Reset Form

SUPPLEMENTARY INFORMATION TO FEDERAL APPLICATION END STAGE RENAL DISEASE (ESRD) FACILITY

State Form 51053 (R3/4-07)
Indiana State Department of Health-Division of Acute Care

Division of Acute Care Use Only

Date Received *(month, day, year)* _____ **Date Approved** *(month, day, year)* _____

All questions on this application must be answered completely in print or type script. Supporting documentation must be attached to the application. Complete all sections on this application. An incomplete application or illegible application will be returned without processing.

Please Type or Print Legibly

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Other**
Submit a dated and signed copy of the bill of sale, lease or other document of transfer

☐ **Medicare and Medicaid** ☐ **Medicare**

SECTION II - IDENTIFYING INFORMATION

A. Practice Location *(name of facility d/b/a of direct owner)*

If the d/b/a name is different from the direct owner's name submit a "Certificate of Assumed Business Name" document from the State of Indiana, Office of the Secretary of State (SOS) listing the corporation name (direct owner) and doing business name (d/b/a). The d/b/a should be registered with the State of Indiana Office of the Secretary of State.

Name of facility							
Street address *(number and street)*							P.O. Box
City		County					ZIP Code
Telephone number ( )	Fax number ( )	Facility's office hours *(i.e. 8:00 a.m. – 4:00 p.m.)* Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
E-mail address		Web address						

B. Mailing Address *(if different from practice location)*

Street address *(number and street)*		P.O. Box
City	State	ZIP Code

C. Ownership Information ***(direct owner of the facility-d/b/a)***

List the owner/entity as registered with the State of Indiana Office of Secretary of State (SOS) and appears on the SOS document. Submit document from the SOS along with a document from the Internal Revenue Service (IRS) that reflects the corporation name, d/b/a if applicable and EIN number.

Owner/entity			
Street address *(number and street)*			P.O. Box
City	State		ZIP Code
Telephone number ( )	Fax number ( )	EIN number	Fiscal year end date *(mm/dd)*

D. Provider Based

Is this facility hospital/provider based? *(Is yes, list provider based Medicare number)*

Hospital Based? ☐ Yes ☐ No SNF/NF Based? ☐ Yes ☐ No

If yes, submit the documentation requested on the enclosed **Provider Based Determination** letter.

SECTION III - TYPE OF SERVICES

Services Provided *(check all services that apply and where services are provided)*

Hemodialysis: Where are the services provided? ☐ Facility ☐ SNF/NF ☐ Residential/Assisted Living ☐ Home

Peritoneal Dialysis: Where are the services provided? ☐ Facility ☐ SNF/NF ☐ Residential/Assisted Living ☐ Home

Transplantation: ☐ Yes ☐ No

Home Training:

☐ Hemodialysis: *Where are the services provided?* ☐ Facility ☐ SNF/NF ☐ Residential/Assisted Living ☐ Home

☐ Peritoneal Dialysis: *Where are the services provided?* ☐ Facility ☐ SNF/NF ☐ Residential/Assisted Living ☐ Home

Home Support:

☐ Hemodialysis: *Where are the services provided?* ☐ Facility ☐ SNF/NF ☐ Residential/Assisted Living ☐ Home

☐ Peritoneal Dialysis: *Where are the services provided?* ☐ Facility ☐ SNF/NF ☐ Residential/Assisted Living ☐ Home

*If you provide home training/home support services complete the enclosed **Request to Provide Home Hemodialysis Training and Home Hemodialysis Services Questionnaire** and/or the **CAPD/CCPD Services Questionnaire** required by Centers of Medicare and Medicaid Services (CMS) for Medicare certification.*

Do you provide hemodialysis at your facility to patients?

on vents: ☐Yes ☐No **bed or cart bound:** ☐Yes ☐No **morbid obesity:** ☐Yes ☐No

Number of Stations: _____Total Stations _____Hemodialysis + _____Hemodialysis Training

PLEASE NOTE: Indiana does not have reciprocal agreements to cross state lines to conduct surveys. Hemodialysis in NF outside of Indiana will not be approved for an Indiana ESRD facility.

SECTION IV – STAFFING

All positions are required.

The resumes submitted to the department must reflect the qualifications listed below or the application will be rejected.

A. Administrator/Director/CEO *(as defined in 42 CFR 405.2136)*

The Chief executive officer (CEO) as defined at 405.2102 is a person who: (1) Holds at least baccalaureate degree or is equivalent and has at least one year of experience in an ESRD unit; or (2) is a registered nurse or physician director as defined in the regulations; or (3) as of September 1, 1976, has demonstrated capability by acting for at least two years as a chief executive officer in a dialysis unit or transplantation unit.

Name *(enter full name)*

*Submit a copy of applicable licenses (billfold) from the Indiana Professional Licensing Agency with expiration date, resume that reflects name of employers, month/year of employment and **must include the above qualifications on the resume**. The Administrator/Director/CEO may also serve as the Physician Director or the Nurse Director if qualifications are met.*

B. Alternate Administrator/Director/CEO *(as defined in 42 CFR 405.2136)*

The Chief executive officer (CEO) as defined at 405.2102 is a person who: (1) Holds at least baccalaureate degree or is equivalent and has at least one year of experience in an ESRD unit; or (2) is a registered nurse or physician director as defined in the regulations; or (3) as of September 1, 1976, has demonstrated capability by acting for at least two years as a chief executive officer in a dialysis unit or transplantation unit.

