

APPENDIX B: AHCA Application for Hospital Emergency Service Exemption



APPLICATION FOR HOSPITAL EMERGENCY SERVICE EXEMPTION

INSTRUCTIONS

1. Type or print in ink.
2. Attach additional pages if necessary.
3. Complete all sections.
4. Sign and date the form. (If an incomplete form is submitted, the exemption request will be denied.)
5. Mail completed form and all supporting documentation to:

Agency for Health Care Administration
Hospital & Outpatient Services Unit
2727 Mahan Drive, Mail Stop #31
Tallahassee, FL 32308

SECTION I

1. For each service exemption requested, a separate application must be submitted.
2. An exemption request must be submitted for every service that you propose to provide on a part-time basis, and are unable to provide either directly or indirectly through arrangement with another hospital or physician, on a 24 hour per day, 7 day per week basis.

SECTION II

1. List all professionals at your hospital that are credentialed to perform the service for which you are requesting an exemption.
2. For each professional listed, include the full name, license number, specialty type, credentials and the privileges held at the hospital.
3. Attach a copy of the hospital bylaws concerning medical staff privileges.

SECTION III

1. Provide the number of patients presenting at the emergency department and receiving services at your hospital for the past 12 months, related to the exemption request.
2. Provide the number of patients presenting at your hospital's emergency department and transferred to another facility to receive services for the past 12 months, related to the exemption request.
3. Provide the number of patients diverted to other hospitals for emergency treatment for the past 12 months, related to the exemption request.
4. Provide the number of patients receiving services on an inpatient basis for the past 12 months, related to the exemption request.
5. Provide a projection of the number of emergency procedures related to the exemption request to be performed in your hospital's emergency department for the upcoming 12 months.

SECTION IV

1. List all hospitals within 50 miles that have the capability to provide the service on a 24 hour per day, 7 day per week basis, related to the exemption request.
2. Include the name of each hospital and the distance in miles it is located from your hospital.

SECTION V

1. Document all attempts made by your hospital to enter into agreements with other hospitals or physicians to provide the service on a 24 hour per day, 7 day per week basis. Attach copies of all documentation to support your initiatives. Document all efforts that have taken place in the past 12 months to recruit additional physicians. Include all other information that you feel is pertinent to why your hospital cannot provide the service 24 hours per day, 7 days per week.

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**APPLICATION FOR HOSPITAL
EMERGENCY SERVICE EXEMPTION**

Name of Facility	Name of Facility Owner / Licensee
Authorized Representative/Contact Person	Address
Mailing Address	Mailing Address
City, State and Zip Code	City, State and Zip Code
Telephone ()	Telephone ()
<p>I. SERVICE CATEGORY FOR WHICH EXEMPTION IS REQUESTED (NOTE: A SEPARATE APPLICATION IS REQUIRED FOR EACH SERVICE CATEGORY)</p>	
<p>II. PROFESSIONALS CREDENTIALLED TO PROVIDE THE SERVICE (INCLUDE NAME, LICENSE NUMBER, SPECIALTY TYPE, CREDENTIALS, AND PRIVILEGES) (ATTACH A COPY OF THE HOSPITAL BYLAWS CONCERNING MEDICAL STAFF PRIVILEGES).</p>	

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EMERGENCY SERVICE EXEMPTION CONTINUED – PAGE 3	
V. (CONTINUED FROM PAGE 2)	
<p>SIGNATURE OF AFFIRMATION</p> <p>I, _____ HEREBY AFFIRM THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT ANY FALSE STATEMENTS ARE SUBJECT TO PUNISHMENT PURSUANT TO S. 837.06, F.S.</p>	
<p>_____ SIGNATURE OF CHIEF EXECUTIVE OFFICER</p>	<p>_____ DATE</p>

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