FORM APPROVED
OMB 0938-0360

END STAGE RENAL DISEASE APPLICATION/NOTIFICATION AND SURVEY AND CERTIFICATION REPORT

PART I - APPLICATION - TO BE COMPLETED BY FACILITY

1. Name of Facility

2. Provider Number ☐ ☐ ☐ ☐ ☐ ☐

3. Street Address

4. City

5. County

6. State

7. ZIP Code

8. Telephone No.

9. Facsimile No.

10. Fiscal Year Ending Date

11. Name/Address/Telephone Number of Authorized Official
Name: Address: Telephone No.

12. Type of Application/Notification: (V1) *(check all that apply and specify in Remarks section* [see item 27]*)*
☐ 1. Initial ☐ 2. Expansion to new location ☐ 3. Change of ownership
☐ 4. Change of location ☐ 5. Expansion in current location ☐ 6. Change of services/operations
☐ 7. Other *(specify)* _____

13. Ownership (V2) ☐ For Profit ☐ Not for Profit ☐ Public

14. Is this Facility Hospital-Based *(check one)* (V3) ☐ Yes ☐ No *If Yes, hospital provider number*
(V4) ☐ ☐ ☐ ☐ ☐ ☐

15. Is this Facility SNF-Based *(check one)* (V5) ☐ Yes ☐ No *If Yes, SNF provider number*
(V6) ☐ ☐ ☐ ☐ ☐ ☐

16. Is this facility owned and/or managed by a multi-facility organization? (V7) ☐ Yes ☐ No *If Yes, name and address of parent organization*
Name: Address:
(V8)

17. Services Provided: (V9) *(check all that apply and specify in Remarks section* [see item 27]*)*
☐ 1. Hemodialysis ☐ 2. Peritoneal Dialysis ☐ 3. Transplantation ☐ 4. Home Training: __ Hemodialysis __ Peritoneal Dialysis ☐ 5. Home Support: __ Hemodialysis __ Peritoneal Dialysis

18. Is Reuse Practiced? (V10) ☐ Yes ☐ No

19. Reuse System (V11) *(check all that apply)* ☐ 1. Manual ☐ 2. Semi-Automated ☐ 3. Automated

20. Germicide (V12) *(check all that apply)* ☐ 1. Formalin ☐ 2. Heat ☐ 3. Gluteraldehyde ☐ 4. Peracetic Acid Mixture
☐ 5. Other *(specify)* _____

21. Number of Dialysis Patients
(V13) _____ Total Patients = (V14) ___Hemodialysis + (V15) ___Peritoneal Dialysis

22. Number of Stations *(check all that apply and include isolation stations under Total Stations)*
(V16) _____ Total Stations = (V17) ___Hemodialysis + (V18) ___Hemodialysis Training

23. Does the facility have isolation stations? (V19) ☐ Yes ☐ No

24. Total Number of Patients *(enter number of dialysis facility patients treated on each shift for full week prior to submission of this form)*

A. SUNDAY				B. MONDAY				C. TUESDAY				D. WEDNESDAY			
1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
E. THURSDAY				**F. FRIDAY**				**G. SATURDAY**							
1	2	3	4	1	2	3	4	1	2	3	4				

25. Total Number of patients followed at home (V20) _____

26. Staffing				
(list full-time equivalents)	(V21) ☐ Registered Nurse	__ __ __ . __ __	(V22) ☐ Licensed Practical Nurse	__ __ __ . __ __
	(V23) ☐ Social Worker	__ __ __ . __ __	(V24) ☐ Dietitian	__ __ __ . __ __
	(V25) ☐ Technicians	__ __ __ . __ __	(V26) ☐ Others	__ __ __ . __ __

27. Remarks: *(Use this space for explanatory statements for Items 1–26)*

28. The information contained in this Application Survey and Certification Report (Part I) is true and correct to the best of my belief. I understand that incorrect or erroneous statements may cause the Request for Approval to be denied, or facility approval to be rescinded, under 42 C.F.R. 405.2100 and 405.2180, respectively.

