



DIALYSIS SUPPLEMENTAL APPLICATION

This application must be completed in conjunction with the CNA Allied Health Care Facilities Common Application.

Instructions:

1. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

Name of Applicant: _____

1. Medicare Provider # _____ Medicaid Provider # _____

Medicare Survey Date _____

Accreditation: By What Organization _____ Date of Accreditation Survey _____

Were any deficiencies cited in the most recent surveys? If yes, explain. _____

Submit your most recent survey(ies) with the completed application.

Submit most recent CMS Annual Facility Survey Form (CMS-2744A).

2. **Physician Director**

Name: _____

Board Certification/Specialty: _____

Role and Responsibilities: _____

3. **Medical Staff**

Do you require physicians who have privileges to treat patients at your facility to have their own professional liability insurance? Yes No. If yes, what limits are required? \$ _____ each claim/\$ _____ aggregate.

4. **Allied Health Providers**

Nursing Supervisor Credential/Training: _____

Dietician Credential/Training: _____

Social Worker Credentials/Training: _____

5. **Policies and Procedures**

Note polices and procedures in writing. Check all that apply.

Patient Bill of Rights.

List of patient and staff responsibilities.

Patient admission, transfer and discharge.

Grievance mechanism

Mechanism to evaluate and assist patients with emotional, non-compliance, and behavioral problems.

Documentation that patients are informed regarding their rights, responsibilities and grievance mechanisms.

Procedures for patient referral from RDF and for acceptance by the Back-up Facility

Transfer and back-up agreements



6. Medical Quality Measures

Provide the most recent Medicare Quality Measures.

- a. Anemia Percentage - how well patients have their anemia under control.

Hematocrit of 33 or greater? [] Yes [] No

If NO, please explain: _____

- b. Hemodialysis Adequacy - how many patients get enough waste removed from their blood during dialysis treatments.

Urea Reduction Ratio (URR) of 65 or greater [] Yes [] No

If No, please explain: _____

- c. Patient/Facility Survival Rate:

[] Better than Expected (by 20% or more) [] As Expected [] Worse than Expected (by 20% or more).

If Worse than Expected explain: _____

7. Equipment

- a. Have any serious adverse events required reporting to the FDA? [] Yes [] No.

If yes, explain: _____

- b. Does the applicant reuse/reprocess dialyzers? [] Yes [] No.

If yes, do you conform to the Advancement of Medical Instrumentation protocols? [] Yes [] No

- c. Do you maintain operational logs for:

[] Delivery and circulation system

[] Reprocessing

[] Water Treatment

8. Metrics (past 12 months). If you operate in more than one state please break out treatments by state on a separate sheet.

Table with 3 columns: Metrics, CURRENT, PROJECTED. Rows include # of hemodialysis treatments, # of home care peritoneal dialysis treatments, # of Hospital inpatient treatments, # of Long Term Care facility treatments, # of dialysis stations, and Revenue.

Percentage of Adult/Pediatric Patients _____

9. Outside Laboratory Services

Do you provide laboratory testing for patients outside of your dialysis clinics? [] Yes [] No. If yes, what revenue is associated with this service? \$ _____



10. Home Care

- a. If you have listed peritoneal dialysis how are home care patients directed in an emergency? _____

- b. How is the equipment/supplies transported to the patient's home?
 company vehicle third party vehicle employee vehicle.
- c. How do home patients report problems and get questions answered promptly? _____

AUTHORIZATION

Signature in full

Date

Name - please print

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

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