Form Approved
OMB No. 0938-0267

GENERAL INSTRUCTIONS FOR COMPLETING FORM CMS-359

Purpose of this form: The filing of this request for certification will initiate the process of obtaining a decision as to whether the Conditions of Participation are (continue to be) met.

Instructions: Please answer all questions as of the current date. Return the form to the State Survey 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 Survey agency may be obtained from the nearest Social Security District Office.

Question I – Identifying Information

- Insert the full name under which the CORF operates, its address and telephone number.
- Medicare/Medicaid provider number - Leave blank on all initial certifications. On all re-certifications, insert the facility's six digit provider number.
- State/County/Region code - Leave blank. The appropriate CMS Location will complete

Question II – Eligibility

- All applicants are to check block #1 (Medicaid) because CORF services are covered only under the Medicare program.
- Blocks #2 and #3 are for future use only.
- Do not enter anything for related provider number. The State Survey agency will complete this section.

Question III – Type of Control

- Check only one category.
- Check the category that is most descriptive of the type of organization operating the facility.
- Use the following as a guide:
    - **Proprietary** - For profit corporations.
    - **Non-profit church** - A church affiliated facility governed by a board of directors and financed by contributions and earnings.
    - **Non-profit other than church** - A facility which is generally governed by a community based board of directors and financed by contributions and earnings.
    - **Government** - A facility primarily administered by the State, county, city or other local unit of government.

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Question IV - Services Provided

- Blocks #1, #2 and either #3 or #4 must be completed for the facility to be eligible for participation since these are mandatory services.

- Please indicate in each block how services are provided, using the following figures:
    1. Employees
    2. Under Arrangement
    3. Independent Contractor

- These terms are defined below. **Note that more than one figure may be used for each block.**

    - **Employee** - An individual who is paid a salary per unit time of work (i.e., hourly, yearly) is covered under Social Security and Workmen's Compensation and accrues benefits (i.e., sick leave, vacation)

    - **Under Arrangement** - The facility has an agreement with an organization to use their personnel. The facility pays the organization and not the individuals providing the services.

    - **Independent Contractor** - An individual who is paid a sum of money based upon services rendered or units of time. However, the independent contractor is not covered under Social Security through the facility and does not accrue benefits. The individual generally has a contract with the facility.

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 0938-0267 (Expires 02/29/2024). This is a required to retain or obtain a benefit (please select one)] information collection. The time required to complete this information collection is estimated to average 30 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 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 Caroline Gallaher at caroline.gallaher@cms.hhs.gov.

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY REPORT FOR CERTIFICATION TO PARTICIPATE IN THE MEDICARE PROGRAM (CMS-359)

(Please read the attached instructions before completing form)

I. Identifying Information

Name Of Facility	Street Address	Medicare/Medicaid Provider Number (RD1)

City, County, State	Zip Code	Telephone No. *(Area Code)* (RD2)	State/County (RD3)	State Region (RD4)

II. Eligibility

Request To Establish Eligibility In:

☐ 1. Medicare ☐ 2. Medicaid ☐ 3. Both (RD5)

Related Provider Number (RD6)

III. Type Of Control *(Check one)*

Proprietary	**Non-Profit**	**Government**
☐	☐ Church	
	☐ Other	

(RD7)

Does your organization currently participate in Medicare as a provider of Outpatient Physical Therapy/Speech Pathology (e.g., Rehabilitation Agency)?

☐ Yes ☐ No (RD8)

If yes, list Provider No. _____ (RD9)

NOTE: More than one number may be used for each block.

1. Employees
3. Under Arrangement
3. Independent Contractor

These terms are defined in the instructions on the reverse side of this form.

☐ 1. Physical Therapy	☐ 4. Psychological Services	☐ 7. Speech Pathology
☐ 2. Physician Services	☐ 5. Occupational Therapy	☐ 8. Orthotic/Prosthetic Services
☐ 3. Social Services	☐ 6. Respiratory Therapy	☐ 9. Nurses

Blocks #1, #2, and either #3 or #4 must be completed for the facility to be eligible for participation. (RD10)

Whoever knowingly and willfully makes, or causes to be made, a false statement or representation on this statement may be prosecuted under applicable Federal or State law. In addition, knowingly and willfully failing to fully, and accurately disclose this requested information may result in denial of a request to participate, or where the entity already participates, a termination of its agreement of contract with the State agency or the Secretary as appropriate.

Signature of Authorized Official	Title	Date (RD11)