Rural Health Clinic Initial Application for Medicare and Medicaid Participation

Indiana Department of Health

Dear Applicant:

This letter sets forth the requirements and procedures that a facility must meet to participate in the Medicare Program as a Rural Health Clinic ("RHC").

Please note that the Indiana Department of Health **cannot** conduct your initial survey for Medicare; you will have to go through an accreditation organization (AO) for Medicare. The recognized accreditation organizations for rural health clinics are the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) and The Compliance Team (TCT).

This letter explains the requirements and procedures through which you may be approved to participate in the Medicare program as a provider of services ("Provider"). Due to limited resources, the Centers for Medicare and Medicaid Services (CMS) currently is not budgeting initial rural health clinic certification surveys. The change in policy is applicable immediately for all rural health clinics that rely on CMS survey and certification work. The provider has an option to select a CMS-approved AO to conduct the initial certification survey. The provider must obtain accreditation with "deemed status" from the AO to be eligible for consideration as a provider of Medicare services with CMS. The Indiana Department of Health ("Department") will continue to collect and process the paperwork for the initial applications for CMS. The provider may obtain information on rural health clinics from the Medicare webpage: www.cms.hhs.gov/medicare.asp.

The Social Security Act (the Act) provides for a system of quality assurance in the Medicare program based on objective, onsite outcome-based surveys by federal and state surveyors. The survey and certification (S&C) system provides beneficiaries assurance that basic standards of quality are being met by health care providers and that, if these standards of quality are not met, remedies are promptly implemented.

CMS accomplishes these vital quality assurance functions under the specific direction for the ACT and in concert with states, CMS-approved AOs, and various contracts with qualified organizations. All CMS or state certification surveys for Medicare must be performed by Medicare-qualified surveyors consistently applying federal regulations, protocols, and guidance. Most types of providers or suppliers seeking to participate in Medicare must first demonstrate compliance with quality of care and safety requirements through an on-site survey.

Initial surveys of new providers or suppliers have become more challenging for four reasons:

- Resource limitations
- Many new providers
- More responsibilities
- Anti-fraud initiatives

Longstanding CMS policy makes complaint investigations, recertification, and core infrastructure work for existing Medicare providers a higher priority compared with certification of new Medicare providers.

The Department will no longer be conducting initial Medicare certification surveys. The rural health clinic has the option of becoming Medicare-certified through accreditation by a CMS-approved AO instead of a survey by CMS or the Department. Such accreditation is deemed to be equivalent to a recommendation by the Department for CMS certification. In such cases, the applicants have an alternate route to Medicare certification via CMS acceptance of the AO's accreditation.

If the facility is found in compliance, the effective date of admission to the program will be no earlier than the date of exit for the survey or date of an acceptable Plan of Correction is received if Standard Level finding(s) are found. Applicants that are denied approval to participate in the Medicare program will be notified of such denial, along with the reason(s) for denial and information about the right to appeal the decision.

To be approved as a supplier of rural health clinic services, a clinic must be in an area designated by the Bureau of Census as non-urbanized and by the Secretary of Health and Human Services as a shortage area, where a shortage of personal health services or a shortage of primary medical care resources exists.

The CMS determines whether a RHC area is considered non-urbanized and therefore potentially eligible to apply for RHC status. Under the law, the clinic must also employ either a physician's assistant or a nurse practitioner; must make arrangements with a physician for medical direction, guidance and supervision; and must make arrangements with a Medicare certified hospital for referral and admission of patients by the clinic. Departmental regulations specify the minimal health and safety standards RHCs must meet to qualify for reimbursement under this law.

It must be determined if the RHC meets the criteria for RHC status before the Indiana Department of Health Division of Acute Care will approve the application. Submit a letter of approval from the Partner Relations, Indiana Department of Health. The letter must identify if the RHC has been approved for a HPSA, MUA, or MUP designation. Contact Gabrielle Long at the address listed below for confirmation of the RHC designation eligibility for RHC certification.

