

Extension Site Approval Under Medicare

(Complete for each extension site)



Comprehensive Outpatient Rehabilitation Facilities

Parent Medicare Provider Number: _____

Extension Site Location: Name of site _____

Address _____

City _____ State _____ Zip _____

County _____ Phone #: _____

ATTACH THE FOLLOWING DOCUMENTS TO THIS CHECKLIST AND SUBMIT TO THE STATE SURVEY AGENCY:

- ___ 1. An explanation of services rendered and available from the extension location, and whether the services are provided directly by agency employees or under a written contract. (Include specific modalities available.) (Note only OT, PT and SLP may be provided at the extension site)
- ___ 2. A detailed explanation on how the parent CORF will provide proper supervision to the **extension site**.
- ___ 3. A list of all persons working at the location, the job function of each, and documentation of the qualifications of each professional worker
- ___ 4. A list of all contracts in effect and applicable to the extension location, including but not limited to physical therapists, occupational therapist, speech pathologist, linen services, pest control, and housekeeping services.
- ___ 5. The name and address of the physician who is available to the extension site for furnishing necessary medical care in the event of an emergency.
- ___ 6. The hours of operation, and a schedule of the professional staff who will be working during the operating hours.
- ___ 7. A certification from the agency's administrator that agency policies and procedures are in effect and a copy of such are on-site at the extension location.
- ___ 8. A copy of the Table of Contents (or other list) outlining the contents of the policies and procedures.
- ___ 9. An explanation of the manner in which the agency's Infection Control Committee monitors the extension site operation.
- ___ 10. A detailed floor plan, drawn to scale, indicating the location of all rehab equipment and all furniture.
- ___ 11. An inventory of patient care equipment that is available and on-site for use at the extension location, signed and dated by the agency administrator.
- ___ 12. Evidence of approval of the building by the local fire authority.
- ___ 13. A signed statement from the administrator of the agency indicating that he/she will ensure that all Medicare regulations will be met at all times at the new location.
- ___ 14. The date the first Medicare patient was treated.

Submitted by: _____ Date: _____
(Name & Title of Authorized Official)