



AAAASF ACCREDITATION APPLICATION

Application will not be processed if failed to complete in its entirety

Date: _____	
Type of Accreditation (check one only): <input type="checkbox"/> Surgical <input type="checkbox"/> Procedural <input type="checkbox"/> Medicare <input type="checkbox"/> Oral & Maxillofacial	Facility Class (check one only): <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C-M <input type="checkbox"/> C
Specialty Information (to be determined by the Facility/Medical Director)	
Please list primary specialty, if more than one, add secondary specialty. List all specialties as stated on board certification.	
Primary: _____	
Secondary: _____	
Legal Business Name (not DBA name): _____	
Facility/Medical Director: _____	
Facility/Medical Director E-mail address: _____	
Name of office manager/head nurse: _____	
Previously accredited or denied accreditation by any accrediting organization <input type="checkbox"/> No <input type="checkbox"/> Previously Accredited <input type="checkbox"/> Denied Name of Accrediting Organization: _____	
Please Note: <ul style="list-style-type: none"> • Previous denial by AAAASF or another accreditation agency does not preclude application for accreditation. Any facility may reapply for accreditation at any time following receipt of a denial notification • Failure to disclose previous accreditation, denial or revocation thereof may result in denial or loss of AAAASF Accreditation 	
Alternate Facility Name (if applicable): _____	Type of Alternate Facility Name: <input type="checkbox"/> Doing Business As Name <input type="checkbox"/> Other (Specify): _____
Identify the type of organizational structure (Check one): <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Business Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> General Partnership <input type="checkbox"/> Registered Limited Liability Partnership <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Professional Limited Liability Company <input type="checkbox"/> University Faculty Practice Corporation (501(c)(3), not-for-profit) <input type="checkbox"/> Other (Please Specify): _____	
Is the facility entirely physician owned (specify percentage that each physician owns): <input type="checkbox"/> Yes <input type="checkbox"/> No	Please Note: Changes in facility ownership must be reported to the AAAASF Office within thirty (30) days.

Name(s) of facility owner(s), controlling stockholder and/or beneficial ownership	
Name: _____	Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Telephone #: _____	Telephone #: _____
License Number: _____	License Number: _____
Percent of Business Owned: %	Percent of Business Owned: %
Name: _____	Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Telephone #: _____	Telephone #: _____
License Number: _____	License Number: _____
Percent of Business Owned: %	Percent of Business Owned: %

Facility State License Information:		License Not Applicable <input type="checkbox"/>	
License Number:		State Where Issued:	
Effective Date (mm/dd/yyyy):		Expiration/Renewal Date (mm/dd/yyyy):	

Facility Location Information:			
Address Line 1:			
Address Line 2:			
City/Town:		State:	Zip:
Telephone Number:		Fax Number:	
Website Address:		E-mail Address:	

Contact Person -We will contact this person if questions arise during the processing of this application:			
Contact Name:		E-mail Address:	
Telephone Number:		Fax Number:	

Physician/Surgeon Name: Medical Specialty: (as stated by board certification) **State License Number:**

1.		
Email address:		
2.		
Email address:		
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Email address:		
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Email address:		
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Email address:		
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Email address:		
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Email address:		
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Email address:		
10.		
Email address:		

Additionally, please submit the following documentation along with the completed application either by mail or fax to:

AAAASF Office
7500 Grand Ave, Suite 200
Gurnee, IL 60031
Or
Fax: 847-775-1985

- A floor plan of the facility (does not need to be to scale and must clearly identify each room purpose and dimensions)
- Copy of each physician/surgeon State Medical License
- Copy of each physician/surgeon Board Certificate or letter of admissibility by the certifying board
- Hospital appointment (or reappointment) letter
- Copy of each physician/surgeon delineation of Hospital Privileges (approved list of procedures from the hospital)
- Copy of Certificate of Incorporation (Required for applicants in the State of New York only)
- Proof that the 855B form has been processed by the carrier (Required for Medicare applicants only)
- Equipment List (**Required for Medicare applicants only**)

The following forms also need to be completed.

- Completed HIPAA Business Agreement signed by Medical Director
- Six completed Random Case Peer Review forms - If this facility is not able to perform cases until accredited you will not be required to submit these cases until after a New Facility Survey is completed at which time you will have six months to complete the process.
- Authorization to Release Form completed and signed by each physician/surgeon
- Facility Identification Form signed by Medical Director
- Staff Identification Form
- Facility Director's Attestation signed by Medical Director
- New York OBS Addendum (NEW YORK OBS ONLY)

Please take a moment to answer the following marketing survey:	
How did you become aware of our accreditation program?	
Name a publication or website from which you receive work-related medical information.	
What was the deciding factor in choosing our accreditation program?	
<input type="checkbox"/> <input type="checkbox"/>	
Are you the person responsible for selecting AAAASF for accreditation? Yes No	
If no, please list here the responsible person's name, title and email address.	

