DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AUTHORIZATION FOR STATE AGENCY HOME HEALTH AGENCY VALIDATION SURVEY

1. NAME AND ADDRESS OF STATE AGENCY	2. NAME AND ADDRESS OF HOME HEALTH AGENCY CMS CERTIFICATION NUMBER: _____

3. **THIS HHA IS CURRENTLY DEEMED BY *(NONE OR MORE THAN 1 MAY BE CHECKED):***

☐ ACHC ☐ CHAP
☐ TJC ☐ NONE

4. ***CHECK A OR B; DO NOT CHECK BOTH***

A. ☐ **THIS VALIDATION SURVEY IS BASED ON A SAMPLE SELECTION. CHECK 1 OR 2. DO NOT CHECK BOTH.**

1. ☐ PLEASE CONDUCT A FULL VALIDATION SURVEY FOLLOWING THE PROTOCOLS AND PROCEDURES FOR A MEDICARE CERTIFICATION SURVEY WITHIN 60 CALENDAR DAYS OF _____ *(ENTER AO NAME)* ACCREDITATION SURVEY END DATE.
THE SCHEDULED END DATE OF THE ACCREDITATION SURVEY IS: _____

IF APPLICABLE, CHECK ONE OR MORE OF THE FOLLOWING:

☐ THIS IS AN INITIAL ACCREDITATION SURVEY FOR THIS CURRENTLY PARTICIPATING, NON-DEEMED FACILITY.

☐ THIS IS AN INITIAL ACCREDITATION SURVEY FOR THIS AO; HHA IS CURRENTLY DEEMED.

2. ☐ THIS IS A MID-CYCLE VALIDATION SURVEY. PLEASE CONDUCT A FULL VALIDATION SURVEY FOLLOWING THE PROTOCOLS AND PROCEDURES FOR A MEDICARE CERTIFICATION SURVEY

SA MUST COMPLETE ALL VALIDATION PACKET DOCUMENTS LISTED IN EXHIBIT 63 FOR ANY FULL VALIDATION SURVEY.

B. ☐ **THIS VALIDATION SURVEY IS BASED ON ALLEGATIONS OF SIGNIFICANT DEFICIENCIES WHICH COULD AFFECT THE HEALTH AND SAFETY OF PATIENTS. *CHECK ONE OF THE FOLLOWING:***

☐ POTENTIAL IJ—INITIATE SURVEY WITHIN 2 WORKING DAYS; OR

☐ INITIATE SURVEY WITHIN 45 CALENDAR DAYS

SA MUST NOT NOTIFY THE FACILITY OR AO IN ADVANCE OF THE SURVEY

5. **AREAS TO BE SURVEYED *(FOR SAMPLE VALIDATION SURVEYS, CHECK ALL; FOR ALLEGATION SURVEYS, CHECK ALL APPLICABLE CONDITIONS)*:**

☐ 484.4	PERSONNEL QUALIFICATION	☐ 484.32	THERAPY SERVICES
☐ 484.10	PATIENT'S RIGHTS	☐ 484.34	MEDICAL SOCIAL SERVICES
☐ 484.11	RELEASE OF PATIENT IDENTIFIABLE OASIS INFO	☐ 484.36	HOME HEALTH AIDE SERVICES
☐ 484.12	FEDERAL, STATE AND LOCAL LAWS	☐ 484.38	QUALIFYING TO FURNISH OUTPATIENT PT OR SPEECH
☐ 484.14	ORGANIZATION, SERVICES AND ADMINISTRATION	☐ 484.48	CLINICAL RECORDS
☐ 484.16	PROFESSIONAL PERSONNEL	☐ 484.52	EVALUATION OF THE AGENCY'S PROGRAM
☐ 484.18	ACCEPTANCE OF PATIENTS, POC, & MEDICAL SUPERVISION	☐ 484.55	COMPREHENSIVE ASSESSMENT OF PATIENTS
☐ 484.20	REPORTING OF OASIS INFORMATION		
☐ 484.30	SKILLED NURSING SERVICES		

6. SIGNATURE OF REGIONAL REPRESENTATIVE	7. REGION	8. DATE

ORIGINAL TO: STATE SURVEY AGENCY
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