PRELIMINARY EVIDENCE REPORT CHECKLIST

FOR PROVIDERS. BY PROVIDERS.

HOME HEALTH

This checklist constitutes the requirements of the Preliminary Evidence Report (PER), which is mandatory for organizations applying for initial Home Health accreditation.

Review and acknowledge that all of the following requirements have been met and submit this signed checklist with the required items listed below.

Verification of the following is required for organizations seeking an initial Medicare Provider Number:

- ☐ The organization has completed the CMS-855 application and received written confirmation the application has been "processed" and "the application is being forwarded with a recommendation to the state and CMS Regional Office."
  - » **Submit a copy of the letter from CMS or the Medicare Administrative Contractor (MAC). This is applicable for companies seeking an initial Medicare Provider Number.**
  - » **Please follow up with your MAC if the approval letter is greater than 6 months. It is the responsibility of the agency to make sure your 855a is still active. It is the responsibility of the agency to report any changes that would affect the status of your 855a to your MAC and/or CMS.**
- ☐ The organization can demonstrate they are able to provide all services needed by patients being served and is able to demonstrate operational capacity of all facets of the organization
- ☐ The organization must be providing nursing and at least one other therapeutic service (Physical Therapy [PT], Speech Language Pathology [SLP], Occupational Therapy [OT], Medical Social Services [MSS], or Home Health Aide [HHA])
  - » At least one of these services must be offered solely by W-2/W-4 employees
- ☐ The organization must have provided care to a minimum of 10 patients requiring skilled care (not required to be Medicare patients)
  - » At least 7 of the required 10 patients should be receiving skilled care from the Home Health Agency (HHA) at the time of the initial Medicare survey
  - » If the HHA is located in a medically underserved area, as determined and approved by the CMS Regional Office (RO), please contact ACHC for further guidance
- ☐ The organization has a current license, in the state where it is currently doing business, if applicable.
  - » **Please note: not all states require a license, therefore this only pertains to organizations that operate in states that require a license. Also, some states allow an Initial Medicare Certification survey to take place with a provisional license and some do not.**
  - » **Please submit a copy of your current license, if applicable**

Confirmation of the following (initial in spaces provided):

_____ I attest that this organization possesses all policies and procedures as required by the ACHC Accreditation Standards

_____ I acknowledge that this organization was/is/will be in compliance with ACHC Accreditation Standards as of _____ date.

Your organization will be placed into scheduling once this document, the Agreement for Accreditation Services and Business Associate Agreement are submitted to your Account Advisor and payments are up to date. ACHC will strive to conduct your survey as soon as possible.

****PLEASE NOTE: YOUR ORGANIZATION MUST ALWAYS BE IN COMPLIANCE WITH MEDICARE REGULATIONS, CONDITIONS OF PARTICIPATION, AND APPROPRIATE STATE REGULATIONS**.

I, having the authority to represent this organization, verify that _____ (organization's legal name) has met the above requirements for survey. If this organization fails to meet any of the aforementioned requirements when the ACHC Surveyor arrives for your survey, the survey performed by ACHC will not be accepted as a legitimate Initial Medicare Certification Survey by CMS. This will result in additional charges to the organization for a subsequent survey to be performed when the organization has notified ACHC it has met all of the above requirements.

Name: _____ Title: _____

Date: _____ Signature: _____