural and Distance Form   Cancel

Address of each Off-Campus Provider-Based location created/acquired after 1/1/2008 of the CAH under evaluation (regardless of NP designation)	Surrounding Hospital's or CAH's CCN & Address from geocoding spreadsheet	Distance from off-campus location	Actions
address	CNN cnn Address address Remove Add Surrounding Hospital or CAH	distance	Remove

Figure 106: Rural and Distance Verification Form, Page 3 of 3