Primary Care Office Manager
Indiana Department of Health
2 North Meridian Street, Section 2J
Indianapolis, IN 46204
GLong@health.in.gov

In those instances where a central organization provides rural health services at more than one clinic site, each site is considered a clinic and the location of the clinic site determines its location eligibility (i.e. rural, shortage area) rather than the location of the central organization. A separate **Verification of Clinic Date-Rural Health Clinic Program (Form CMS-29)** is required for each clinic site.

Please complete and return all copies of the enclosed promptly, keeping in mind that your institution cannot claim provider reimbursement for services furnished prior to approval. Should you have questions regarding the forms, or if you need more **Request to Establish Eligibility** forms for multiple clinic locations, please contact the Department at 317-233-7302.

If your facility is provider-based to a hospital, or a critical access hospital, you must receive Civil Rights Clearance for Initial Certifications. You must complete and return the enclosed Office of Civil Rights application package along with all request policies and documentation. Any questions concerning the Civil Rights Application should be directed to the Office of Civil Rights.

Subject to availability, we are also enclosing the Medicare Conditions for Coverage. The conditions are only a part of the Medicare regulations contained in Title 42, Chapter IV of the Code of Federal Regulations that rural health clinics must meet. You can purchase 42 CFR Chapter IV from the Superintendent of Documents, US Government Printing Office, Washington, DC 20402; however, the needed information is supplied in Medicare materials provided to you without charge, and explanations are furnished either by this office or by your Medicare carrier.

If you are opening a new facility to be certified for participation in the Medicare and/or Medicaid programs, **please be advised that the provision for services to Medicare (Title XVIII) and/or Medicaid (Title XIX) recipients cannot be made prior to the official date of certification.** A facility must be in substantial compliance with federal requirements to enter the Medicare or Medicaid programs.

CMS determines if requirements are met. The **Health Insurance Benefits Agreement** will be countersigned with one copy returned to the agency along with notification that your agency has been approved. If operation of the entire institution is later transferred to another owner, ownership group, or to a lessee, the agreement will usually be automatically assigned to the successor, but you are required to notify the CMS at the time you are planning such a transfer.

To qualify for payment, your facility must be in compliance with the requirements for participation as determined by the AO, the requirements for reimbursement (including financial solvency), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, the latter three of which determination is made by the Office of Civil Rights in Chicago.

If you are buying an existing certified entity, the previous owner's provider agreement(s) will automatically be assigned to you provided that your application is approved. Please note that in assuming the previous owner's provider agreements, you will also be assuming responsibility and liability for implementing and/or abiding by the terms of the previous owner's plan for correcting any deficiencies.

An attachment has been provided to a CMS informational letter and CMS approved accrediting organization contact list for your convenience. Review the letter from CMS for your options for initial certification.

Please note that the processing of your application for participation in the Medicare and/or Medicaid program(s) cannot commence until this division has received all of the required completed forms and documentation.

In addition, please note that your application for participation in the Medicare program cannot be processed and/or initial certification survey conducted until the Fiscal Intermediary/Carrier has approved the Medicare Provider/Supplier Enrollment Application (Form CMS-855A).

To speed up processing of your application, make sure it is accurate and complete. If the application is not completed accurately and/or documentation is missing it hinders and delays processing. The application must be completed in its entirety to be accepted. Review all regulations before submitting your application to the Indiana Department of Health.