ANNUAL FEES FOR ACCREDITATION
Regular, Procedural or Oral & Maxillofacial

Survey Fees for Accreditation
Regular, Procedural, or Oral & Maxillofacial Surgery

Number of physicians in staff	Total number of specialties	Class A	Classes B, C-M, C
1-2	Up to 2	\$790	\$1160
3-5	Up to 2	\$1100	\$1610
3-5	3 or more	\$1380	\$1890
6-9	Up to 2	\$3490	\$4210
6-9	3 or more	\$3760	\$4480
10 plus	Up to 2	\$4910	\$6200
10 plus	3 or more	\$5180	\$7050
Annual fee is based on the total number of physicians, total number of specialties of the physicians and facility class.			
Annual fee and survey fees are subject to change.			

\$2,100 Full Survey Fee for any size facility or any class.
 \$775 Start-up Survey Fee. A one-time additional fee for new facilities located in applicable states, where cases have not yet been conducted under the applied for anesthesia class. This is required if the facility is in a state that mandates accreditation and is not able to do cases until accredited. Facilities located in California, New York, Florida, Indiana, Nevada, Ohio, Texas, and Washington may be subject to this fee. This list is not intended to be exhaustive and the Startup Survey Fee may apply in other states as regulations evolve.
 Facilities may request in writing an expedite survey for an additional \$500. All credentials must be submitted and processed prior to survey. Talk with your accreditation specialist for details.

Regular Program Annual Fee (see schedule above): \$ _____ + \$2,100 Full Survey Fee + Start-up Survey (if applicable): \$775 = Total amount of payment: \$ _____

ANNUAL FEES FOR MEDICARE ACCREDITATION
Ambulatory Surgery Centers

Survey Fees for Medicare ASC Accreditation

Number of physicians in staff	Total number of specialties	Facility Class A, B, C-M, C	Facility Size
1-2	Up to 2	\$1800	Small
3-5	Up to 2	\$2250	Small
3-5	3 or more	\$2530	Small
6-9	Up to 2	\$4830	Medium
6-9	3 or more	\$5100	Medium
10 plus	Up to 2	\$6810	Large
10 plus	3 or more	\$7670	Large
Annual fee based on the total number of physicians, total number of specialties of the physicians and facility class.			
Facilities may not request an expedited survey. Surveys are unannounced.			
Annual fee and survey fees are subject to change.			

\$3,300 Full Survey Fee for small size facilities
 \$4,300 Full Survey Fee for medium size facilities
 \$4,800 Full Survey Fee for large size facilities
 and
 \$2,850 Life and Safety Code Survey Fee is required for all ASC facilities.
 \$775 Start-up Survey Fee. A one-time additional fee for new facilities located in applicable states, where cases have not yet been conducted under the applied for anesthesia class. This is required if the facility is in a state that mandates accreditation and is not able to do cases until accredited. Facilities located in California, New York, Florida, Indiana, Nevada, Ohio, Texas, and Washington may be subject to this fee. This list is not intended to be exhaustive and the Startup Survey Fee may apply in other states as regulations evolve. State ASC licensing laws may also impact the applicability of this fee.
 The Life Safety Code fee is also applicable every third year when the facility is due for re-survey.

Medicare ASC Annual Fee (see schedule above): \$ _____ + \$ _____ Full Survey Fee (see list above) + \$2,850 Life and Safety Code Survey Fee + Start-up Survey (if applicable): \$775 = Total amount of payment: \$ _____

Payment by credit card

You may submit your application via email to reception@aaaasf.org or via fax to 847-775-1985. If you prefer, you may pay with a credit card over the phone by calling the accounting department directly at 888-545-5222.

Check type of credit card: Visa MasterCard American Express

Name on card: _____ Card #: _____

Billing zip code: _____ Three-digit code: _____ Exp. Date: _____ Signature: _____

OR

Payment by check

Submit completed application with supporting documentation and check made out to AAAASF.

AAAASF Office
 7500 Grand Ave, Suite 200
 Gurnee, IL 60031

Fee and refund policy:

The first-year accreditation annual fee plus initial survey fee is due with each accreditation application. Additional fees will apply if special survey requests are made or for those facilities located outside the continental USA. After an application has been submitted and processed, AAAASF will refund 50% of the annual fee and 100% of the survey fee if the facility has not been surveyed. If the facility was surveyed, only 50% of the annual fee will be refunded. If the accreditation process is not completed within one year of the received date, a new application and appropriate fee is required. No refunds will be issued if the application expires. Upon receiving accreditation and once an anniversary date is established, the facility will be invoiced 6 months prior to the anniversary date. Fees must be paid by the due date on the invoice for the accreditation process to begin. Otherwise, late fees will be applied and other penalties will follow.