

TENNESSEE CRITICAL ACCESS HOSPITAL PROGRAM
APPLICATION FOR FINANCIAL FEASIBILITY STUDY FOR POTENTIAL
DESIGNATION AS A CRITICAL ACCESS HOSPITAL

I. Applicant Hospital Identification

Hospital Name: _____ Medicare Provider #: _____
 Address: _____
 Administrator/CEO: _____
 Phone: _____ Fax: _____

II. Criteria for Eligibility

Applicant hospital meets or will meet the not-for-profit eligibility requirement within 9 months from the completion of the financial feasibility study, provided the study concludes that conversion is warranted. Any other eligibility requirements that are not currently met must be met within one (1) year from the date of completion of the feasibility study. (Check appropriate statements):

Currently Meets	Agrees to Meet Within Specified Time Frame	Criteria
_____	_____	1. Eligibility Criteria: Is a licensed not-for-profit or public hospital and is located in a county in a rural area ¹
_____	_____	2. Federal and State Criteria (must agree to meet at least one): Is located more than 35 miles from another hospital, or Is located more than 15 miles in mountainous terrain or areas with only secondary roads, or Is certified by the State as a Necessary Provider of Health Care Services ²
_____	_____	3. Rural Health Network ³ Membership: Has written agreements with at least one Affiliate Hospital that is a member of the network for: 1) patient referral and transfer, 2) development and use of communications systems and 3) provision of emergency and non-emergency transportation: Affiliate Hospital: _____ Address: _____ Administrator/CEO: _____ Phone: _____ Fax: _____
_____	_____	Has or plans to have written agreements for credentialing and quality assurance with at least one hospital that is a member of the network or with a Peer Review Organization: Hospital/PRO: _____ Address: _____ Administrator/CEO: _____ Phone: _____ Fax: _____

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| _____ | _____ | 4. Emergency Services:
Agrees to make available 24-hour emergency care services, seven days a weeks, regardless of inpatient census ⁴ |
| _____ | _____ | 5. Bed Size:
Agrees to provide not more than 25 licensed beds, of which no more than 15 beds may be occupied at any one time by acute care patients |
| _____ | _____ | 6. Staffing:
Agrees to maintain staffing levels of at least one registered nurse if the facility has at least one acute care patient, or one licensed nurse if the facility has no acute care patients |
| _____ | _____ | 7. Acute Care Inpatient Length of Stay:
Agrees to or has a written policy in effect to limit all inpatient lengths of stay to no more than 96 hours, except under the following conditions: 1) inclement weather, 2) emergency conditions, or 3) as approved by the Peer Review Organization on a case-by-case basis |

III. Supporting Documentation

A. Indicate the number of Applicant Hospital and Affiliate Hospital medical staff for each specialty listed:

Medical Staff	Applicant Hospital	Affiliate Hospital
1. Active Medical Staff		
Family Practice Physician		
General Internal Medicine		
General Surgeon		
OB/GYN		
Orthoped		
Radiologist		
2. Emergency Room Staff		
Physicians (on-site)		
Physicians (on-call)		
Other (specify)		
3. Courtesy/Consulting Staff		
Pathologist		
Other (specify)		
Other (specify)		
Other (specify)		

B. Please provide the following pertaining to the Applicant Hospital:

- ____ Number of licensed acute care beds (current)
- ____ Number of swing-beds (current)
- ____ Number of licensed beds to be used for acute care only (as CAH)
- ____ Number of licensed swing beds to be used for either acute or extended care (as CAH)

C. Please provide the following information:

- Number of referrals/transfers from Applicant to Affiliate Hospital in the last fiscal year:

(Referrals/Transfers) (Year)

- Number and percent of residents of the county where the Applicant Hospital is located that were treated in the Affiliate Hospital in the last fiscal year:

(Number) (Percent) (Year)

- Distance and driving time to the closest acute care facility to the Applicant Hospital:

(Distance) (Driving time) (Name of hospital) (County)

- Has the Applicant Hospital closed in the past five years? Yes ____ No ____
If yes, date of closure _____ and date of re-opening _____

- Has the Applicant Hospital decreased services in the past 5 years? If so, please list discontinued services and date discontinued:

(Service) (Date) (Service) (Date)

(Service) (Date) (Service) (Date)

(Service) (Date) (Service) (Date)

- Has the Applicant Hospital been designated as a Sole Community Provider by Medicare?

Dates: _____ Application pending? Yes ____ No ____
(From) (To)

- Has the Applicant Hospital been designated as a Medicare Dependent Hospital?

Dates: _____ Application pending? Yes ____ No ____
(From) (To)

Administrator/CEO Signature

Date

Hospital Board Chair Signature

Date

Notes:

¹ For the purpose of the Tennessee Critical Access Hospital program, “rural” is defined as 1) not located in an area designated as a Metropolitan Statistical Area (MSA), 2) not located in an urban area, or 3) not classified by HCFA as an urban hospital.

² For designation as a “Necessary Provider,” the hospital must meet one of the following criteria:

- 1) The hospital is located in a Health Professional Shortage Area (HPSA)
- 2) The hospital is located in a Medically Underserved Area (MUA)
- 3) The hospital is located in a county where the percentage of families with income less than 200% of the Federal poverty level is higher than the state average
- 4) The hospital is located in a county with a poverty rate that exceeds the state average
- 5) The hospital is located in a county with an unemployment rate that exceeds the state average
- 6) The hospital is located in a county where the percentage of population age 65 or older exceeds the state average

³ A “Rural Health Network” is defined as an organization consisting of at least one Critical Access Hospital and at least one full-service acute care hospital where participants have developed network-related agreements.

⁴ Emergency care must include at least one physician on duty or on call at all times and available to the hospital on-site or by telephone within 20 minutes.

Office Use Only:

Activity	Date Completed	Date Planned	Not Planned
Financial Feasibility Study for CAH			
Medical Staff Planning/Education			
Hospital Board Planning/Education			
Community Planning/Education			