

# Heartland Kidney Network – New Facility Contact Form

**WELCOME!** As a new facility, you are now part of Heartland Kidney Network. We ask that you take a few minutes to provide contact information for key positions at your facility.

Thank you for your time and we look forward to serving as a resource for your unit soon.

**Please Print All Entries.** This form requires the signature of the Unit Administrator or Medical Director for validation. Include your provider number at the bottom of each page to ensure changes are made to the appropriate unit. Return both pages to the Network office via **fax (816) 880-1775**

**Facility Name:** \_\_\_\_\_ **NPI#** \_\_\_\_\_

**Provider #:** \_\_\_\_\_ (if different from Physical Address)

Physical Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_

Facility Email: \_\_\_\_\_

## Facility Name and Address Change Requests:

Please be advised that the Network **can only change** a facility's name or physical address after receipt of Medicare's current Letter of Certification. If you have an updated Letter of Certification form from Medicare at your unit, please mail or fax a copy to the Network so that we can update our records and ensure mail is sent to the appropriate address and facility name.

## Facility Disaster Coordinator Information – Mandatory

The position "*Data Committee*" is used to designate the "*Facility Disaster Coordinator*" required by CMS. You must list a Primary and Backup person and supply a home phone number and cell number if available. This will help the Network to facilitate emergency communications during a disaster.

Primary Name: \_\_\_\_\_ Position (Job Description): Data Committee

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Backup Name: \_\_\_\_\_ Position (Job Description): Data Committee

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Shift Information:

Please supply the following shift information in 24 hour format time.

|  |  |
|--|--|
|  | Number of Monday/Wednesday/Friday Shifts   |
|  | Monday/Wednesday/Friday Open Time          |
|  | Monday/Wednesday/Friday Close Time         |
|  | Number of Tuesday/Thursday/Saturday Shifts |
|  | Tuesday/Thursday/Saturday Open Time        |
|  | Tuesday/Thursday/Saturday Closed Time      |

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## Clarifying Instructions: List ONLY staff who work at THIS facility on this form.

- **Staff Changes:** In an effort to keep this facility's staff up to date in our database, please complete all requested changes and return both pages of this form to the Network via **fax (816) 880-1775**
- **Email Addresses:** Please include email addresses so that we may take advantage of technology and improve communications between the Network and the ESRD facilities.
- **Special Addresses** and phone numbers are **only** accepted for the following positions and **only** if that individual holds the **same position at more than one facility:**
  - 1) Unit Administrator    2) Medical Director    3) Roster Recipient
  - 4) 2728 Contact    5) 2746 Contact    6) 2744 Facility Survey Contact
  - **For your convenience, special address space** is provided on this form to request the preferred mailing address on behalf of these select staff members. This information is not required. If one of the select positions, indicated above, has a contact address different from the facility, including suite numbers and different buildings on a university campus, please list the address to ensure they receive important mail on a timely basis.
  - **Multiple Locations - Examples:** 1) The Roster contact may handle rosters for multiple facilities, but prefers to have all mail sent to one facility or to an off-site location; 2) The Medical Directors may prefer to receive mail at their office address rather than the unit address.

If you have additional questions regarding completion of the Facility Contact Change Form, please contact Serena at the Network office via **phone at (816) 880-1707** or via **email at [stimko@nw12.esrd.net](mailto:stimko@nw12.esrd.net)** .

I certify the information provided on this contact change form is current and correct for the facility.

First & Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Indicate Your Position at this Facility: (please check the line)    \_\_\_\_\_ Unit Administrator    \_\_\_\_\_ Medical Director

Fax this completed all pages of this form to Heartland Kidney Network - (816) 880-1775

## Would you consider joining our email list?

Heartland Kidney Network has a subscription email service where you can subscribe or unsubscribe at any time to received timely communications from the Network such as our monthly e-Newsletter. If you or your staff is interested you can click on the link below for more information:

<http://www.heartlandkidney.org/administration/communications.html>

# Heartland Kidney Network – New Facility Contact Form

Add Facility Contact Information for your unit:

## Section A: Contact Position

Please add the following contact(s) for staff position(s): (Circle the corresponding position and complete)

\*\*To add additional staff members, please copy this page and send it in addition to the original two-page form.

**Contact Change #1:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #2:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #3:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #4:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #5:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #6:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #7:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #8:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #9:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #10:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #11:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

**Contact Change #12:** FACREP FACALT NEPH HDNUR SW DIET TECH QI REGDIR REGVP

First & Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

# Heartland Kidney Network – New Facility Contact Form

## Section B: Special Contact Address

Please add the following special contact (s) for staff position(s): (Circle the corresponding position and complete)  
\*\*To add additional staff members, please copy this page and send it in addition to the original two-page form.

