END STAGE RENAL DISEASE APPLICATION/NOTIFICATION AND SURVEY AND CERTIFICATION REPORT

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Name of Facility

2. Provider Number ☐ ☐ ☐ ☐ ☐ ☐

3. Street Address

4. City

5. County

6. State

7. ZIP Code

8. Telephone No.

9. Facsimile No.

10. Fiscal Year Ending Date

11. Name/Address/Telephone Number of Authorized Official
Name: Address: Telephone No.

12. Type of Application/Notification: (V1) *(check all that apply and specify in Remarks section* [see item 27]*)*
☐ 1. Initial ☐ 2. Expansion to new location ☐ 3. Change of ownership
☐ 4. Change of location ☐ 5. Expansion in current location ☐ 6. Change of services/operations
☐ 7. Other *(specify)* ____________________

13. Ownership (V2) ☐ For Profit ☐ Not for Profit ☐ Public

14. Is this Facility Hospital-Based *(check one)* (V3) ☐ Yes ☐ No *If Yes, hospital provider number*
(V4) ☐ ☐ ☐ ☐ ☐ ☐

15. Is this Facility SNF-Based *(check one)* (V5) ☐ Yes ☐ No *If Yes, SNF provider number*
(V6) ☐ ☐ ☐ ☐ ☐ ☐

16. Is this facility owned and/or managed by a multi-facility organization? (V7) ☐ Yes ☐ No *If Yes, name and address of parent organization*
Name: Address:
(V8)

17. Services Provided: (V9) *(check all that apply and specify in Remarks section* [see item 27]*)*
☐ 1. Hemodialysis ☐ 2. Peritoneal Dialysis ☐ 3. Transplantation
☐ 4. Home Training: __ Hemodialysis __ Peritoneal Dialysis
☐ 5. Home Support: __ Hemodialysis __ Peritoneal Dialysis

18. Is Reuse Practiced? (V10) ☐ Yes ☐ No

19. Reuse System (V11) *(check all that apply)* ☐ 1. Manual ☐ 2. Semi-Automated ☐ 3. Automated

20. Germicide (V12) *(check all that apply)* ☐ 1. Formalin ☐ 2. Heat ☐ 3. Gluteraldehyde ☐ 4. Peracetic Acid Mixture
☐ 5. Other *(specify)* ____________________

21. Number of Dialysis Patients
(V13) ______ Total Patients = (V14) ___Hemodialysis + (V15) ___Peritoneal Dialysis

22. Number of Stations *(check all that apply and include isolation stations under Total Stations)*
(V16) ______ Total Stations = (V17) ___Hemodialysis + (V18) ___Hemodialysis Training

23. Does the facility have isolation stations? (V19) ☐ Yes ☐ No

24. Total Number of Patients *(enter number of dialysis facility patients treated on each shift for full week prior to submission of this form)*

A. SUNDAY				B. MONDAY				C. TUESDAY				D. WEDNESDAY			
1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
E. THURSDAY				**F. FRIDAY**				**G. SATURDAY**							
1	2	3	4	1	2	3	4	1	2	3	4				

25. Total Number of patients followed at home (V20) ______

26. Staffing	(V21) ☐ Registered Nurse	__ __ __ . __ __	(V22) ☐ Licensed Practical Nurse	__ __ __ . __ __
(list full-time equivalents)	(V23) ☐ Social Worker	__ __ __ . __ __	(V24) ☐ Dietitian	__ __ __ . __ __
	(V25) ☐ Technicians	__ __ __ . __ __	(V26) ☐ Others	__ __ __ . __ __

27. Remarks: *(Use this space for explanatory statements for Items 1–26)*

28. The information contained in this Application Survey and Certification Report (Part I) is true and correct to the best of my belief. 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. 405.2100 and 405.2180, respectively.

Signature of Authorized Official	Title	Date

PART II TO BE COMPLETED BY STATE AGENCY

29. ESRD Provider Number *(if the facility has a provider number)* ☐ ☐ ☐ ☐ ☐ ☐

30. Network Number (V27) ☐ ☐

31. State Region (V28)	32. State County Code (V29)

33. Type of Survey (V30) *(check all that apply)* ☐ Initial ☐ Complaint ☐ Recertification ☐ Other

34. Survey Protocol (V31) *(check all that apply)* ☐ Basic ☐ Initial ☐ Supplemental ☐ Combination

35. Surveyor Name/Number *(print)*	Professional Discipline *(print)*

36. Date of Survey

According to the Paperwork Reduction 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 of 0938-0360. The time required to complete this information collection is 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

INSTRUCTIONS FOR FORM CMS-3427

PART I - DOCUMENTATION NEEDED TO PROCESS FACILITY APPLICATION/NOTIFICATION

A completed request for approval as a supplier of End Stage Renal Disease (ESRD) services in the Medicare program *(Part I - Form CMS-3427)* must include:

- A copy of the Certificate of Need approval, if such approval is required by the State, and
- A narrative statement describing the need for the service(s) to be provided.

IDENTIFYING INFORMATION (ITEMS 1–11, 13–15)

Enter the name and address *(actual physical location)* of the ESRD facility or unit where the services are performed. If the mailing address is different, show the mailing address in the Remarks block (*Item 27*). If the facility is owned or managed by an organization, indicate the name and address of the parent organization *(Item 16)*. Show the name of an authorized person who is responsible for the management of the facility (*Item 11*). Check the applicable block to indicate whether the facility is hospital or SNF based *(Box 14 or 15)* and enter the provider number of the hospital or SNF.

TYPE OF APPLICATION (ITEM 12)

Check appropriate category. If this is an in-unit expansion request, show the location of the additional stations. A "change of service/ operations" would indicate any change in items 17 or 18. *(Separate building locations require separate approvals.)*

TYPE OF SERVICE AND DIALYSIS STATIONS (ITEMS 17–23)

Check each service for which you are requesting approval *(Item 17)*. Enter the number of stations for which you are asking approval *(Item 22)*. If this is an expansion request, show the total number of stations (including those previously approved) for which you are asking approval.

REMARKS (ITEM 27)

You may use this block for explanatory statements related to items 1–26.

COPY OF CERTIFICATE OF NEED APPROVAL

If State law requires Certificate of Need approval, you must submit a copy of the approval.

Forward a copy of completed form CMS-3427 (Part I) to the State agency.

PART II - SURVEY AND CERTIFICATION REPORT - TO BE COMPLETED BY THE STATE AGENCY

Record deficiencies identified on an Initial, Recertification, Complaint or Other survey as follows: (Steps A–E are optional if you are using ASPEN or any other computer generated report.)

A. In the first column, identify the data tag number from the Interpretive Guidelines for End Stage Renal Disease Facilities.

B. In the second column, write the regulatory citation. If it is a Condition for Coverage, enter "CfC" below the regulatory citation.

C. In the third column, describe the findings and evidence under "Comments."

D. Draw horizontal lines to separate identified tag numbers.

E. If more space is needed, photocopy the "Deficiencies and Comments" page and continue the recording.

F. If available, in lieu of A–E , attach a computer-generated list.

Upon completion of the survey data, enter the CMS-3427 and forward to the Centers for Medicare & Medicaid Services regional office, if requested.