

Please follow **STEP 1** to **STEP 4** to complete the form. If the org is CMS certified, please submit a CMS approval letter of the change.



ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Change Notification Form

			Date Submitted:	
Organization Name:			AAAHC ID#:	
Organization Type:		Accreditation Expiration Date:		
Address:			State:	
Primary Contact:			Email:	
Effective date (for change):				

STEP 1: Identify change(s) and provide supporting information. Select type(s) of change from each relevant group below. Check all that apply. For each change selected, enter or submit (as email attachment) the information requested.

Group 1: Simple changes

Admin Change Name Position Email Phone Effective Date Designate this person as primary contact? YES NO If No, who should be the primary contact?	Name Change (Legal and/or DBA) Submit: ▶ Copy of updated license/state notification ▶ Copy of license with submission ▶ CMS approval letter for Medicare Certified organizations	End of Accreditation/Closure Submit: ▶ Narrative (Please include date of closure.)	Temporary Closure/Interruption of Services Submit: ▶ Narrative (Please include begin and end date of service interruption.)
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Group 2: Complex changes

Ownership Change Submit: ▶ Narrative describing ownership change, name change, additions/changes to key staff as a result of the ownership change ▶ Most recent Organizational Chart ▶ Previous and updated list of owners with ownership percentage changes ▶ List of Governing Body members ▶ Changes in policies and procedures Additional for Medicare Certified ASCs: ▶ Evidence that CMS was notified of the ownership change (CHOW) and the approval letter. ▶ If the organization is requesting a new CCN number, please provide: <ul style="list-style-type: none"> • CMS 855B Medicare Enrollment Application for a new • CMS approval Letter 	Relocation Renovation New Satellite Location Submit: ▶ Description of additions/changes in key staff members, services provided, and policies and procedures developed to support any new services ▶ 8 ½" x 11" architectural floor plans including room sizes and locations of procedure and/or operating rooms, as well as location of emergency exits and diagram of patient flow through the facility ▶ Description of material and staff flow through each space; photographs (up to but no more than 9 of relevant patient care areas, as well as "clean" and "dirty" areas ▶ Occupancy Permit or Fire inspection report	Scope of Service Submit: ▶ Changes made to policies and procedures to support the expansion of service(s) ▶ List of procedures approved by the Governing Body ▶ Description of the physicians and/or health care professionals providing the new service(s) (specialty, if appropriate), including a brief description of the process by which they are credentialed and privileged by the organization. Note that each state may have its own delineation of scope of service for the provider; please address any limitations that were a factor in the privileging. ▶ Description of any new equipment used, including a brief description of privileging and/or training of the health care professionals who use it ▶ Description of any changes to the facility, if applicable
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	<ul style="list-style-type: none"> ► Confirmation of notification to the applicable state authority and CMS, if Medicare certified ► Any other applicable inspection reports from local, state, or federal agencies <p>Additional for organizations undergoing renovation:</p> <ul style="list-style-type: none"> ► Risk Assessment <p>Additional for organizations adding new satellite location(s):</p> <ul style="list-style-type: none"> ► Completed Satellite Facility Form (found on pages 3-4). ► If your new satellite is seeking Medical or Dental Home accreditation, please fill out the self-assessments. 	<ul style="list-style-type: none"> ► Confirmation of notification to the application state authority and CMS, if Medicare certified
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Group 3: Unusual or Adverse Events

Media related events Submit: ► Narrative	Legal events Submit: ► Narrative	Patient care related adverse events <i>(Do not include any patient identifying information.)</i> Submit: ► Narrative	Bankruptcy Submit: ► Narrative
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Group 4: Miscellaneous changes

Other changes/Miscellaneous (not included options above): Supporting documents included (please specify below):

- 1.
- 2.
- 3.

STEP 2: Medicare Information (if CMS certified). Please forward any proof of acceptance or confirmation from CMS.

Date the Medicare enrollment Form CMS-855B was filled with the fiscal intermediary for review and verification: _____

Is the organization planning on maintaining the current CCN number?				YES	NO
Previous CCN Number		New CCN Number			
Will the new owner accept assignment of the current/prior owner's Medicare provider agreement?				YES	NO

STEP 3: Attestation and Signature

By signing below, I certify that the information in this application is accurate, complete, and current as of this date. I acknowledge that the AAAHC policies must be continually adhered to. Any material change in the relationship between the applicant organization and the new service site(s) being requested to be added must be reported to the AAAHC.

