MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA

SECTION I: to be completed by hospital

| Name of Hospital | Street Address | | City or County | | | State | ZIP Code | | |
|--------------------------------------|---------------------------------|----|--------------------------|---------|--------|----------------------------|--------------|-------------------------------------------------------------------|-----|
| | | | | | | | | | |
| B1 | | B2 | | | B3 | B4 | | | B5 |
| Hospital Provider Number | Total Number of Beds | | Total Number of Certifie | ed Beds | | Other Data — Does the hosp | ital operate | a forensic unit? | |
| | | | | | | | □ Yes | □ No | |
| B6 | | B7 | | | B8 | | | | B9 |
| For the past year: A. Total number o | f admissions to certified areas | | | | B. Age | e Range of Patients | | | |
| from (mont | n) (year) | _ | | B10 | | | | | B11 |
| C. Medicare/Medicaid Billings | | | | | D. Oth | | | parate MEDICAID ONLY-Reside atric patients under the age of 22 | |
| | Billed | | Collected | | | | □ Yes | □ No | |
| MEDICARE/Part A | | | | | | | | | |
| MEDICARE/Part B | | | | | | | | | |
| MEDICAID | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | B12 |

13. Current Hospital Statistics (on days of survey) [certified beds only]

| Name of Ward | Bed Capacity | Patient Census |
|--------------|--------------|----------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | Total Patient Census |

MEDICARE/MEDICAID PSYCHIATRIC HOSPITAL SURVEY DATA (contd)

SECTION II: to be completed by the survey team

| Dates of Survey (beginning) | Dates of Survey (ending date) | Type of Survey: | Initial (B16) | Recertification (B17) | Follow-up (B18) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------|-------------------------------------|------------------------|-------------------------------------------|
| /// (mm) (day) (year) | (mm) (day) (year) B15 | | Complaint (B19) | Second Follow-up (B20) | Concurrent with General Hospital (B21) |
| Survey Team Composition | | Total Number of S | urveyors on Site | | |
| Administrator Nurse Dietician Pharmacist Social Worker LSC Specialist Sanitarian | (B22) (B23) (B24) (B25) (B26) (B27) (B28) | □ SA □ RO □ Consultar □ CO | (B32) (B33) nt (B34) (B35) | | |
| Physician Psychologist Other | (B29) (B30) (B31) | Total Number o | of Surveyors on Site | (B36) | |

19. Certification of Findings

I certify that I have reviewed each Condition of Participation and Related Standards for Psychiatric Hospitals, and unless indicated on the CMS-2567, the Facility was found to be in compliance with the Conditions and/or Standards.

| Signature | Title | Date |
|-----------|-------|------|
| | | |
| Signature | Title | Date |
| | | |
| Signature | Title | Date |
| | | |
| Signature | Title | Date |
| | | |

According to the Paperwork Reduction Act 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 is 0938-0378. The time required to complete this information collection is estimated to average 15 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.