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

FORM APPROVED
OMB No. 0938-0624

REQUEST FOR APPROVAL AS A HOSPITAL PROVIDER OF EXTENDED CARE SERVICES (SWING-BED) IN THE MEDICARE AND MEDICAID PROGRAMS

Pursuant to Section 1883 of the Social Security Act (the Act) and 42 CFR §482.66, Medicare Condition of Participation, Special Requirements for hospital providers of extended care services.

(*Please see attached instructions before completing this form)*

CMS REGIONAL OFFICE USE ONLY

Medicare Hosp. No.	DHH Reg Office	State Reg.		
Date of RO Receipt	Date of SA Receipt	State	County	Code

IDENTIFYING INFORMATION

Name of Facility			Street Address	
City	County	State	Zip Code	Telephone No. (include area code)
Name of Chief Executive Officer			Medicare Provider Number	

BED COUNT

See instructions on calculation of bed count (*over*) – Attach documentation

49 or fewer…… ☐
50-99 beds Agree to 5 week-day transfer requirement (b*elow*)……☐

(check one)

I certify, as an authorized official of the hospital, that the hospital has more than 49 and fewer than 100 beds, and I agree to transfer swing-bed patients within 5 weekdays (*excluding weekends and holidays*) beginning when there is an available skilled nursing facility (SNF) bed in the geographic region, unless the patient's physician certifies that transfer is not medically appropriate pursuant to Section 1883(d)(A) of the Act. I also certify that the hospital has an availability agreement with each SNF in the geographic region (*copies attached*), excluding those Medicare participating SNFs unwilling to enter into such agreements. The geographic region is defined as an area which includes the SNF's with which a hospital has traditionally arranged transfers and all other SNF's within the same proximity to the hospital. In the case of a hospital without existing transfer practices upon which to base a determination, the geographic region is an area that included all the SNF's within 50 miles of the hospital (*see reverse side*).

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST FOR APPROVAL OR, WHERE THE ENTITY IS ALREADY APPROVED, A TERMINATION OF ITS APPROVAL.

Signature of Authorized Official (*sign in ink*)	Date

FORM HCFA-605 (4/93)

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