Extension Site Approval Under Medicare

(Complete for each extension site)

Comprehensive Outpatient Rehabilitation Facilities

Parent Medicare Provider Number: ________________________

Extension Site Location: Name of site ____

Address ____

City ________________________________ State _________ Zip ____________

County ________________________ Phone #: ___________________________

ATTACH THE FOLLOWING DOCUMENTS TO THIS CHECKLIST AND SUBMIT TO THE STATE SURVEY AGENCY:

____ 1. An explanation of services rendered and available from the extension location, and whether the services are provided directly by agency employees or under a written contract. (Include specific modalities available.) (Note only OT, PT and SLP may be provided at the extension site)

____ 2. A detailed explanation on how the parent CORF will provide proper supervision to the **extension site.**

_____ 3. A list of all persons working at the location, the job function of each, and documentation of the qualifications of each professional worker

____ 4. A list of all contracts in effect and applicable to the extension location, including but not limited to physical therapists, occupational therapist, speech pathologist, linen services, pest control, and housekeeping services.

____ 5. The name and address of the physician who is available to the extension site for furnishing necessary medical care in the event of an emergency.

____ 6. The hours of operation, and a schedule of the professional staff who will be working during the operating hours.

____ 7. A certification from the agency's administrator that agency policies and procedures are in effect and a copy of such are on-site at the extension location.

____ 8. A copy of the Table of Contents (or other list) outlining the contents of the policies and procedures.

____ 9 An explanation of the manner in which the agency's Infection Control Committee monitors the extension site operation.

____ 10. A detailed floor plan, drawn to scale, indicating the location of all rehab equipment and all furniture.

____ 11. An inventory of patient care equipment that is available and on-site for use at the extension location, signed and dated by the agency administrator.

____ 12. Evidence of approval of the building by the local fire authority.

____ 13. A signed statement from the administrator of the agency indicating that he/she will ensure that all Medicare regulations will be met at all times at the new location.

____ 14. The date the first Medicare patient was treated.

Submitted by: ____ Date: ________________

(Name & Title of Authorized Official)