AAAASF ACCREDITATION APPLICATION

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

Date:

Type of Accreditation (check one only):	Facility Class (check one only):
☐ Surgical ☐ Procedural ☐ Medicare ☐ Oral & Maxillofacial	☐ A ☐ B ☐ C-M ☐ 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

☐ No ☐ Previously Accredited ☐ Denied Name of Accrediting Organization:

Please Note:

- 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:
	☐ Doing Business As Name ☐ Other (Specify):

Identify the type of organizational structure (Check one):

☐ Sole Proprietor ☐ Business Corporation ☐ Limited Liability Company ☐ General Partnership

☐ Registered Limited Liability Partnership ☐ Professional Corporation ☐ Professional Limited Liability Company

☐ University Faculty Practice Corporation (501(c)(3), not-for-profit) ☐ Other (Please Specify):

Is the facility entirely physician owned (specify percentage that each physician owns):	Please Note: Changes in facility ownership must be reported to the AAAASF Office within thirty (30) days.
☐ Yes ☐ No	

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: %

Revised January 15, 2019: Effective January 15, 2019

Facility State License Information: License Not Applicable ☐		
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:		
3.		
Email address:		
4.		
Email address:		
5.		
Email address:		
6.		
Email address:		
7.		
Email address:		
8.		
Email address:		
9.		
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
- Completed Anesthesia Validation Form
- Facility Identification Form signed by Medical Director
- Staff Identification Form
- Medical 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?
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			
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.			

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

$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			
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.			

Survey Fees for Medicare ASC Accreditation
$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 Startup 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.