Reset Form

EXTENSION SITE QUESTIONNAIRE FOR OUTPATIENT PHYSICAL / OCCUPATIONAL / SPEECH THERAPY

State Form 55642 (7-14)
Indiana State Department of Health-Division of Acute Care

INSTRUCTIONS: *1. Answer all questions on this questionnaire and submit requested documentation.*
2. If the extension site questionnaire is incomplete or not legible it will be returned to facility without processing.

Basic Information

1. Ownership – Identify the owner's name, address, city, state, ZIP code and EIN Number. Indicate whether or not the primary and the new extension sites are owned by the same entity, and name the owning entity below.

Direct owner's name		EIN number
Street address *(number and street)*		
City	State	ZIP Code
Is primary and extension site owned by the same entity? ☐ Yes ☐ No *If no, discontinue application.*		

2. Primary Location – Indicate Medicare provider number, name, street address, city, state, county, ZIP code, and telephone number, including area code.

Primary location's name		
Street address *(number and street)*		County
City	State	ZIP Code
Telephone number ( )	Medicare number	Facility number

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
P.M.	P.M.	P.M.	P.M.	P.M.	P.M.	P.M.

Services Provided	Yes or No	Provided Directly	Provided by Contract
Occupational Therapy	☐ Yes ☐ No	☐	☐
Physical Therapy	☐ Yes ☐ No	☐	☐
Speech Pathology	☐ Yes ☐ No	☐	☐

3. Administration:

a) Name of administrator designated by board of directors _________________________.
b) Qualifications ______________________________________.
c) Name of assistant administrator ____.
d) Qualifications ________________________________.

4. Existing Extension Site Locations - Include names, address, telephone numbers, distance from primary site (in miles), facility number, individual designated to manage day to day operations of each location on the days the administrator is not on site, and qualifications.

Extension Site Name/ Facility number		Distance from Primary Site (miles)	Telephone number ( )	
Street address *(number and street)*	City		State	ZIP Code
Competent Individual		Qualifications		
Extension Site Name/ Facility number		Distance from Primary Site (miles)	Telephone number ( )	
Street address *(number and street)*	City		State	ZIP Code
Competent Individual		Qualifications		
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Street address *(number and street)*	City	State	ZIP Code
Competent Individual		Qualifications	
Extension Site Name/Facility number		Distance from Primary Site (miles)	Telephone number ( )
Street address *(number and street)*	City	State	ZIP Code
Competent Individual		Qualifications	

5. Proximity – An extension office must be located within thirty (30) miles of the primary site. Please provide a map indicating mileage from primary site to new extension sites.

6. New Extension Site Locations – Include names, address, telephone numbers, distance from primary site (in miles), facility number, individual designated to manage day to day operations of each location on the days the administrator is not on site, and qualifications.

Extension Site Name/Facility number		Distance from Primary Site (miles)	Telephone number ( )
Street address *(number and street)*		County	
City	State	ZIP Code	
Competent Individual	Qualifications		
Date Treated First Patient *(month, day, year)*	Request Tentative Effective Date *(month, day, year)*		

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
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Services Provided	Yes or No	Provided Directly	Provided by Contract
Occupational Therapy	☐ Yes ☐ No	☐	☐
Physical Therapy	☐ Yes ☐ No	☐	☐
Speech Pathology	☐ Yes ☐ No	☐	☐

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Physical Therapy	☐ Yes ☐ No	☐	☐
Speech Pathology	☐ Yes ☐ No	☐	☐

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Physical Therapy	☐ Yes ☐ No	☐	☐
Speech Pathology	☐ Yes ☐ No	☐	☐

7. Staff, Primary Location – List the type of employees, including contracted staff, education level, expiration date of license, and if full or part time (*your list should include, but is not limited to: Administrator; Assistant Administrator; Office Managers; Supervisors; Therapists – PT, OT, SP, etc.*). The facility may provide an additional attachment, if needed.

Type of Employees (Ex. Administrator, Alternate Administrator, Manager, Supervisor, PT, OT, COTA, SP, etc.)	Education Level (Ex. HS, AS, BS, MS, PhD, MD)	Expiration date of license *(month, day, year)*	Full (F) or Part Time (P)

Type of Employees (Ex. Administrator, Alternate Admin, Manager, Supervisor, PT, OT, COTA, SP, etc.)	Education Level (Ex. HS, AS, BS, MS, PhD, MD)	Expiration date of license *(month, day, year)*	Full (F) or Part Time (P)

8. Staff, New Extension Site Location – List the type of employees, including contracted staff, education level, expiration date of license, and full or part time (*your list should include, but is not limited to: Administrator; Assistant Administrator; Office Managers; Supervisors; Therapists – PT, OT, SP, etc.*). The facility may provide an additional attachment, if needed.