List of Enclosed Forms to be Completed and Returned with Application

- Supplementary Information to Federal Application Rural Health Clinic (RHC) (State Form 51054)
- Request to Establish Eligibility to Participate in the Health Insurance for the Aged and Disabled Program to Provide Rural Health Clinic Services (Form CMS-29). Instructions for completion are contained on the first page of the form.
    - One (1) copy of the Health Insurance Benefits Agreement (Form CMS-1561A). **Note:** On the second line of the Health Insurance Benefits Agreement (form HCFA-1561A), after the term "Social Security Act" enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). Ordinarily, this is the same as the business name used on all official IRS correspondence concerning payroll withholding taxes, such as W-3 or 941 forms. For example, the ABC Corporation, owner of the Wildwood Health Center, would enter on the agreement "ABC Corporation d/b/a Wildwood Health Center." A partnership of several persons might complete the agreement to read "Robert Johnson, Louis Miller, and Paul Allen, partners, Easy Care Health Services." A sole proprietorship would complete the agreement to read "John Smith d/b/a Wembly Walk-in Center."
- The person signing the Health Insurance Agreement must be someone who has the authorization of the owners of the enterprise to enter into this agreement. If the Health Insurance Benefits Agreement is signed by someone other than an officer, director or partner of the enterprise, then one of the officers, directors or partners of the enterprise as listed on the Medicare General Enrollment Health Care Provider/Supplier Application (Form HCFA-855) or Disclosure of Ownership and Control Interest Statement (Form HCFA-1513) must give that individual written permission to sign. Please submit a copy of this letter of authorization.
- Staffing and Staff Responsibilities Form – Complete, sign, and return with application
- Provider-Based Questionnaire - This form must be completed to determine if entity meets criteria as provider based of another Medicare certified provider for the purpose of Medicare certification and reimbursement.
- If the rural health clinic is provider-based to a hospital or critical access hospital, please review the attached Office of Civil Rights letter.

Documentation/Information to be Submitted with Application

- Copy of the "Articles of Incorporation" or "Certificate of Assumed Business Name" signed by the Indiana Secretary of State for doing business in Indiana
- Copy of a SS-4 form or comparable document from the Internal Revenue Services (IRS) that reflects the corporation name and EIN
- Copies of current valid Indiana licenses on staff – Refer to Supplementary Information to Federal Application Rural Health Clinic (RHC) (State Form 51054)

Any questions concerning your initial certification survey should be directed to your accreditation association.

Please ensure all forms required for initial Certification processing are signed. Also, note your request for participation in the Medicare program cannot be forwarded and/or processed to CMS-RO until your fiscal intermediary/carrier has approved and the department has received the Medicare Provider/Supplier Enrollment Application (Form CMS-855A), the survey results from the AO and the completed forms (CMS-29, CMS-1561A, Provider Based Questionnaire, and the OCR Attestation of Compliance, if applicable).

Submit the completed application to:

Indiana Department of Health
Home and Community Based Care Division
2 North Meridian Street
Indianapolis IN 46204

Enclosed for reference is the ISDH website for rules/regulations and/or other documentation listed below that can be accessed and downloaded from the internet:

https://www.in.gov/health/cshcr/acute-and-continuing-care/rural-health-clinic-certification-program/

- ✓ Federal Regulations – 42 CFR Part 491
- ✓ Accreditation Organization listing

If you have questions, please contact the Program Coordinator at 317-233-7302.

OMB Control Number 0945-0008
Exp. Date: 04/30/2026

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSURANCE OF COMPLIANCE

Under the Paperwork Reduction Act of 1995, as amended, and 5 C.F.R. § 1320.5(b)(2)(i), persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The OMB control number for this collection is 0945-0008. In lieu of completing this hard copy form and mailing it in, the Applicant may provide this assurance via the U.S. Department of Health and Human Services' Assurance of Compliance online portal at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf.

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, SECTION 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND FEDERAL CONSCIENCE AND NONDISCRIMINATION LAWS

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964, as amended (codified at 42 U.S.C. § 2000d *et seq*.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin (including limited English proficiency) be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973, as amended (codified at 29 U.S.C. § 794), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of their disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972, as amended (codified at 20 U.S.C. § 1681 *et seq*.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex (including pregnancy, sexual orientation, and gender identity), be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975, as amended (codified at 42 U.S.C. § 6101 *et seq*.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18116), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin (including limited English proficiency), age, disability, or sex (including pregnancy, sexual orientation, and gender identity) be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

As applicable, the Church Amendments, as amended (codified at 42 U.S.C. § 300a-7), the Coats-Snowe Amendment (codified at 42 U.S.C. § 238n), the Weldon Amendment (*e.g.,* Consolidated Appropriations Act, 2022, Pub. L. No.

