TEXAS Health and Human Services

Form 2020
October 2014-E

Home and Community Support Services Agencies (HCSSA)

Notification of Readiness for Initial Survey

Instructions

- Complete all information in each of the boxes, as appropriate.
- **Mail or fax this completed form to your regional program manager.** (Refer to the HHS website for the regional office address and fax number.)
- Please retain a copy of this form for your records.

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

Important: Read all of 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 40 TAC §97.521(b); and

(2) submit this form to the designated survey office, except as described in 40 TAC §97.521(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 40 TAC §97.521(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 40 TAC §97.521(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

Please mark the home health services that the agency is providing:

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

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 Telephone 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 Telephone 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 Telephone 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 Telephone 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 Telephone 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. **Please 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. Stop here.

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

Do not complete Section 2 below unless your agency meets the "access-to-care" exception. An agency must have a CMS Regional Office (RO) letter approving the agency's request for an "access-to-care" exception to the priority assignment for an initial Medicare certification survey. The licensing unit must also receive a confirmation from the CMS RO granting the agency an "access-to-care" exception.
Note: There are no exceptions to this requirement.

For additional information on the "access-to-care" exception, refer to the most up-to-date provider letter concerning CMS Direction Regarding Workload Prioritization for HHSC relating to an agency seeking initial Medicare certification. An individual may also refer to the CMS Regional Survey and Certification Letter No. 10-01 — Processing of Potential Provider Requests for Exception to the Priority Assignment of Initial Surveys for additional information.

Mark the category or categories of services for which 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.

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

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

_____ _____
Signature of authorized representative Date