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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-62294 (09/2024) | | | | | | **STATE OF WISCONSIN** | | | | | | | | | | |
| **HOSPICE MULTIPLE LOCATION QUESTIONNAIRE**  This completed questionnaire will be used by the state agency to recommend that a hospice, with separate or multiple locations, meets or does not meet the Medicare regulations for separate certification. | | | | | | | | | | | | | | | | |
| **Section A – Demographic Data** | | | | | | | | | | | | | | | | |
| Name – Parent Location | | | | | | | | | | | | | | | | |
| Street Address – Parent Location | | | | City | | | | | County | | | | State | ZIP Code | |
| Name – Multiple Location | | | | | | | | | | | | | | | | |
| Street Address – Multiple Location | | | | City | | | | | County | | | | State | | ZIP Code | |
| Telephone Number | | | FAX Number | | | | Hours of Operation | | | | | | | | | |
| Identify counties served | | | | | | | | | | | | | | | | |
| Identify services provided | | | | | | | | | | | | | | | | |
| Date Multiple Location Became Operational (MM/dd/yyyy) | | | | | Distance From Main Location | | | | | | Travel Time From Location | | | | | |
| **Section B – Multiple Location Determination** | | | | | | | | | | | | | | | | |
|  | Yes  No | Is the multiple location part of the currently certified hospice and is it a single business entity under common ownership? | | | | | | | | | | | | | | |
|  | Yes  No | Do the parent hospice and multiple location have **separate professional staff who are managed/supervised by administrative staff that are separately located from the parent office?** | | | | | | | | | | | | | | |
|  | Yes  No | Does the multiple location serve different client populations such that the services provided at the multiple location are different than those provided at the parent office? | | | | | | | | | | | | | | |
|  | Yes  No | Do the parent hospice and multiple location have **separate inpatient sites**? | | | | | | | | | | | | | | |
|  | Yes  No | Do the parent hospice and multiple location have **separate medical directors**? | | | | | | | | | | | | | | |
| If the answers to any of the above questions 2-5 are **"Yes,"** the multiple location may need to seek separate Medicare certification. Stop and consult with state agency staff. Do not proceed further with questionnaire.  Proceed to Section C if all responses to questions 2-5 are **“No”.** | | | | | | | | | | | | | | | | |
| **Section C – Multiple Location Assessment** | | | | | | | | | | | | | | | | |
| 1. Do the parent hospice and multiple location have common administrative staff for orientation and training, supervision, hiring and firing, and ability to monitor and exercise control over services provided by personnel under arrangement or contracts at multiple location?  * Provide Organizational Chart delineating lines of authority. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Do the parent hospice and branch location have common policies and personnel rules? Who is responsible for monitoring? | | | | | | | | | | | | | | | | |
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| 1. Do the parent hospice and branch location have shared billing, clerical support staff, and ancillary services? | | | | | | | | | | | | | | | | |
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| 1. Ability of the governing body to manage the location.  * Provide documentation to show the governing body’s role in managing the multiple location. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Any changes made to the lines of authority, and professional and administrative control. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Ability of the Medical Director to assume responsibility for the medical component of the hospice’s patient care at all locations.  * Provide information on how the Medical Director will assume responsibility for all locations. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Changes in the Interdisciplinary Groups (IDG(s)) providing hospice services.  * Provide information on how the multiple location will participate in IDG. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Changes in staffing or the client population, or both. How will the multiple location be staffed?  * Provide staffing listing with titles. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Changes in the way clinical records are maintained, protected, and safeguarded against loss, destruction, or unauthorized use.  * Provide information on how this is completed. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Ability of the hospice to provide all hospice services at the multiple location.  * Provide list of services and programs. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Identify other relevant factors. | | | | | | | | | | | | | | | | |
| **Section D – Requestor Information** | | | | | | | | | | | | | | | | |
| **Signature** – Person Completing Form | | | | | | | | | | Date Signed (MM/dd/yyyy) | | | | | | |
| Name – Person Completing Form (Print) | | | | | | | | Title | | | | | | | | |
| Email Address | | | | | | | | Phone Number | | | | | | | | |
| Section E –State Agency Recommendation | | | | | | | | | | | | | | | | |
| **Surveyor Recommendation:**  Approval of Multiple Location Site  Denial of Multiple Location Site | | | | | | | | | | | | | | | | |
| **Signature** – Surveyor | | | | | | | | | | | | Date Signed (MM/dd/yyyy) | | | | |