117-103, Div. H, Title V § 507(d), 136 Stat 49, 496 (Mar. 15, 2022)) as extended by the Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023, Pub. L. No. 117-180, Div. A, § 101(8) (Sep. 30, 2022); , Section 1553 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18113), and Section 1303(b)(4) of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18023(b)(4)), and 45 C.F.R. Part 88, to the extent that the rights of conscience are protected and associated discrimination and coercion are prohibited, in any program or activity for which the Applicant receives Federal financial assistance. Consistent with applicable court orders, the version of Part 88 in effect as of [October 20, 2022] is found at 76 Fed. Reg. 9968-9977 (Feb. 23, 2011).

The Applicant agrees that compliance with this assurance constitutes a material condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees, and assignees for the period during which such assistance is provided.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

_____
Date

_____
Signature of Authorized Official

Please mail form to:

U.S. Department of Health & Human Services Office for Civil Rights
200 Independence Ave., S.W. Room 509F Washington, D.C. 20201

_____
Name and Title of Authorized Official (please print or type)

_____
Name of Agency Receiving/Requesting Funding

_____
Street Address

_____
City, State, Zip Code

The Applicant may provide this assurance via the U.S. Department of Health and Human Services' Assurance of Compliance online portal at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf in lieu of mailing it to the address provided.

INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF CLINIC DATA
RURAL HEALTH CLINIC PROGRAM

The filing of this verification of clinic data is part of the process of obtaining a decision as to whether the rural health clinic conditions for certification are met.

Please do not delay returning the form. Assistance in filling out the form is available from the State agency.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date.

Do not complete the categories identified as State/County or State Region. Return the form to the State agency in the envelope provided; retain a copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from your Center for Medicare & Medicaid Services (CMS) regional office at **http://www.cms.hhs.gov/RegionalOffices/**.

Detailed Instructions for Specific Questions

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

The Following to be Completed by the Clinic

Question I – Identifying Information
Insert the full name under which the clinic operates. A rural health clinic site is the location at which health services are furnished. If a central organization operates more than one permanent clinic site, a separate Verification of Clinic Data form for each rural health clinic site must be submitted. In these instances, the location of the health clinic site, rather than of the central organization, will determine eligibility to participate. The applicant site must be situated in a rural area which is designated as either an area with a shortage of personal health services or as a health manpower shortage area because of its shortage of primary medical care manpower. If the name of the rural health clinic site does not identify the owner(s), the name and address of the owner(s) are to be inserted in the space provided; otherwise, that space is to be left blank.

Question II – Medical Direction
Insert the name and address of the physician(s) responsible for providing medical direction for the health clinic site.

Question III – Clinic Personnel
(A), (B), and (C) – Personnel are to be described in terms of full-time equivalents. To arrive at full-time equivalents, add the total number of hours worked by personnel in each category in the week ending prior to the week of filing the request and divide by the number of hours in the standard work week (as determined by the clinic policies). If the result is not a whole number, express it as a quarter fraction only (e.g., .00, .25, .50, or .75).

Exclude all trainees and volunteers.

In addition to the physician, a nurse practitioner, physician assistant or a certified nurse-midwife is required for clinic eligibility and must be shown in B and/or C respectively.

(D) – Where other types of personnel are utilized (e.g., technicians, aides, etc.), the discipline, by name is to be indicated in addition to the full-time equivalents.

Under (A), (B), and (C), include in the count only those personnel defined as follows:

Physician – A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which such function or action is performed. (A physician listed in II, above, should be included in this category for purposes of determining full-time equivalents.)

