Community Health Accreditation Partner
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CHAP

INSTRUCTIONS FOR COMPLETION OF THE CMS 643 AND 417—HOSPICE

- Please complete the documents with the agency representative and CMS855A—Accuracy Counts
- Enter the Certification Number for the Organization (If they do not have a Certification Number—Leave Blank)
- Enter the name of the facility as it appears on the 855A (include DBA as appropriate)
- Enter Survey Date (This is the last day of the survey only)
- Questions

1. Was the hospice surveyed for compliance with 42CFR 418.10? (If the Hospice directly operates an inpatient unit answer “yes” otherwise the answer is “no”).
2. If this hospice provides inpatient care directly, is the inpatient care provided on the premises?

   (If the Hospice directly operates an inpatient unit answer “yes” otherwise the answer is “no”).
3. Has a waiver for core nursing services been granted? (Yes or no, if yes must answer #4).
4. If “yes” for #3.
5. Indicate type of setting(s) in which the hospice provides routine home care. (May chose more than one).
6. Fill in the number of hospice patients residing in a SNF, NF or other residential facility who receive routine home care from the hospice.
7. Fill in the number of hospice patients admitted during recent 12 month period.
8. Number of records reviewed during survey.
9. Number of home visits conducted to patients in a private residence.
10. Number of home visits conducted to patients in residential facilities.
11. Does this hospice operate under the same certification number at more than one location? (Yes or No).
12. If yes to #11, enter the number of locations.

13. Does the hospice operate as part of another entity that participates in the Medicare program? (Yes or No)
14. If yes to #13, enter the Medicare certification number of the entity.

- Surveyor Signature: First and Last Name with Credentials
- Title: CHAP SITE VISITOR
- Date: Last day of the Site Visit

Hospice Survey and Deficiency Report:

- List the Tag: “L” with number. (Do not put “-“ between the L and the number).
- COP: List on the corresponding COP. (It is not necessary to put “CFR”
- Comments: This is where a condition level deficiency will be indicated.

Hospice Request for Certification in the Medicare Program (CMS-417

- Section I: Demographics will pull over with the exception of telephone number (PH5)
    - Related Certification number should be filled out with Q14 number, if applicable
- Section II: Indicate the type of hospice (check one) and include fiscal year
- Section III: Indicate the type of control (check one)
- Section IV: Services Provided (Staff are indicated by “1” and under arrangement “2”)

**Note if under arrangement in Section IV then they are not listed as employees in Section V.

- Section V: Complete the number of FTEs (or partial FTEs) by professional category.
- Ensure to double check math as the number of employees should be totaled and added to the number of volunteers for the total number. (This is an area where errors frequently occur).
- Name of Authorized Representative and Title: (Agency Representative)
- Date