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

REQUEST FOR VALIDATION OF ACCREDITATION SURVEY FOR HOME HEALTH AGENCY

1. NAME AND ADDRESS OF STATE AGENCY	2. NAME AND ADDRESS OF HOME HEALTH AGENCY PROVIDER NUMBER
3. HOME HEALTH AGENCY ACCREDITED BY ☐ JCAHO ☐ CHAP ☐ OTHER _____	4. PLEASE REQUEST COMPLETION OF ☒ CMS-2567

5. ☒ PLEASE DO NOT NOTIFY THE HOME HEALTH AGENCY IN ADVANCE OF YOUR SURVEY.

6. ☐ THIS VALIDATION IS BASED ON A **SAMPLE SELECTION**.
THE DATE OF LAST ACCREDITATION SURVEY WAS _____ . PLEASE CONDUCT A FULL VALIDATION SURVEY BETWEEN 60 DAYS AND 6 MONTHS FROM THE DATE OF THE AO SURVEY. CONFINE THE SURVEY TO THOSE CONDITIONS OF PARTICIPATION FOR WHICH THE ACCREDITED HOME HEALTH AGENCIES ARE DEEMED TO MEET.

☐ THIS VALIDATION IS BASED ON **ALLEGATIONS** OF SIGNIFICANT DEFICIENCIES WHICH COULD AFFECT THE HEALTH AND SAFETY OF PATIENTS IN THIS HOME HEALTH AGENCY. PLEASE CONDUCT A SURVEY WITHIN 45 DAYS AFTER THIS REQUEST, FOR THE PURPOSE OF ASCERTAINING WHETHER THE HOME HEALTH AGENCY MEETS THE CONDITIONS CHECKED. SURVEY ALL APPLICABLE CONDITIONS, STANDARDS, AND ELEMENTS.

7. AREAS TO BE SURVEYED *(Check all applicable Conditions; enter all applicable Standards)*

CONDITION(S)	STANDARDS
☐ Patient's Rights (484.10)	_____
☐ Release of Patient Identifiable OASIS Info (484.11)	_____
☐ Federal, State and Local Laws (484.12)	_____
☐ Organization, Services and Administration (484.14)	_____
☐ Professional Personnel (484.16)	_____
☐ Acceptance of Patients, POC, & Medical Supervision (484.18)	_____
☐ Reporting of OASIS Information (484.20)	_____
☐ Skilled Nursing Services (484.30)	_____
☐ Therapy Services (484.32)	_____
☐ Medical Social Services (484.34)	_____
☐ Home Health Aide Services (484.36)	_____
☐ Qualifying to Furnish Outpatient PT or Speech (484.38)	_____
☐ Clinical Records (484.48)	_____
☐ Evaluation of the Agency's Program (484.52)	_____
☐ Comprehensive Assessment of Patients (484.55)	_____

A COPY OF THE ALLEGATION IS ENCLOSED. A COPY OF THE ALLEGATION WAS PREVIOUSLY FORWARDED TO THE ACCREDITING AGENCY. THE NAME OF THE COMPLAINANT SHOULD NOT BE DISCLOSED UNLESS THERE IS SPECIFIC AUTHORIZATION.

8. SIGNATURE OF REGIONAL REPRESENTATIVE	9. REGION	10. DATE

ORIGINAL TO: STATE SURVEY AGENCY

COPIES TO: CMS Accreditation Staff
Accreditation Organization