Nurse practitioner – A registered professional nurse who is currently licensed to practice in the State, who meets the State's requirements governing the qualifications of nurse practitioners and who meets one of the following conditions:

1. Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or
2. Has satisfactorily completed a formal one academic year educational program that:
   (i) prepares registered nurses to perform an expanded role in the delivery of primary care;
   (ii) includes as least four months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and
   (iii) awards a degree, diploma, or certificate to persons who successfully complete the program; or
3. Has successfully completed a formal educational program for preparing registered nurses to perform an expanded role in the delivery of primary care that does not meet the requirements of paragraph (2) of this section, and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

Physician assistant – A person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians and who meets at least one of the following conditions:

1. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or
2. Has satisfactorily completed a program for preparing physician's assistants that:
   (i) was at least one academic year in length:
   (ii) consisted of supervised clinical practice and at least four months (in the aggregated) of classroom instruction directed toward preparing students to deliver health care; and
   (iii) was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or
3. Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of paragraph (2) of this section and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

Question IV – Type of Control

Identify the rural health clinic in terms of its type of control by checking the appropriate column and row under A, B, C or D. Nonprofit status is based on Internal Revenue Service tax exemption interpretation; i.e., section 501 of the Internal Revenue Code of 1954.

Indicate if the rural health clinic site is or will be a provider-based entity to a hospital or critical access hospital (CAH), in accordance with the provider-based rules located at 42 CFR 413.65. If yes, provide the hospital or CAH's CMS Certification Number (CCN) for the main provider to which the clinic is/will be provider-based.

State Agency Responsibility

A function of the resurvey process is to obtain updated statistical information on organizations providing rural health clinic services. At the time of resurvey, the surveyor will bring this form and request that a representative of the organization complete, sign, and date it by the completion of the onsite visit. The surveyor will review the form for completeness and accuracy and initial after the signature of the organization's representative. On all resurveys insert the clinic's assigned CCN.

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 0938-0074. The time required to complete this information collection is estimated to average 10 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB N0. 0938-0074

VERIFICATION OF CLINIC DATA – RURAL HEALTH CLINIC PROGRAM

Medicare program must complete this form and return it to the State agency that is handling the certification process. If a return envelope is not provided, the name and address of the State agency may be obtained from the Center for Medicare & Medicaid Services (CMS) regional office at **http://www.cms.hhs.gov/RegionalOffices/**.
This form is also to be completed when the State agency surveys a participating RHC.

CMS CERTIFICATION NO. (RH1)
STATE/COUNTY (RH2)
STATE REGION (RH3)

I. **IDENTIFYING INFORMATION** (TO BE COMPLETED FOR EACH CLINIC SITE)	NAME OF CLINIC	STREET ADDRESS	
	CITY, COUNTY AND STATE	ZIP CODE	TELEPHONE NO. *(Including Area Code)* (RH4)
NAME AND ADDRESS OF CLINIC OWNER(S) (RH5)			
II. **MEDICAL DIRECTION**			

III. **CLINIC PERSONNEL** (FULL TIME EQUIVALENTS)	(A) PHYSICIAN (RH6)	(B) NURSE PRACTITIONER (RH7)	(C) PHYSICIAN ASSISTANT (RH8)	(D) OTHER (RH9)

IV. **TYPE OF CONTROL** (check one)		A. INDIVIDUAL	B. CORPORATION	C. PARTNERSHIP	D. GOVERNMENT
	1. PROFIT	◯	◯	◯	STATE 3. ◯ LOCAL 4. ◯ FEDERAL 5. ◯
	2. NON- PROFIT	◯	◯	◯	

Is the RHC a provider-based entity to a hospital or critical access hospital (CAH)? Yes ◯ No ◯ (RH11)
(check one)

(RH10) If yes, please indicate the CMS Certification Number of the hospital/CAH _____ (RH12)

I certify that this information is true, correct, and complete. I agree, if approval is granted, that all services rendered by the clinic shall be in conformity with Federal, State, and local laws. I further understand that a violation of such laws will constitute grounds for withdrawal of approval under the regulations. If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE (RH13)

HEALTH INSURANCE BENEFITS AGREEMENT

(Agreement with Rural Health Clinic Pursuant to
Section 1861(aa)(2)(K)(ii) of the Social Security Act)
(CMS-1561A)