Type of Employees (Ex. Administrator, Alternate Administrator, Manager, Supervisor, PT, OT, COTA, SP, etc.)	Education Level (Ex. HS, AS, BS, MS, PhD, MD)	Expiration date of license *(month, day, year)*	Full (F) or Part Time (P)	Facility Address *(Street, City)*	Facility Number

Type of Employees (Ex. Administrator, Alternate Admin, Manager, Supervisor, PT, OT, COTA, SP, etc.)	Education Level (Ex. HS, AS, BS, MS, PhD, MD)	Expiration date of license *(month, day, year)*	Full (F) or Part Time (P)	Facility Address *(Street, City)*	Facility Number

9. Administrative Services – Do the administrative services originate from a central location, a corporate office, a regional office or office other than the primary location? If so, indicate the address of this location, and explain the function it performs. ***Identify documentation submitted to ISDH by corresponding number.***

THE FOLLOWING MUST BE SIGNED AND DATED BY THE ADMINISTRATOR OF THE PRIMARY LOCATION.

I certify that the responses to this Extension Site Questionnaire are true, correct, and complete.

Signature	
Printed Name	Date *(month, day, year)*

EXTENSION SITE QUESTIONNAIRE
(*06/30/2014)*

The Division of Acute Care, Indiana State Department of Health, must receive the extension site questionnaire completed in its entirety and all requested documentation in order to process the request to add an extension site. If the questionnaire is incomplete or not legible the questionnaire will be returned to the facility without processing.

Purpose
The purpose of this questionnaire is to gather regulatory information for establishing outpatient physical therapy extension sites.

Definitions
A determination will be made based on the following Outpatient Physical Therapy definitions located at 42 CFR 485:

Extension Location **-** *A location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the rehabilitation agency. The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the conditions of participation as a rehabilitation agency.*

Please Note:

- *The extension location is situated within a thirty (30) mile radius of where ninety (90) percent of the agency's primary site's population lives. Sites beyond that area may require the extension location to be independently certified as a primary site.*
  Consideration may be given for greater or shorter distances based on unusual geographic features.

Supervision*-Authoritative procedural guidance that is for the accomplishment of a function or activity and that—*
(1) Includes initial direction and periodic observation of the actual performance of the function or activity; and
(2) Is furnished by a qualified person—
(i) Whose sphere of competence encompasses the particular function or activity; and
(ii) Who (unless otherwise provided in this subpart) is on the premises if the person performing the function or activity does not meet the assistant-level practitioner qualifications specified in § 485.705.

Rehabilitation Agency ***-*** *An agency that—*
(1) Provides an integrated, interdisciplinary rehabilitation program designed to upgrade the physical functioning of handicapped disabled individuals by bringing specialized rehabilitation staff together to perform as a team; and
(2) Provides at least physical therapy or speech-language pathology services.

Administrator *- is a person who has a bachelor's degree and:*
(i) *Has experience or specialized training in the administration of health institutions or agencies; or*
(ii) *Is qualified and has experience in one of the professional health disciplines.*

Please note:
When the administrator is unable to carry out delegated duties, a similarly qualified alternate is to be ***readily available*** *(on the premises)* ***at all times*** *to assume the administrator's responsibilities.*
If an organization's extension location is applying to be a primary site, the current administrator cannot become the administrator of the new primary site unless he/she relinquishes his current position. Additionally, the current administrator cannot serve as an alternate administrator for the new primary site unless he/she will work solely at the newly approved site and the current primary site has hired a new administrator.
The administrator (42 CFR 485.709) is given internal control of the rehabilitation agency by the governing body. The administrator

must assume overall administrative responsibility for the entire organizational operation, including extension locations and/or off premises activities. Furthermore, the administrator must serve as a full time administrator, meaning he/she can only be responsible for a single Medicare certified organization. A competent individual must be available at each extension location to manage the day to day operations of that location on the days the administrator is not onsite. The competent individual is responsible for reporting to the administrator.

Contact for Assistance

If you have any questions, please contact the **Program Director at the Indiana State Department of Health Division of Acute Care at 317-233-7502.**

OPT-Program Director
Indiana State Department of Health
2 N Meridian St
Acute Care Division - 4A 07
Indianapolis, IN 46204