APPLICATION FOR CHANGE IN LICENSE SUPPLEMENT A

TO BE COMPLETED BY:
Office of Primary Care and Rural Health

This supplement has been reviewed by this office and the hospital listed in item "1":

☐ **meets CAH eligibility criteria** ☐ **does not meet CAH eligibility criteria**

_____ _____
Signature **Date**

Complete this supplement if you are applying for designation as a Critical Access Hospital (CAH)

1. **Facility Identifying Information**

Please enter the name and address of the hospital that is applying for designation as a CAH exactly as it appears on the State License Certificate.

_____

_____

_____

_____

2. **Bed Count**

The **current number** of licensed acute care beds is _____.

The **current number** of swing beds is_____.

The **current number** of authorized beds is_____.

The **proposed number** of authorized beds is_____.

3. **Bed Count After CAH Certification**

After CAH certification this hospital agrees to (check only one):

☐ Provide not more than 25 authorized acute care beds.
The number of authorized acute care beds after CAH certification **will be**_____.
The number of licensed acute care beds after CAH certification **will be**_____.

OR

☐ Participate in the swing bed program and provide not more than 25 authorized beds, of which no more than 10 of these beds may be occupied at any one time by swing bed patients. The number of licensed beds after CAH certification **will be**_____, and the number of authorized beds **will be**_____. The number of swing beds after CAH certification **will be**_____.

In addition to the previous bed count restrictions, after CAH certification a hospital may also (check all that apply):

☐ Provide up to 10 additional beds for psychiatric care. The number of beds for psychiatric care **will be**_____.

AND

☐ Provide up to 10 additional beds for rehabilitation care. The number of beds for rehabilitation care **will be**_____.

Note: No more than 45 total beds may be authorized beds.

4. **Eligibility**

☐ Hospital currently participates in the Medicare program and meets applicable conditions of participation. Hospital's Medicare Provider number is_____.

OR

☐ Hospital closed or downsized to a clinic on_____.
(date)

5. **Location**

Hospital is located: (check all that apply, **item a, b, or c must be checked and d is required**)

☐ a. in a rural area (i.e., located outside of a metropolitan statistical area),

OR

☐ b. in a Metropolitan Statistical Area (MSA) identified by the Goldsmith Modification Formula as rural,

OR

☐ c. in an MSA that has been identified by state criteria as rural for CAH purposes,

AND

☐ d. more than a 35-mile drive, or a 15-mile drive in mountainous terrain or area with secondary roads, from the nearest hospital or CAH.

6. **Length of Stay**

This hospital will have a written policy in effect to limit acute inpatient stays to an annual average of 96 hours or less.

Check here ☐ if Hospital agrees to the above statements regarding length of stay.

7. **State Hospital Licensure Rules**

Hospital will meet all general acute care hospital standards as set forth by the Department of Public Health's licensure rules.

Check here □ if Hospital agrees to the above statements regarding meeting all general acute care hospital standards as set forth by the Department of Public Health's licensure rules.

8. **Network Membership**

Hospital has written and signed agreements with at least one hospital that is a member of the network for:

a. patient referral and transfer,

b. development and use of communications systems (including, where feasible, telemetry systems and systems for electronic sharing of patient data).

c. provision of emergency and non-emergency transportation; and

d. has a signed agreement for credentialing and quality assurance with at least one hospital that is a member of the network or a PRO or equivalent entity.

Check here □ if Hospital has obtained these written and signed agreements. Copies of these agreements must accompany this application.

9. **Documentation of Board, Medical Staff and Community Involvement in Decision to Convert to a Critical Access Hospital.**

Hospital has (check all that apply):

□ completed a Community Health System Assessment, a copy of which is enclosed with this application.

□ completed a Financial Feasibility Study documenting the financial impact of facility conversion to a Critical Access Hospital Status, a copy of which is enclosed with this application.

□ provided education to the medical staff of the facility and submits minutes of medical staff meetings where the Critical Access Hospital Program was considered or has a report detailing the medical staff education process, a copy of which is enclosed in this application.

□ provided education to the community on the benefits of the facility as a Critical Access Hospital; copies of these educational activities documents are attached to this application.

_____ _____

Signature of Hospital Administrator Date

This supplement, along with the application for change in license and all other supporting documentation should be returned to:

Alabama Department of Public Health
Division of Provider Services
P.O. Box 303017
Montgomery, AL
36130-3017