For the purpose of establishing eligibility for payment under Title XVIII of the Social Security Act,

hereafter referred to as the Rural Health Clinic, hereby agrees:

(A) To maintain compliance with the conditions for certification set forth in part 491 of chapter IV, title 42 of the Code of Federal Regulations, and to report promptly to the Centers for Medicare & Medicaid Services any failure to do so;

(B) Not to charge the beneficiary or any other person for items and services for which the beneficiary is entitled to have payment made under the provisions of part 405 of chapter IV, title 42 of the Code of Federal Regulations (or for which the beneficiary would have been entitled if the Rural Health Clinic had filed a request for payment in accordance with §410.165 of chapter IV), except for any deductible or coinsurance amounts for which the beneficiary is liable under §405.2410;

(C) To refund as promptly as possible any money incorrectly collected from a beneficiary or from someone on his or her behalf;

(D) To accept beneficiaries for care and treatment without limitations, except as it may impose on all other persons;

(E) To accept any additional provisions that the Secretary finds necessary or desirable for the efficient and effective administration of the Medicare program.

This agreement, upon submission by the Rural Health Clinic and upon acceptance for filing by the Secretary of Health and Human Services, shall be binding on the Rural Health Clinic and the Secretary. The agreement may be terminated by either party in accordance with regulations. In the event of termination, payment will not be available for Rural Health Clinic services furnished on or after the effective date of termination.

This agreement shall become effective on the date specified below by the Secretary or the Secretary's delegate, and shall remain in effect unless terminated.

In the event of a transfer of ownership, the agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement, or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Accepted for Rural Health Clinic By:

Signature	Title
Printed Name	**Date**

Accepted for Secretary of Health & Human Services By:

Signature	Title
Printed Name	**Date**

PRA Disclosure Statement

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 **0938-0832 (Expires 01/31/2027)**. This is a **mandatory** information collection. The time required to complete this information collection is estimated to average 1 hour 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

****CMS Disclosure****

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact CMS at **QSOG_RHC-FQHC@cms.hhs.gov**.

SUPPLEMENTARY INFORMATION TO FEDERAL APPLICATION
RURAL HEALTH CLINIC (RHC)

State Form 51054 (R/4-05)
INDIANA STATE DEPARTMENT OF HEALTH - DIVISION OF ACUTE CARE

Division of Acute Care Use Only

Date Received_____ **Date Approved**_____

THE APPLICTION MUST BE COMPLETED IN ITS ENTIRETY IN ORDER FOR ISDH TO PROCESS THE APPLICATION

Please Type or Print Legibly

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Other**

Submit a dated and signed copy of the bill of sale, lease or other document of transfer

SECTION II - IDENTIFYING INFORMATION

A. Practice Location *(name of facility-practice location)d/b/a of direct owner (entity)*

If the d/b/a is different from the direct owner submit Articles of Incorporation from the Office of the Secretary of State listing the d/b/a. The d/b/a should be registered with the Office of the Secretary of State and appear on the Articles of Incorporation submitted to ISDH with the application.

Name of Agency		
Street Address		P.O. Box
City	County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's office hours *(i.e. 8:00 a.m. – 4:00 p.m. Monday - Friday)*

B. Mailing Address *(if different from practice location)*

Street Address		P.O. Box
City	State	Zip Code +4

C. Ownership Information *(direct owner (entity) of the rural health clinic (d/b/a)*

The owner/entity as registered with the Office of Secretary of State and appears on the Articles of Incorporation form submitted to ISDH. Submit Articles of Incorporation from the Office of Secretary of State along with a W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.

Ownership *(Operator(s) of the facility-practice location) The owner-applicant entity as registered with the secretary of state*			
Street Address			P.O. Box
City	State		Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

D. Provider Based

Is this facility a provider based facility? ☐ Yes ☐ No *(Is yes, provide provider Medicare number)*

If yes, please submit the documentation requested on the enclosed **Provider Based Designation** letter.

