REQUEST FOR VALIDATION OF ACCREDITATION SURVEY FOR HOSPICE

1. NAME AND ADDRESS OF STATE AGENCY

2. NAME AND ADDRESS OF HOSPICE

PROVIDER NUMBER

3. HOSPICE ACCREDITED BY

☐ JCAHO ☐ CHAP ☐ OTHER _____

4. PLEASE REQUEST COMPLETION OF

☒ CMS-2567

5. ☒ PLEASE DO NOT NOTIFY THE HOSPICE 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 ACCREDITED HOSPICES ARE DEEMED TO MEET.

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

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

CONDITION(S)	STANDARDS
☐ General Provisions (418.50)	
☐ Governing Body (418.52)	
☐ Medical Director (418.54)	
☐ Professional Management (418.56)	
☐ Plan of Care (418.58)	
☐ Continuation of Care (418.60)	
☐ Informed Consent (418.62)	
☐ Inservice Training (418.64)	
☐ Quality Assurance (418.66)	
☐ Interdisciplinary Group (418.68)	
☐ Volunteers (418.70)	
☐ Licensure (418.72)	
☐ Central Clinical Records (418.74)	
☐ Furnishing of Core Services (418.80)	
☐ Nursing Services (418.82)	
☐ Nursing Services—Waiver (418.83)	
☐ Medical Social Services (418.84)	
☐ Physician Services (418.86)	
☐ Counseling Services (418.88)	
☐ Furnishing of Other Services (418.90)	
☐ Therapy Services (418.92)	
☐ Home Health Aide & Homemaker Services (418.94)	
☐ Medical Supplies (418.96)	
☐ Short Term Inpatient Care (418.98)	
☐ Hospices that Provide Inpatient Care Directly (418.100)	

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