

Facility:

Date:

Surveyor:

## Survey Packet Checklist

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Purpose: Surveyors may use this optional checklist of applicable forms and documents that are included in a survey packet with the report after the exit conference.

Directions: Check off applicable items as you verify their inclusion in the packet.

**Table 1. Survey Types**

<input checked="" type="checkbox"/>	All Survey Types
<input type="checkbox"/>	Client and/or Patient Identifier
<input type="checkbox"/>	Staff Identifier (if used in Form CMS-2567)
<input type="checkbox"/>	Federal Survey report (Form CMS-2567)
<input type="checkbox"/>	Survey Team Composition and Workload Report (Form CMS-670)
<input type="checkbox"/>	Certification and Transmittal (C&T) (Form CMS-1539) <ul style="list-style-type: none"><li>• If no deficiencies are cited, use the A code.</li><li>• If Conditions of Participation (CoPs) or Conditions for Coverage (CfCs) are not met, use the B code.</li><li>• If standard-level deficiencies are cited, the C&amp;T is generated after an acceptable Plan of Correction (POC) has been received.</li></ul>
<input type="checkbox"/>	POC accepted by the Team
<input type="checkbox"/>	Post Certification Revisit Report (Form CMS-2567B) <ul style="list-style-type: none"><li>• For follow-ups only</li></ul>

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**Table 2. Complaints**

<input checked="" type="checkbox"/>	Complaints
<input type="checkbox"/>	Complaint Intake Form and Complaint Findings
<input type="checkbox"/>	Form CMS-2802 for Deemed Facilities
	Note: If multiple complaints are completed at the same time, only one Client Identifier List, Form CMS-2567, and Form CMS-670 need to be completed. If these are not included in this packet, please indicate the complaint file number where these items can be found.

**Table 3. Ambulatory Surgical Center (ASC)**

	Ambulatory Surgical Center (ASC)
<input type="checkbox"/>	CMS-377: ASC Request for Certification in the Medicare Program
<input type="checkbox"/>	Infection Control Worksheet

**Table 4. End Stage Renal Disease**

<input checked="" type="checkbox"/>	End Stage Renal Disease (ERSD)
<input type="checkbox"/>	Form CMS-3427: ESRD Application/Notification and Survey & Certification Report

**Table 5. Hospice**

<input checked="" type="checkbox"/>	Hospice
<input type="checkbox"/>	Form CMS-643: Hospice Survey & Deficiencies Report
<input type="checkbox"/>	Form CMS-417: Hospice Request for Certification in the Medicare Program

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**Table 6. Hospital/Critical Access Hospital**

<input checked="" type="checkbox"/>	Hospital/Critical Access Hospital (CAH)
<input type="checkbox"/>	Exhibit 286: Hospital/CAH Database Worksheet
<input type="checkbox"/>	Form CMS-437: Psychiatric Unit Criteria Worksheet (if applicable)
<input type="checkbox"/>	Form CMS-437A: Rehabilitation Unit Criteria Worksheet (if applicable)
<input type="checkbox"/>	State Survey Report (2567 State Form)

(State Operations Manual 2014)