SECTION III - UDERSERVED AREA

Is the clinic designated as in underserved area? ☐ Yes ☐ No

SECTION IV – STAFFING AND STAFFING RESPONSIBILITIES

A. Administrator (office manager)

Name *(enter full name)*

B. Physician/MD

A physician is present for sufficient periods of time, at least once in every 2 week period *(except in extraordinary circumstances*), to provide the medical direction, medical care services, consultation and supervision and is available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. **Refer SOM: 491.8 Staffing and Staff Responsibilities.**

Name *(enter full name)* ***Submit a current copy of the physician's Indiana license (billfold size)***	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

C. Physician Assistant/Nurse Practitioner/Certified Nurse Midwife

A nurse practitioner or a physician assistant must be available to furnish patient care services at least 60 percent of the time the clinic operates. **Refer SOM: 491.8 Staffing and Staff Responsibilities.**

A physician assistant or nurse practitioner in addition to the physician is required for clinic eligibility. *(select appropriate box)*

☐ Physician Assistant ☐ Nurse Practitioner ☐ Certified Nurse Midwife

Submit a current copy of the physician assistant, nurse practitioner and/or certified nurse midwife Indiana license (billfold size).

Name of Physician Assistant *(enter full name)*	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

Name of Nurse Practitioner *(enter full name)*	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

Name of Certified Nurse Midwife *(enter full name)*	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

SECTON V - OWNERSHIP OF APPLICANT ENTITY

A. Ownership Information *(officers/directors/managing agents/managing employees of the rural health clinic)*

List all individuals *(persons)* associated with the applicant entity and indicate the individual's title *(i.e. officer, director, member, partner, president, vice president, secretary, etc)*. If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

Name	Title	Business Address (street address/city/state/zip)

B. Type of Change in Ownership *(applicable for change of ownership only – do not complete if initial application)*

☐ Asset Purchase Agreement ☐ Assignment of Interest ☐ Lease

☐ Merger ☐ New Partnership ☐ Sale

☐ Termination of Lease ☐ Transfer of Asset Agreement ☐ Other _____

C. Type of Entity *(Complete for initial and change of ownership applications)*

For Profit

☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Other *(specify)* _____

NonProfit

☐ Church Related
☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Other *(specify)* _____

Government

☐ State
☐ County
☐ City
☐ City/County
☐ Hospital District
☐ Federal
☐ Other *(specify)* _____

If a Limited Partnership, submit a copy of the "Application For Registration" and Certificate of Registration" signed by the Indiana Secretary of State.

If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed the Indiana Secretary of State.

If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

If the "doing business as" (dba) name is different from the corporation's *(direct owner)* name submit "Articles of Incorporation" signed by the Indiana Secretary of State that list the d/b/a name.

Submit a *W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.*

Applicant's signature or signature of authorized agent should appear below	
Signature of Authorized Representative	
Title	**Date**

NOTIFY THE INDIANA STATE DEPARTMENT OF HEALTH IN WRITING OF ANY CHANGES IN YOUR STAFF AND/OR SERVICES

SUBMIT CHANGES TO:

INDIANA STATE DEPARTMENT OF HEALTH
ACUTE CARE DIVISION
PHNSS-PROGRAM DIRECTOR
2 NORTH MERIDIAN STREET
SECTION 4A 07
INDIANAPOLIS IN 46204

STAFFING AND STAFF RESPONSIBILITIES
(Type or print legibly)

Physician Information	
Physician's Name	
Days/Hours Available *(i.e .Monday 2 hrs, Tuesday 4 hrs etc)*	
Responsibilities	
Signature of Physician	Date
Signature of Authorized Representative	Date

Physician Assistant, Nurse Practitioner or Midwife Information **❑ Physician Assistant □ Nurse Practitioner □ Midwife** **(Please mark accordingly)**	
Name of Physician Assistant, Nurse Practitioner or Midwife	
Days/Hours Available *(i.e. Monday 2 hrs, Tuesday 4hrs, etc)*	
Responsibilities	
Signature of Physician Assistant, Nurse Practitioner or Midwife	Date
Signature of Authorized Representative	Date