MISSISSIPPI
CRITICAL ACCESS HOSPITAL APPLICATION
Mississippi State Department of Health
Office of Rural Health

THE ORIGINAL AND 10 COPIES OF THE APPLICATION AND ALL SUPPORTING DOCUMENTATION SHOULD BE FORWARDED TO:

FLEX Coordinator
Office of Rural Health, MS State Department. of Health,
PO Box 1700, Jackson, MS 39215-1700

I. HOSPITAL INFORMATION

Hospital Name_____

PO Address _____ Street Address _____

City_____ State _____ Zip _____

Telephone_____ Fax _____ E-Mail _____

County Name _____ County Status: __Rural __Urban

Medicare Provider # _____ Medicaid Provider # _____

Contact Person_____

II. HOSPITAL STATUS

Check facility status: __Public __Nonprofit License #_____

Has the hospital been classified as an urban hospital for purposes of the standardized payment amount by HCFA or the Medicare Geographic Classification Review Board under Sec. 412.230 (e) of this chapter, and/or among a group of hospitals that have been redesignated to an adjacent urban area under Sec. 412.232 of this chapter?

__Yes __No

Is this hospital currently licensed in accordance with the Mississippi State Department of Health Minimum Standards of Operations for Hospitals ?

__Yes __No

III. STATE CRITERIA FOR DETERMINING A NECESSARY PROVIDER OF HEALTH CARE SERVICES

Indicate all the following criteria that apply to the facility. In Mississippi, to be certified as a necessary provider of health services, a Critical Access Hospital must meet at least two (2) or more of the following criteria

Criteria 1. The hospital is located in a county that is federally designated as a Health Professional Shortage Area (HPSA) for medical care.

__Yes __No

Criteria 2. The hospital is located in a county that is federally designated as a Medically Underserved Area (MUA).

__Yes __No

Criteria 3. The hospital is located in a county where the percentage of families with incomes less than 100 percent of the federal poverty level is higher than the state average for families with incomes less than 100 percent of poverty.

__Yes __No

Criteria 4. The hospital is in a county with an unemployment rate that exceeds the state's average unemployment rate.

__Yes __No

Criteria 5. The hospital is located in a county with a percentage of population age 65 and older that exceeds the state's average.

__Yes __No

Criteria 6. The number of Medicare admissions to the hospital exceeds 50 percent of the facility's total number of admissions as reported in the most recent Hospital Annual Report for the facility.

__Yes __No

IV. COMMUNITY INVOLVEMENT

1. Attach a copy of the local governing authority minutes authorizing CAH conversion.
2. Date conversion explained to the hospital medical staff? _____
3. Date conversion explained to the hospital staff? _____
4. a) Date conversion explained to other health providers in the community? (Nursing homes, home health, pharmacist, etc.) _____
   b) Attach list of other health services providers in your community.
5. Furnish evidence of public notice of intent to convert.

V. ORGANIZATIONAL STRUCTURE

Chief Executive Officer _____Phone _____

Chief Financial Officer _____Phone _____

Director of Nurses _____ Phone _____

Attach list of medical staff along with specialties.

VI. TRAUMA AND EMERGENCY SERVICES

Do you agree to make available 24-hour-a-day emergency care? __Yes __No

Do you agree to participate in the organized regional trauma care system WHEN implemented? __Yes __No

VII. NUMBER OF BEDS AND LENGTH OF STAY

1. Number of Beds and Services when converted to CAH

Acute Inpatient Beds Operating _____

Swing Beds _____

SNF Beds _____

Will the CAH provide: Routine deliveries?
__Yes __No

Routine surgery services
Inpatient? __Yes __No Outpatient? __Yes __No

2. Length of Stay

a) Include a copy of your policies and procedures addressing patient transfers. Inpatient discharges or transfers must occur within 96 hours of admission, unless a longer period is required because of inclement weather or other emergency conditions.

b) All CAHs will be required to sign a memorandum of agreement (MOA) with IQH (formerly the MS Foundation for Medical Care). The MOA will include IQH's review procedures for obtaining a waiver review when the patient's medical condition requires an inpatient stay longer than 96 hours.

VIII. FINANCIAL FEASIBILITY

1. Include a copy of the financial feasibility study conducted by your hospital (must include a three year CAH cost and revenue projection). Reimbursement from payer sources other than Medicare should be considered in the analysis as the 96 hour length of stay applies to ALL patients.

