

<input type="checkbox"/> Initial Credentialing
<input type="checkbox"/> Recredentialing



110 W. Fremont St.
 Owatonna, MN 55060
 Fax: 507-444-7774

Organizational Assessment Form
Please complete this form ONLY if applicable to your facility type.

Please check your facility type below. Only one box may be checked per form. A separate form must be completed for each facility type. Please make additional copies as needed.

- | | |
|--|---|
| <input type="checkbox"/> Behavioral Health Facility (Circle One)
<i>Inpatient Residential Ambulatory/Outpatient</i> | <input type="checkbox"/> Medical Supply Company |
| <input type="checkbox"/> Chemical Dependency Facility (Circle One)
<i>Inpatient Residential Ambulatory/Outpatient</i> | <input type="checkbox"/> Medication Therapy Management Services |
| <input type="checkbox"/> Freestanding Birthing Center | <input type="checkbox"/> Orthotics and Prosthetics Provider |
| <input type="checkbox"/> Freestanding Surgery Center | <input type="checkbox"/> PCA Agency Only |
| <input type="checkbox"/> Home Health Care Agency | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Sleep Center/Sleep Lab |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Other: Please specify: _____ |

FACILITY IDENTIFICATION

NPI # _____ Federal Tax ID # _____

Legal Business Name: _____

Doing Business As (DBA) Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____ Fax: _____

ACCREDITATION

At least one box must be checked. If accredited, attach a copy of the current accreditation letter (required).

- Accreditation Association for Ambulatory Health Care (AAAHC)
- Accreditation Commission for Health Care, Inc. (ACHC)
- American Academy of Sleep Medicine (AASM)
- American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
- American College of Radiology (ACR)
- American Osteopathic Association – Healthcare Facilities Accreditation Program (AOA – HFAP)
- Clinical Laboratory Improvement Act (CLIA)
- Commissions of Accreditation of Rehabilitation Facilities (CARF)
- Community Health Accreditation Program, Inc. (CHAP)
- Council on Accreditation of Services for Families and Children, Inc. (COA)
- Council on Quality and Leadership (CQL)
- Department of Alcohol and Drug Abuse (DASA)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Other Accreditation: Specify: _____
- Not accredited

CERTIFICATION

Attach a copy of the most recent on-site survey (with corrective action plan if applicable)

1. Is the facility participating in the Medicare Program? Yes No Pending
If yes, provide the date of the last full Centers for Medicare & Medicaid Services (CMS) Survey: _____
Medicare Number: _____
2. Has the facility had an on-site survey by the State Department of Human Services (DHS)/State Department of Health (MDH)? Yes No Pending
If yes, provide the date of the last full State Department of Health survey: _____
3. If a Behavioral Health facility, has a post-licensing on-site survey been completed: Yes No
If yes, specify agency that conducted survey: _____
Date completed: _____
4. Does your facility have a formal Diabetic Education Program? Yes No
If yes, attach documentation of certification.
5. If a medical supplier of medical equipment, prosthetics, orthotics and supplies, have you received Medicare accreditation and obtained a surety bond? Yes No
If yes, attach documentation of accreditation.

This next section is for HOSPITALS ONLY:

1. Do you have a written safety plan/program? Yes No
2. Have you implemented a computerized physician order entry system? Yes No
3. If your hospital has an intensive care unit, is it staffed at least 1 hour per day by a physician specially trained to care for critically ill patients (a hospitalist)? Yes No N/A

DISCLOSURE QUESTIONS

Please provide a complete explanation if either of the following questions is answered in the affirmative. Use a separate sheet to continue, if necessary.

1. Has the facility's license ever been restricted, conditioned, suspended, or terminated? Yes No

2. Does the facility have any current State or Federal sanctions or limits? Yes No

3. Name of Facility: _____

The undersigned, on behalf of the facility named above, hereby certifies that the above information is true, correct, and complete to the best of my knowledge. I further acknowledge (i) that the organization will be bound by the terms of South Country Health Alliance's Credentialing Plan; (ii) that South Country Health Alliance may inquire of third party agencies for the purpose of verifying the information in this form; and (iii) that any material misstatement in or omission from the form may constitute grounds for denial or revocation of participation.

Authorized Signature

Print Name of Person Completing This Form

Email

Signature

Title

Facility Name

Date

REQUIRED DOCUMENTATION

PLEASE ATTACH COPIES OF THE FOLLOWING DOCUMENTS:

- Facility State License; and
 - Most recent survey results from Centers for Medicare & Medicaid Services (CMS), including corrective action plan if deficiencies were cited and evidence from CMS that all deficiencies are remedied (please submit entire survey);
- AND/OR
- Most recent State Department of Human Services (DHS) or State Department of Health (MDH) on-site survey, including corrective action if deficiencies were cited and evidence that all deficiencies have been remedied (please submit entire survey); AND
 - Accreditation Letter indicating effective date of accreditation
 - Current copy of Certificate of Liability Insurance for facility

Note: It is the responsibility of the facility to conduct criminal background checks for all personnel or volunteers as required by applicable state law.