Signature of Authorized Official	Title	Date

PART II TO BE COMPLETED BY STATE AGENCY

29. ESRD Provider Number *(if the facility has a provider number)* ☐ ☐ ☐ ☐ ☐ ☐

30. Network Number (V27) ☐ ☐

31. State Region (V28)	32. State County Code (V29)

33. Type of Survey (V30) *(check all that apply)* ☐ Initial ☐ Complaint ☐ Recertification ☐ Other

34. Survey Protocol (V31) *(check all that apply)* ☐ Basic ☐ Initial ☐ Supplemental ☐ Combination

35. Surveyor Name/Number *(print)*	Professional Discipline *(print)*

36. Date of Survey

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection of 0938-0360. The time required to complete this information collection is 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

INSTRUCTIONS FOR FORM CMS-3427

PART I - DOCUMENTATION NEEDED TO PROCESS FACILITY APPLICATION/NOTIFICATION

A completed request for approval as a supplier of End Stage Renal Disease (ESRD) services in the Medicare program *(Part I - Form CMS-3427)* must include:

- A copy of the Certificate of Need approval, if such approval is required by the State, and
- A narrative statement describing the need for the service(s) to be provided.

IDENTIFYING INFORMATION (ITEMS 1–11, 13–15)

Enter the name and address *(actual physical location)* of the ESRD facility or unit where the services are performed. If the mailing address is different, show the mailing address in the Remarks block (*Item 27*). If the facility is owned or managed by an organization, indicate the name and address of the parent organization *(Item 16)*. Show the name of an authorized person who is responsible for the management of the facility (*Item 11*). Check the applicable block to indicate whether the facility is hospital or SNF based *(Box 14 or 15)* and enter the provider number of the hospital or SNF.

TYPE OF APPLICATION (ITEM 12)

Check appropriate category. If this is an in-unit expansion request, show the location of the additional stations. A "change of service/ operations" would indicate any change in items 17 or 18. *(Separate building locations require separate approvals.)*

TYPE OF SERVICE AND DIALYSIS STATIONS (ITEMS 17–23)

Check each service for which you are requesting approval *(Item 17)*. Enter the number of stations for which you are asking approval *(Item 22)*. If this is an expansion request, show the total number of stations (including those previously approved) for which you are asking approval.

REMARKS (ITEM 27)

You may use this block for explanatory statements related to items 1–26.

COPY OF CERTIFICATE OF NEED APPROVAL

If State law requires Certificate of Need approval, you must submit a copy of the approval.

Forward a copy of completed form CMS-3427 (Part I) to the State agency.

PART II - SURVEY AND CERTIFICATION REPORT - TO BE COMPLETED BY THE STATE AGENCY

Record deficiencies identified on an Initial, Recertification, Complaint or Other survey as follows: (Steps A–E are optional if you are using ASPEN or any other computer generated report.)

A. In the first column, identify the data tag number from the Interpretive Guidelines for End Stage Renal Disease Facilities.

B. In the second column, write the regulatory citation. If it is a Condition for Coverage, enter "CfC" below the regulatory citation.

C. In the third column, describe the findings and evidence under "Comments."

D. Draw horizontal lines to separate identified tag numbers.

E. If more space is needed, photocopy the "Deficiencies and Comments" page and continue the recording.

F. If available, in lieu of A–E , attach a computer-generated list.

Upon completion of the survey data, enter the CMS-3427 and forward to the Centers for Medicare & Medicaid Services regional office, if requested.

ESRD Application (CMS-3427)