2. Provide copies of your audited financial statements and notes for the three most recently completed years.

3. Provide information on most recently completed fiscal year:
   # of admissions _____ # of days _____
   # of deliveries _____ # of inpatient surgeries _____

4. Provide information on most recently completed fiscal year:
   # of outpatient visits _____ # of ER visits _____

IX. NETWORK AGREEMENT

Include a copy of the signed network agreement with other hospital(s) detailing:
1. Patient referral and transfers
2. Communications systems
3. Provisions for ER and non-ER transportation
4. Arrangements for credentialing and quality assurance

I certify that this application is correct and that this hospital currently meets or will meet all of the above criteria at the time of survey.

_____

_____

_____ _____

Hospital Name and Address Administrator

_____

Date

MISSISSIPPI
CRITICAL ACCESS HOSPITAL APPLICATION Instructions
FORM 602 E

PURPOSE
To allow acute care hospitals to apply for the critical access hospital status.

INSTRUCTIONS
Application to be completed by hospital representative and signed by hospital CEO (Administrator). Ten copies of the application and supporting documentation should be submitted to the State Office of Rural Health at the MSDH.

Section I (Hospital Information)
Applicant should provide the following:

Hospital Name, address, telephone #, fax #, email, medicare provider #, medicaid provider #, and contact person.

Section II (Hospital Status)
Applicant must indicate public or nonprofit status and facility license #.

Indicate whether hospital has been classified by Centers for Medicaid and Medicare Services as an urban hospital for purposes of the standardized payment.

Indicate if hospital licensed in accordance with the MSDH.

Section III (Criteria for Necessary Provider)
If applicant applying for Critical Access Hosptial status as necessary provider. Applicant must indicate the following:

1. If located in a HPSA
2. If located in a MUA
3. If % of families with incomes less than 100% of federal poverty level in county where hospital is located is higher than state average.
4. If unemployment rate of county where hospital is located exceeds the state average.
5. If % of elderly population in county where hospital is located exceeds state average.
6. If number of Medicare admissions to hospital exceeds 50% of facility's total admissions according to the most recent Hospital Annual Report for the facility.

Section IV (Community Involvement)
For this section, applicant must:

1. Submit copy of the local governing authority minutes authorizing CAH conversion.
2. Provide date conversion explained to the hospital medical staff.
3. Provide date conversion explained to the hospital staff.
4. Provide date conversion explained to other health providers in the community (i.e. Nursing homes, home health, pharmacist, etc).
5. Submit a listing of other health service providers in the community.
6. Submit evidence of public notice of intent to convert.

Section V (Organizational Structure)
Applicant must indicate the following:
Chief Executive Officer, Chief Financial Officer, Director of Nurses and attach list of medical staff along with specialist.

Section VI (Trauma and Emergency Services)

Applicant must indicate if planning to make available 24-hour-a-day emergency care.

Applicant must indicate if planning to participate in the organized regional trauma care system when implemented

Section VII (Number of beds and length of stay)

1. Applicant must indicate the level of the following after conversion:
   # Acute Inpatient Beds Operating, # Swing Beds, and # SNF Beds__
2. Applicant must indicate if hospital will provide routine deliveries, routine inpatient and outpatient surgery services after conversion.
3. Length of Stay
   Applicant must submit the following:
   a. A copy of their policies and procedures addressing patient transfers. Policies must adhere to inpatient discharges or transfers occurring within 96 hours of admission, unless a longer period is required because of inclement weather or other emergency conditions.

   b. A signed memorandum of agreement (MOA) with Information and Quality Healthcare (IQH). The MOA must include IQH's review procedures for obtaining a waiver review when the patient's medical condition requires an inpatient stay longer than 96 hours.

Section VIII (Financial Feasibility)

Applicant must submit the following:

1. A copy of the financial feasibility study conducted by the hospital. The feasibility study must include:
   a. A three year CAH cost and revenue projection; and
   b. analysis of the reimbursement from payer sources other than Medicare to appropriate account for the 96 hour length of stay which applies to all patients.
2. Copies of the hospital's audited financial statements and notes for the three most recently completed years.
3. Information on # of admissions, # of days, # of deliveries and # of inpatient surgeries, # of outpatient visits, and # of ER visits for the most recently completed fiscal year.

Section IX (Network Agreement)

Applicant must submit a copy of a signed network agreement with another hospital(s) detailing the following:

1. Patient referral and transfers
   2. Communications systems
   3. Provisions for ER and non-ER transportation
   4. Arrangements for credentialing and quality assurance
2. Hospital CEO must certify application.