**\*Only one Contact Name and Information per position**

### Special Contact Address #1:

**ADMIN      MEDDIR      2728      2746      2744      ROST**

First & Last Name: \_\_\_\_\_      Credentials: \_\_\_\_\_  
Title: \_\_\_\_\_      Email: \_\_\_\_\_  
Special Mailing Address: (if different from either facility address) \_\_\_\_\_  
Business Name: (if different than facility name) \_\_\_\_\_  
Address1: \_\_\_\_\_  
Address2: \_\_\_\_\_  
City: \_\_\_\_\_      State: \_\_\_\_\_      Zip: \_\_\_\_\_  
Phone: (    ) -      Fax: (    ) -      Email: \_\_\_\_\_

### Special Contact Address #2:

**ADMIN      MEDDIR      2728      2746      2744      ROST**

First & Last Name: \_\_\_\_\_      Credentials: \_\_\_\_\_  
Title: \_\_\_\_\_      Email: \_\_\_\_\_  
Special Mailing Address: (if different from either facility address) \_\_\_\_\_  
Business Name: (if different than facility name) \_\_\_\_\_  
Address1: \_\_\_\_\_  
Address2: \_\_\_\_\_  
City: \_\_\_\_\_      State: \_\_\_\_\_      Zip: \_\_\_\_\_  
Phone: (    ) -      Fax: (    ) -      Email: \_\_\_\_\_

### Special Contact Address #3:

**ADMIN      MEDDIR      2728      2746      2744      ROST**

First & Last Name: \_\_\_\_\_      Credentials: \_\_\_\_\_  
Title: \_\_\_\_\_      Email: \_\_\_\_\_  
Special Mailing Address: (if different from either facility address) \_\_\_\_\_  
Business Name: (if different than facility name) \_\_\_\_\_  
Address1: \_\_\_\_\_  
Address2: \_\_\_\_\_  
City: \_\_\_\_\_      State: \_\_\_\_\_      Zip: \_\_\_\_\_  
Phone: (    ) -      Fax: (    ) -      Email: \_\_\_\_\_

### Special Contact Address #4:

**ADMIN      MEDDIR      2728      2746      2744      ROST**

First & Last Name: \_\_\_\_\_      Credentials: \_\_\_\_\_  
Title: \_\_\_\_\_      Email: \_\_\_\_\_  
Special Mailing Address: (if different from either facility address) \_\_\_\_\_  
Business Name: (if different than facility name) \_\_\_\_\_  
Address1: \_\_\_\_\_  
Address2: \_\_\_\_\_  
City: \_\_\_\_\_      State: \_\_\_\_\_      Zip: \_\_\_\_\_  
Phone: (    ) -      Fax: (    ) -      Email: \_\_\_\_\_

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## Special Contact Address #5:

**ADMIN      MEDDIR      2728      2746      2744      ROST**

First & Last Name: \_\_\_\_\_ Credentials: \_\_\_\_\_  
Title: \_\_\_\_\_ Email: \_\_\_\_\_  
Special Mailing Address: (if different from either facility address) \_\_\_\_\_  
Business Name: (if different than facility name) \_\_\_\_\_  
Address1: \_\_\_\_\_  
Address2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (    ) -                      Fax: (    ) -                      Email: \_\_\_\_\_

## Special Contact Address #6:

**ADMIN      MEDDIR      2728      2746      2744      ROST**

First & Last Name: \_\_\_\_\_ Credentials: \_\_\_\_\_  
Title: \_\_\_\_\_ Email: \_\_\_\_\_  
Special Mailing Address: (if different from either facility address) \_\_\_\_\_  
Business Name: (if different than facility name) \_\_\_\_\_  
Address1: \_\_\_\_\_  
Address2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (    ) -                      Fax: (    ) -                      Email: \_\_\_\_\_

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## KEY TERMS & DEFINITIONS

**Letter of Certification:** This letter is provided by Centers for Medicaid and Medicare Services (CMS) through the state agency or the Division of Health and Human Services documenting that a facility is an approved provider through the ESRD System. This document contains the provider number, approved name, and address of the dialysis facility.

### Section A: Contact Position Definitions (no special addresses)

- DATACOM** (Data Committee) “Facility Disaster Coordinator. The person(s) whom the network will call during a disaster. CMS mandates a primary and backup contact including home and/or cell numbers in case the facility is inoperable during a disaster.”
- FACREP** (Facility Representative) “Voting member of the Network Coordinating Council”  
One per Facility
- FACALT** (Facility Alternate) “Alternate facility representative to the Network Coordinating Council”  
One per Facility
- NEPH** (Nephrologist) “Nephrologist that consider this facility their Home Unit with dialysis privileges”  
\*\*VISION Facility’s should indicate all Nephrologists at their Unit
- HDNUR** (Head Nurse) “Nurse responsible for nursing services”
- SW** (Social Worker)
- DIET** (Dietitian)
- TECH** (Chief Technician) “Person responsible for the water system and/or machine maintenance”
- QI** (Quality Improvement Coordinator) “Person responsible for coordinating quality improvement projects”
- REGDIR** (Regional or Area Manager/Director or Hospital Administrator) “Person who oversees the Unit Administrator.”
- REGVP** (Regional Vice President or Hospital Vice President)  
“Person who oversees the Regional or Area Manager/Director or Hospital Administrator.”

### Section B: Special Contact Address Definitions

The only six positions that may request a Special Address are: Unit Administrator; Medical Director; Roster Recipient; 2728 Contact; 2746 Contact; 2744 Facility Survey Contact

#### **\*\*ONLY ONE CONTACT PER FACILITY**

- ADMIN** (Unit Administrator) “Person meeting the regulation defining Chief Executive Officer”
- MEDDIR** (Medical Director) “Person responsible for patient care and other responsibilities defined by regulation”
- 2728** (2728 Contact) “Person responsible for filing the 2728 forms”
- 2746** (2746 Contact) “Person responsible for filing the 2746 forms”
- 2744** (Facility Survey Contact) “Person responsible for completing & returning the annual facility survey”
- ROST** (Monthly Roster Contact) “Person responsible for completing & returning the monthly patient report”