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

RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS & CRITICAL ACCESS HOSPITALS (CAHS) IN EMERGENCY CASES INVESTIGATION REPORT

1. Name of Facility	2. Street Address	
3. City and/or County	4. State	5. ZIP Code

6. CMS Certification No.	7. Name of CEO and CEO email address	8. Telephone Number
9. State/Region Code	10. State/Country Code	11. Dates of Survey _____ / _____ / __________ to _____ / _____ / __________

12. Medicare No. of Certified Beds	13. ACTS Complaint Intake No.	14. Type of Survey _____ Complaint _____ Revisit

15. SA Recommendation:

________ In Compliance - No Further Action
________ Recommend Termination (23 Day)
________ Recommend Termination (90 Day)
________ In Compliance but previously Out of Compliance (choose for self-reported allegations only)
________ Possible Discrimination - refer to OCR

For Complaint Survey: I certify that I have reviewed the requirements of 42 CFR 489.24 and the related provisions of 42 CFR 489.20 and, unless indicated otherwise on the related Form CMS 2567, the facility was found to be in compliance with the regulations.

Signature	Title	Date
Signature	Title	Date

For Revisit: For the purpose of a revisit, I certify that I have reviewed the facility's current compliance with the requirements for which they were not in compliance during the survey on ________________________________ and unless indicated otherwise on the related Form CMS 2567, the facility was found to be in compliance with those requirements.

Signature	Title	Date
Signature	Title	Date