_____ Name	_____ Title	_____ Sign	_____ Date
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STEP 4: Send to AAAHC. Save this completed form to your computer and email it along with all required attachments to:

For primary care: notifyprimarycare@aaahc.org

For Corporate Quality Alliance (CQA) organizations: notifyCQA@aaahc.org

For surgical organizations EAST (of the Mississippi River): notifyEast@aaahc.org

For surgical organizations WEST (of the Mississippi River): notifyWest@aaahc.org

Based on the review, the Accreditation Committee will determine if a Special Survey is required.

AAAHC staff will contact you if additional information is requested by the Accreditation Committee or Clinical Staff.

Satellite Addition Form

To be Submitted with the 2.1.D Notification Form

Date
Submitted

Organization Name:		AAAHC ID#:	
Accreditation Type:		Accreditation Expiration Date:	
Address:		*State:	
Primary Contact:		Email:	

Organizational Integration

1.	Does the currently accredited organization occupy physically connected floor space and/or a geographic location with the site of service location such that the site of service location is represented or reasonably appears to the public as being part of the accredited organization?	
2.	Is there a common organized medical or professional staff for the accredited organization and the site of service location(s)?	
3.	Is the human resources function responsible for all staffing of the site of service location(s) and development and implementation of established personnel activities?	
4.	Does the accredited organization manage all operations of the site of service location(s), i.e., the related entity has little or no management authority or autonomy independent of the accredited organization?	
5.	Does the accredited organization apply its quality improvement program to the site of service location(s) and does it have authority to implement actions intended to improve the performance at the related entity or service?	
6.	Does the accredited organization bill for services provided by the site of service location(s) under the name of the accredited organization?	
7.	Are the policies and procedures applicable to the accredited organization and the site of service locations(s), with few or no exceptions?	
8.	Are patient records of the site of service location(s) integrated into the accredited organization's record system?	

For Office Use Only: Note: Functional integration exists when the entity meets four of the above criteria, including criterion 1, 2, or 3.	Was criterion 1,2, or 3 met?	
	Are there a total of 4 overall criterion checked?	

Service Locations

List all satellite locations owned by, operated by, managed by, or affiliated with the organization that should be included in the accreditation site survey process in the space below.

IMPORTANT – Please be sure to:

Exclude hospitals at which physicians or dentists have staff privileges.

Fill in all requested information. (The following page may be copied as needed for additional sites.)

Include names of service location (s), if doing business under a different name than the legal name shown on the accredited organization's Certificate of Accreditation and the AAAHC web site.

*For sites that are identified as Medical Home or Dental Home below, the site will need to submit a self-assessment based on Chapter 25 or 14.II for each location that is being included.

Service Location #1:

Name:		*Medical Home		*Dental Home	
Address:				*State:	
Primary Contact:		Email:			
Date location began providing services under the current ownership:		Phone:			

Satellite Addition Form

To be Submitted with the 2.1.D Notification Form

Date
Submitted

Service Location #1:

# Credentialed physicians (excluding anesthesiologists):	
# Credentialed anesthesiologists:	
Travel time from main facility and direction (N,S,E,W):	

# Operating rooms in facility:	
# Procedure rooms in facility:	
# Recovery beds in facility:	

Service Location #2:

Name:		*Medical Home		*Dental Home
Address:				*State:
Primary Contact:		Email:		
Date location began providing services under the current ownership:		Phone:		
# Credentialed physicians (excluding anesthesiologists):		# Operating rooms in facility:		
# Credentialed anesthesiologists:		# Procedure rooms in facility:		
Travel time from main facility and direction (N,S,E,W):		# Recovery beds in facility:		

Service Location #3:

Name:		*Medical Home		*Dental Home
Address:				*State:
Primary Contact:		Email:		
Date location began providing services under the current ownership:		Phone:		
# Credentialed physicians (excluding anesthesiologists):		# Operating rooms in facility:		
# Credentialed anesthesiologists:		# Procedure rooms in facility:		
Travel time from main facility and direction (N,S,E,W):		# Recovery beds in facility:		

Service Location #4:

Name:		*Medical Home		*Dental Home
Address:				*State:
Primary Contact:		Email:		
Date location began providing services under the current ownership:		Phone:		
# Credentialed physicians (excluding anesthesiologists):		# Operating rooms in facility:		
# Credentialed anesthesiologists:		# Procedure rooms in facility:		
Travel time from main facility and direction (N,S,E,W):		# Recovery beds in facility:		

Attestation

By signing below, I certify that the information in this application is accurate, complete, and current as of this date. I acknowledge that the AAAHC policies must be continually adhered to. Any material change in the relationship between the applicant organization and the new service site(s) being requested to be added must be reported to the AAAHC.

Name

Title

Sign

Date