CMS-3427 Part I To be completed by the provider.	
Field/Button	**Description**
Authorized Official	Name, address, and phone number of an authorized individual responsible for the management of the provider. These are free form text fields.
Type of Application/Notification (V1)	Select all categories that apply. Specify details in the Remarks section at the end of Part I. For Expansion in Current Location (option 5), indicate the location of additional stations. Change of Services/Operations (option 6) indicates any change in Services Provided (V9) or reuse practices (V10). Separate building locations require separate approvals.
Ownership (V2)	Required. Select the category that best describes the type of organization that owns the provider.
Is this Facility Hospital-Based? (V3)	If the provider is under the administrative control of a Hospital, select this checkbox and complete V4.
Provider Number (V4)	Required if you select the V3 checkbox. You can type in the Hospital's 6-digit Medicare provider number, or use Find Facility to locate and insert the number. This number must be a valid, active provider number for a category 01 provider (Hospital).
Find Facility	Enabled when you select the V3 checkbox. Opens the Find Hospitals window, where you can search for a Hospital by Facility ID, Name, Former Name, Address, City, County, Zip code, Provider Number (current and prior), or License Number. Facilities (providers) returned in this search window are limited to category 01 providers (Hospitals) on the state server.
Is this Facility SNF-Based? (V5)	If the provider is under the administrative control of a nursing home (SNF), select this checkbox and complete V6.
Provider Number (V6)	Required if you select the V5 checkbox. You can type in the SNF's 6-digit Medicare provider number, or use Find Facility to locate and insert the number. This number must be a valid, active provider number for category 02, 03, and 04 providers (SNFs).

Find Facility	Enabled when you select the V5 checkbox. Opens the Find Nursing Homes window, where you can search for a SNF by Facility ID, Name, Former Name, Address, City, County, Zip, Provider Number (current and prior), or License Number. Facilities (providers) returned in this search window are limited to category 02, 03, and 04 providers (SNFs) on the state server.
Is this facility owned and/or managed by a Multi-facility Organization? (V7)	Select if the ESRD facility is owned by an organization that owns or leases two or more nursing facilities. If so, complete V8.
If Yes, name and address of parent organization (V8)	Required if you select V7. Enter the Name and Address of the multi-facility organization that owns the ESRD. These are free form text fields.
Services Provided (V9)	Select all services that the ESRD provides; you must select at least one. Specify details in the Remarks section at the end of Part I.
Is Reuse Practiced? (V10)	Select if reuse is practiced, and complete V11 and V12.
Reuse system (V11)	Select all that apply. You must select at least one category if you select V10.
Germicide (V12)	Select all that apply. You must select at least one germicide if you select V10.
Number of Dialysis Patients (V13-15)	Enter the number of patients receiving: Hemodialysis (V14) Peritoneal Dialysis (V15). You must enter a number for at least one category. ASPEN calculates the total number of patients (V13).
Number of Stations (V16-18)	Enter the number of stations: Hemodialysis (V17) Hemodialysis Training (V18). ASPEN calculates the total number of stations (V16); 999 maximum. If this is an expansion request, include all stations in the count - including those previously approved - for which approval is sought.
Does this facility have Isolation Stations? (V19)	Select if the ESRD has Isolation Stations.

Patients	Enter the number of patients treated at the ESRD on each shift for each day of the full week prior to submission of this CMS-3427. You must enter a whole number for at least one shift Sunday-Saturday.
Total Patients Followed at Home (V20)	Number of home patients as a whole number.
Staffing (FTE)	Number of full-time equivalents (to the nearest quarter-hour) for the following categories of clinic personnel: Registered Nurse (V21), Licensed Practical Nurse (V22), Social Worker (V23), Dietitian (V24), Technicians (V25), Others (V26). You must enter an FTE number for at least one category.
Remarks	Explanatory information as needed for Part I items.

CMS-3427 Part II To be completed by the State Survey Agency	
Field/Button	**Description**
Network Number (V27)	Number of the ESRD Network to which the ESRD is assigned. The Networks act as liaisons between the Federal government and ESRD providers.
Type of Survey (V30)	Select the applicable survey type(s). Initial or Recertification is automatically selected as applicable.
Survey Protocol (V31)	Select the applicable survey protocol(s).

Application PRTF

Field/Button	**Description**
Type of Control	Required. Select the category that best describes the type of entity operating the provider.
Date Attestation Received ...	Required. Enter the date the attestation of compliance was received by the State Medicaid Agency. Must be greater than or equal to 07/01/2001, but cannot be greater than today's date.
Date Attestation Signed ...	Required. Enter the date the attestation of compliance was signed by the PRTF director. Must be greater than or equal to 07/01/2001, but cannot be greater than today's date.
Number of Medicaid residents in the facility	Enter the applicable number.
Number of residents whose benefits are paid by another state	Enter the applicable number.