TEXAS Health and Human Services

Form 2020
December 2023

Home and Community Support Services Agencies (HCSSA)

Notification of Readiness for Initial Survey

Instructions

- Complete all information in each of the boxes, as appropriate.
- **Submit the completed form to your Regional PM via mail, fax, email, or TULIP upload with the subject line or file name as "Form 2020"**. Refer to the HHSC website for your region's phone number and email address.
- Retain a copy of this form for your records.

Section 1: An agency's request for an initial licensure survey

Important: Read all the information carefully.

No later than six months after the effective date of an agency's initial license, an agency must:

(1) admit and provide services to clients as described in 26 TAC Section 558.521(b); and

(2) submit this form to the designated survey office, except as described in 26 TAC Section 558.521(f).

No later than six months after the effective date of the initial license of a hospice with an inpatient unit located at the hospice's principal place of business, a hospice must:

(1) admit and provide routine home services to clients as described in 26 TAC Section 558.521(b);

(2) admit and provide inpatient services to at least one client; and

(3) submit this form to the designated survey office, except as described in 26 TAC Section 558.521(f).

Name of the regional program manager and regional office location

Is the agency requesting an initial licensure survey because of a change of ownership?

☐ **Yes** ☐ **No**

Is the hospice agency requesting an initial health survey because the physical address of the hospice inpatient unit changed?

☐ **Yes** ☐ **No**

I acknowledge by my signature below that the agency is ready for its initial survey. The agency is requesting an initial survey for the following categories:

☐ Personal Assistance Services (PAS) ☐ Licensed Home Health Services (LHHS) ☐ LHHS with Dialysis
☐ Hospice ☐ Hospice with an Inpatient Unit

Signature of authorized representative ______________________ Date ______________________

Mark the home health services that the agency is providing:

☐ Skilled Nursing ☐ Physical Therapy ☐ Speech Therapy ☐ Home Health Aide
☐ Occupational Therapy ☐ Medical Social Worker ☐ Care Attendant

These abbreviations are used in this document: HIC No. — Health Insurance Claim Number; ID No. — Identification Number; CR No. — Clinical Record Number; OASIS — Outcome Assessment Information Set.

The following information must be completed:

Agency Name		License No.	License Issuance Date
Agency Address (Street, City, State, ZIP Code)			
Days and Hours of Operation		Area Code and Phone No.	Fax Area Code and No.
Administrator	Presurvey Completed ☐ **Yes** ☐ **No**	Supervising Nurse (as applicable)	Presurvey Completed ☐ **Yes** ☐ **No**
	Date		Date
Alternate Administrator	Presurvey Completed ☐ **Yes** ☐ **No**	Alternate Supervising Nurse (as applicable)	Presurvey Completed ☐ **Yes** ☐ **No**
	Date		Date

1.

Patient Name		Area Code and Phone No.	HIC No., ID No. or CR No.
Address (Street, City, State, ZIP Code)			
Date Admitted	Physician	Category of Service Provided ☐ **PAS** ☐ **LHHS** ☐ **Hospice**	

2.

Patient Name		Area Code and Phone No.	HIC No., ID No. or CR No.
Address (Street, City, State, ZIP Code)			
Date Admitted	Physician	Category of Service Provided ☐ **PAS** ☐ **LHHS** ☐ **Hospice**	

3.

Patient Name		Area Code and Phone No.	HIC No., ID No. or CR No.
Address (Street, City, State, ZIP Code)			
Date Admitted	Physician	Category of Service Provided ☐ **PAS** ☐ **LHHS** ☐ **Hospice**	

4.

Patient Name		Area Code and Phone No.	HIC No., ID No. or CR No.
Address (Street, City, State, ZIP Code)			
Date Admitted	Physician	Category of Service Provided ☐ **PAS** ☐ **LHHS** ☐ **Hospice**	

Important Information: An agency requesting an initial Medicare certification survey for home health or hospice services must apply with a Centers for Medicare & Medicaid Services (CMS)-approved national accrediting organization (AO) with deeming authority, such as the Joint Commission (JC), the Community Health Accreditation Program, Inc. (CHAP) or the Accreditation Commission for Health Care (ACHC).

An agency must notify HHSC of the AO selection. **Mark** the AO below that will be conducting your agency's initial Medicare certification survey:

☐ JC ☐ CHAP ☐ ACHC

After completing Section 1 above, this Notification of Readiness for Initial Survey form is complete. To request an initial Medicare certification survey, proceed to Section 2.

Section 2: An agency's request for an initial Medicare certification survey

Mark the category or categories of services where you are requesting an initial Medicare certification:

☐ Licensed and Certified Home Health Services (LCHHS) ☐ Hospice Services ☐ Hospice Services with Inpatient Unit

An agency requesting an initial Medicare certification survey for **home health services** must provide the following services:

(1) In addition to completing the information in Section 1 above, an agency must have provided skilled services to a minimum of 10 patients, and at least seven patients must be receiving skilled services at the time of the initial Medicare certification survey. An agency must provide a list of the 10 patients that includes the requested information in Section 1. The agency must attach the additional patient information documentation with this form. The agency must notify the regional program manager if the patient census falls below seven patients at any time after this notice is sent.

An agency requesting an initial Medicare certification survey for **hospice services** must provide the following services:

(1) In addition to completing the information in Section 1 above, an agency must have provided hospice services to a minimum of five patients, and at least three patients should be receiving hospice services at the time of the initial Medicare certification survey. An agency must provide a list of the five patients that includes the requested information in Section 1. The agency must attach the additional patient information documentation with this form. The agency must notify the regional program manager if the patient census falls below three patients at any time after this notice is sent.

Note: If the hospice is requesting an initial Medicare certification survey for a parent hospice with an inpatient unit located at the agency's physical location, the hospice must comply with the requirement in number (1) above for hospice home services and request a federal health survey of the hospice's inpatient unit. A hospice must also have a CMS RO letter approving the agency's request for an “access-to-care” exception to the priority assignment for an initial Medicare certification survey for the hospice's inpatient unit.

For more guidance on how to apply for Medicare certification an agency applying for initial Medicare certification for home health or hospice services may refer to the HHSC website, How to become a licensed HCSSA provider.

I acknowledge by my signature below that my agency is ready for an initial Medicare certification survey.

____
Signature of authorized representative

____
Date