Name *(enter full name)*

*Submit a copy of applicable licenses (billfold) from the Indiana Professional Licensing Agency with expiration date, resume that reflects name of employers, month/year of employment and **must include the above qualifications on the resume**. The Administrator/Director/CEO may also serve as the Physician Director or the Nurse Director if qualifications are met.*

C. Physician Director *(as defined in CFR 405.2102, 405.2161)*

The director of the facility must be a qualified physician director and is defined by §405.2102 as a physician who:

1. Is board-eligible or board-certified in internal medicine or pediatrics by a professional board, and has had at least 12 months of experience or training in the care of patients at ESRD facilities; or
2. During the 5 year period prior to September 1, 1976, served for at least 12 months as director of a dialysis or transplantation program; or
3. In those areas where a physician who meets the definition in paragraph (1) or (2) here is not available to direct a participating dialysis facility, another physician may direct the facility, subject to the approval of the Secretary.

Name *(enter full name)*

*Submit a copy of physician's license (billfold size) from the Indiana Professional Licensing Agency with expiration date, resume that reflects name of employers, month/year of employment and **must include the above qualifications on the resume**. The Physician Director may also serve as Administrator/Director/CEO if qualifications are met.*

D. Nurse Director *(as defined in CFR 405.2102 & 405.2162(a))*

The nurse director of the facility must be a nurse responsible for nursing service and is defined in §405.2102 as a person who is licensed as a register nurse by the State in which practicing, and

1. Has at least 12 months of experience in clinical nursing, and an additional 6 months of experience in nursing care of the patient with permanent kidney failure or undergoing kidney transplantation, including training in and experience with the dialysis process; or

2. Has 18 months of experience in nursing care of the patient on maintenance dialysis, or in nursing care of the patient with a kidney transplant, including training in and experience with the dialysis process;

3. If the nurse responsible for nursing service is in charge of self-care dialysis training, at least 3 months of the total required ESRD experience is in training patients in self care.

"Full time" means employed 40 hours/week by the facility or for the number of hours the facility is open, whichever is less. One nurse could be employed full time at two facilities if one was open Monday/Wednesday/Friday and the second was open Tuesday/Thursday/Saturday. A single RN could not be considered full time by 3 or more facilities.

Name *(enter full name)*

*Submit a copy of Registered Nurse license (billfold size) from the Indiana Professional Licensing Agency with expiration date, resume that reflects name of employers, month/year of employment and **must include the above qualifications on the resume**. The Nurse Director may also serve as Administrator/Director/CEO if qualifications are met.*

SECTION V - OWNERSHIP OF APPLICANT ENTITY

A. Ownership and Controlling Interest *(as defined in CFR 405.2136)*

List names and addresses of individuals or organizations who have or hold direct or indirect ownership of 10% or more in the facility

Name	Business Address *(street address/city/state/zip)*	EIN Number

B. Ownership Information (Officers/Directors/Partners) *(as defined in CFR 405.2136)*

List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, president, vice president, secretary, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

Name	Title	Business Address *(street address/city/state/ZIP Code)*

C. Owed and/or Managed by a Multi-Facility Organization

Is this facility owned and/or managed by a multi-facility organization? ☐ Yes ☐ No *(If yes, name and address of parent organization)*

Name	Address (*street address/city/state/zip)*

D. Type of Change in Ownership *(applicable for change of ownership only – do not complete if initial application)*

☐ Asset Purchase Agreement	☐ Assignment of Interest	☐ Lease
☐ Merger	☐ New Partnership	☐ Sale
☐ Termination of Lease	☐ Transfer of Asset Agreement	☐ Other _____

E. Type of Entity *(Complete for initial and change of ownership applications)*

For Profit	**NonProfit**	**Government**
☐ Individual	☐ Church Related	☐ State
☐ Partnership	☐ Individual	☐ County
☐ Corporation	☐ Partnership	☐ City
☐ Limited Liability Company	☐ Corporation	☐ City/County
☐ Sole Proprietorship	☐ Limited Liability Company	☐ Hospital District
☐ Other *(specify)*_____	☐ Other *(specify)*_____	☐ Federal
_____	_____	☐ Other *(specify)*_____
_____	_____	_____

- If a Limited Partnership, submit a copy of the "Application For Registration" and Certificate of Registration" signed by the State of Indiana, Office of the Secretary of State.
- If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the State of Indiana, Office of the Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the State of Indiana, Office of the Secretary of State.
- If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the State of Indiana, Office of the Secretary of State.
- If the "doing business as" (dba) name is different from the corporation's (direct owner) name submit "Certificate of Assumed Business Name" signed by the State of Indiana, Office of the Secretary of State that list the corporation and d/b/a name.
- Submit documentation from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.

SECTION VII - DOCUMENTATION TO BE SUBMITTED WITH INITIAL APPLICATION

- A letter outlining the details of what the facility is applying for and the services the facility will be providing.
- A copy of the "Articles of Incorporation" or "Certificate of Assumed Business Name" document from the State of Indiana Office of the Secretary of State.
- A document from the Internal Revenue Services (IRS) that reflects the corporation name and EIN number
- Copies of applicable current Indiana licenses (billfold size) from the Indiana Professional Licensing Agency and resumes that reflect qualifications of position.

SECTION VIII - APPLICANT'S SIGNATURE OR SIGNATURE OF AUTHORIZED AGENT SHOULD APPEAR BELOW

Signature of authorized representative	
Title	Date *(month, day, year)*

Notify the Indiana Sate Department of Health (ISDH) in writing of any changes in your staff or services. In your correspondence include the facility name, complete address, CMS Certification Number (CCN) and facility number.

Submit initial application, change of ownership application or changes to:

PHNSS-Program Director
Indiana State Department of Health
Acute Care Division
2 North Meridian Street, Section 4A 07
Indianapolis, IN 46204