MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA

SECTION I: *to be completed by hospital*

Name of Hospital B1	Street Address B2	City or County B3	State B4	ZIP Code B5
Hospital Provider Number B6	Total Number of Beds B7	Total Number of Certified Beds B8	Other Data — Does the hospital operate a forensic unit? ☐ Yes ☐ No B9	

For the past year: A. Total number of admissions to certified areas

from (month)_____ (year)_____ B10

B. Age Range of Patients B11

C. Medicare/Medicaid Billings

	Billed	Collected
MEDICARE/Part A		
MEDICARE/Part B		
MEDICAID		

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

☐ Yes ☐ No B12

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

Name of Ward	Bed Capacity	Patient Census
		Total Patient Census B13

MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA *(contd)*

SECTION II: *to be completed by the survey team*

Dates of Survey (beginning)	Dates of Survey (ending date)	Type of Survey:		
___ ___/ ___ ___/ ___ ___ (mm) (day) (year) B14	___ ___/ ___ ___/ ___ ___ (mm) (day) (year) B15	☐ Initial (B16)	☐ Recertification (B17)	☐ Follow-up (B18)
		☐ Complaint (B19)	☐ Second Follow-up (B20)	☐ Concurrent with General Hospital (B21)

Survey Team Composition		Total Number of Surveyors on Site	
☐ Administrator	(B22)	☐ SA	(B32)
☐ Nurse	(B23)	☐ RO	(B33)
☐ Dietician	(B24)	☐ Consultant	(B34)
☐ Pharmacist	(B25)	☐ CO	(B35)
☐ Social Worker	(B26)		
☐ LSC Specialist	(B27)		
☐ Sanitarian	(B28)		
☐ Physician	(B29)		
☐ Psychologist	(B30)	Total Number of Surveyors on Site _____	(B36)
☐ Other _____	(B31)		

19. 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
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date