

## REQUEST FOR VALIDATION OF ACCREDITATION FOR CRITICAL ACCESS HOSPITAL SURVEY

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|---|---|
| 1. NAME AND ADDRESS OF STATE AGENCY   | 2. NAME AND ADDRESS OF HOSPITAL   |
|   | PROVIDER NUMBER   |
| 3. HOSPITAL ACCREDITED BY:<br><br><input type="checkbox"/> JCAHO <input type="checkbox"/> AOA | 4. PLEASE REQUEST COMPLETION OF<br><br><input checked="" type="checkbox"/> CMS-2567 |

5.  PLEASE DO NOT NOTIFY THE CRITICAL ACCESS HOSPITAL IN ADVANCE OF YOUR SURVEY.

6.  THIS VALIDATION IS BASED ON A **SAMPLE SELECTION**.  
 THE DATE OF THE JCAHO'S ACCREDITATION SURVEY IS SCHEDULED FOR \_\_\_\_\_. PLEASE CONDUCT A FULL VALIDATION SURVEY WITHIN 60 DAYS OF THEIR SURVEY. CONFINE THE SURVEY TO THOSE CONDITIONS OF PARTICIPATION FOR WHICH ACCREDITED HOSPITALS ARE DEEMED TO MEET.

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

Area(s) to be Surveyed  
(Check all applicable conditions; enter all applicable Standards)

| CONDITION(S)   | STANDARDS |
|--|-----------|
| <input type="checkbox"/> Federal, State and Local Laws(485.608)                                      | _____     |
| <input type="checkbox"/> Status and location (485.610)   | _____     |
| <input type="checkbox"/> Compliance with hospital requirements at time of application (485.612)      | _____     |
| <input type="checkbox"/> Agreements (485.616)  | _____     |
| <input type="checkbox"/> Emergency Services (485.618)  | _____     |
| <input type="checkbox"/> Number of Beds and length of stay (485.620)                                 | _____     |
| <input type="checkbox"/> Physical plant and environment (485.623)                                    | _____     |
| <input type="checkbox"/> Organizational Structure (485.627)  | _____     |
| <input type="checkbox"/> Staffing and Staff responsibilities (485.631)                               | _____     |
| <input type="checkbox"/> Provision of services (485.635)   | _____     |
| <input type="checkbox"/> Clinical Records (485.638)  | _____     |
| <input type="checkbox"/> Surgical Services (485.639)   | _____     |
| <input type="checkbox"/> Periodic evaluation and quality assurance review (485.641)                  | _____     |
| <input type="checkbox"/> Organ, tissue and eye procurement (485.643)                                 | _____     |
| <input type="checkbox"/> Special Requirements for CAH providers of long-term care services (485.645) | _____     |

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