

**AAAASF Accreditation Application**

AAAASF will not process incomplete applications or applications without payment. They will be returned to
the facility for completion.

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| Date: |
| Accreditation program: X Pediatric Dentistry | Facility Class (check one only):\_\_ 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 specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Legal business name of facility (not DBA name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Facility/Medical Director name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Facility/Medical Director email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office manager/head nurse name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_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.
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| Alternate Facility Name (if applicable): | Type of Alternate Facility Name:\_\_ Doing Business As (DBA) 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/dentist owned? Specify the percentage that each physician/dentist owns below. \_\_ Yes \_\_ No | Please note: Changes in facility ownership must be reported to the AAAASF office within 30 days. |

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| List name(s) of facility owner(s), controlling stockholder(s), or beneficial ownership. Percentages listed must equal 100%. |
| 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 |
| 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: | Email Address: |
| **Facility Contact:** (We will contact this person if questions arise during the processing of this application.) |
| Contact Name: | Email Address: |
| Telephone Number: | Fax Number: |

**Physician/Dentist Name: Board Certification:** **State License Number:**

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| **1.** |  |  |
| Email address: |
| **2.** |  |  |
| Email address: |
| **3.** |  |  |
| Email address: |
| **4.** |  |  |
| Email address: |
| **5.** |  |  |
| Email address: |
| **6.** |  |  |
| Email address: |
| **7.** |  |  |
| Email address: |

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| **8.** |  |  |
| Email address: |
| **9.** |  |  |
| Email address: |
| **10.** |  |  |
| Email address: |

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

**AAAASF**

**7500 Grand Ave, Suite 200**

**Gurnee, IL 60031**

**Info@aaaasf.org**

**Fax: 847-775-1985**

* A floor plan or diagram of the facility clearly labeling rooms including Dental Room, Prep area, Clean area, Dirty area, etc. (does not need to be to scale and must clearly identify each room purpose and dimensions)
* Copy of each physician/dentist’s State Medical License
* Copy of each physician/dentist’s Board Certificate or letter of admissibility by the certifying board
* Copy of each physician/surgeon’s delineation of Hospital Privileges along with Hospital appointment (or reappointment) letter.
If the Pediatric Dentist has never held privileges, or no longer holds privileges, AAAASF will accept alternate credentialing via primary source verification. (See Standard 1200.30.50)

# 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
	+ Facility Director’s Attestation signed by Medical Director.

**Survey Fees for Pediatric Dentistry Accreditation**

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| **Annual Fees for Accreditation Pediatric Dentistry** |
| Number of dentists on staff | ClassA | ClassesB, C-M, C |
| 1-2 | $869 | $1,276 |
| 3-5 | $1,210 | $1,771 |
| 6-9 | $3,839 | $4,631 |
| 10 plus | $5,401 | $6,820 |
| **Survey Fees** |
| $2,310 Survey Fee for any size facility or any class.Annual fee and survey fees are subject to change. |

Facilities may request an expedited survey for an additional $550 (ask for details). All credentials must be submitted and processed prior to survey.

Annual Fee (see schedule above): $ + $2,310 Survey Fee = Total amount of payment: $

**Payment and Billing**

AAAASF will not process applications without payment. Provide your billing contact below for any questions regarding your facility’s payment.

Billing Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Payment by credit card

You may submit your application via email to info@aaaasf.org or if you prefer, you may pay with a credit card over the phone. A member of our accounting department will contact you at the number above. If the billing contact is not reached by the end of the day, this application will be destroyed and will have to be resubmitted. Applications will not be held for more than 24 hours.

If the credit card is declined, a member of the accounting department will call the billing contact for an alternate credit card. If billing contact cannot be reached by the end of the day, this application will be destroyed, and it will have to be resubmitted. Applications will not be held for more than 24 hours.

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| --- | --- | --- | --- | --- |
| Credit card type: | Visa | MasterCard | American Express | Discover |
| Name on card: |  |  | Card #: |  |

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

# Payment by check:

Submit completed application with supporting documentation and check made out to:

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

***Fee and refund policy:***

*The first-year accreditation annual fee plus the 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.*

*If the facility withdraws its application after it 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 would be refunded. No refunds are issued after the facility is fully accredited.*

*If the facility has not confirmed a survey date within 12 months of the date of application submission, a new application and appropriate fees are required.*

*In the event that a survey date is confirmed prior to the 12-month timeframe but will occur beyond that timeframe (the confirmed survey date cannot be beyond three months after expiration) the survey cannot be postponed, rescheduled, or cancelled. If such occurs, the facility must re-apply for accreditation and re-submit the survey and annual fee. No refunds will be issued if the application expires.*

*Once an anniversary date is established upon achieving accreditation, the facility will be invoiced six months prior to the annual anniversary date. If a facility does not pay its fees by the due date on the invoice, late fees will be applied, and other penalties will follow. If the facility’s accreditation is revoked or terminated for any reason, no fees will be refunded.*