


The Compliance Team™
Accreditation Organization
Rural Health Clinic Accreditation Contract

Legal Business Name _____

dba _____

Address _____

City _____ State _____ Zip _____ County _____

Phone # _____ Fax _____

Hours of Operation _____

Billing Address: Same as above

Address/PO Box _____

City _____ State _____ Zip _____

EIN # _____ NPI # _____

Type of Control:

1. Profit Non-Profit

2. Individual Corporation Partnership Government

If Government, please check type: State Local Federal

3. Is the RHC a provider-based entity to a hospital or critical access hospital (CAH)? Yes No

If yes, please enter the CMS Certification Number of the hospital (CAH) _____

Hospital Accreditation Organization _____

Clinic Contact Information:

Main Contact for TCT Communication _____ Title _____

Phone # _____ Email _____

Medical Director _____

Phone # _____ Email _____

Clinic Manager _____

Phone # _____ Email _____

Accounts Payable _____

Phone # _____ Fax # _____ Email _____

Consultant _____ Email _____

Consulting Firm _____

Established Clinics

Rural Health Clinics Designation Date _____ Clinic CCN # _____

Are you presently accredited? Yes No If yes, please provide a copy of the certificate.

If yes, please provide a copy of the last survey report (Statement of Deficiency with Plan of Correction).

Most recent state survey date _____

Please submit the following with this application:

855 Approval | Copy of CMS 29 | CLIA Waiver | Floor Plan | Organizational Chart | Business Associate Agreement

New Initial Clinics without CCN:

Date the 855A enrollment application was submitted _____

List address for HR files storage, if not onsite _____

Total # of Exam Rooms _____

Total # of Medical Providers _____

Which Electronic Health Records (EHR) program does this location use? _____

Number of RHC Employees:

____ Physician(s) (Salaried Only) ____ Nurses – LPN ____ Certified Medical Assistant(s)

____ Medical Assistant(s) ____ Nurses – Practitioners ____ Radiology Technician(s)

____ Nurses – Registered ____ Physician Assistant(s) ____ Medical Social Worker(s)

Other _____

Check all services provided at the facility:

Chiropractic Dental Mental Health Radiology Urgent Care Center

Is this location a Patient Centered Medical Home (PCMH)? Yes No

If yes, does your State Medicaid require Rural Health Clinics be a PCMH? Yes No

List all payers requiring PCMH designation _____

Are you an accredited PCMH? Yes No If yes, accredited by _____

PCMH Accreditation for Clinics is a separate program. Contact our office for details and pricing.

Applicant Comments _____

Exemplary Provider® Rural Health Clinic Accreditation Program Includes:

- **Safety-Honesty-Caring®**
(Service Specific Accreditation Standards)
- **Scheduled Pre-Survey Conferences**
- **Checklists for Self-Assessment Surveys**
- **On-Site Evaluation**
- **Detailed Scoring Documentation**
- **Three Year Accreditation Term**
- **Patient Outcomes Tracking & Analysis**
- **Access to National Outcomes Database**

FEES: Exemplary Provider® Accreditation Program - Rural Health Clinic

Clinics with 1-4 Exam Rooms = \$7,000.00 (Base Fee)

Clinics with 5 or more Exam Rooms:

Exam Rooms _____ - 4 = _____ x \$600.00 = \$ _____ + \$7,000.00 = \$ _____

Total Contract = \$ _____

e.g., 5 rooms -4 = 1 x \$600.00 = \$600.00 + \$7,000.00 = \$7,600.00 Total Contract \$7,600.00

Clinics with 30 or more exam rooms, call for special pricing.

40% of Total Contract payable with contract. \$ _____

The first installment is due upon execution of this Agreement. The second installment will be billed approximately six months after the initial site evaluation and due upon receipt. The third installment will be billed one year after the second installment and due upon receipt.

This application, together with the General Terms and Conditions attached hereto as EXHIBIT A, which are incorporated herein and made a part hereof, constitutes a binding contract between the applicant identified on the first page hereof (“Applicant”) and The Compliance Team™, Inc. (“TCT”). Applicant represents that all information supplied by Applicant above is true and correct in all material as of the date hereof.

Signature of Authorized Official

Title

Name

Date

Mail: The Compliance Team, Inc. PO Box 160 Spring House, PA 19477

v: 215.654.9110 | f: 215.654.1041 | Email: Accounting@TheComplianceTeam.org