



## Facility Membership Application

**Facility Membership** — As provided in the ESRD Federal Regulations, Section 405.2134, the facility agrees to: (1) Provide representation to the Council; (2) Participate in the activities of the Council; (3) Provide data to the Council and the Medical Review Board; (4) Participate in Medical Review Board Studies; and (5) Pursue Council Goals.

Although it is understood that while membership in the Southern California Renal Disease Council, Inc. is voluntary, participation in Council activities is a condition for Medicare approval of and reimbursement for the provision of ESRD services.

**Instructions:** Please complete this Facility Membership Application and return via mail or fax to Network 18 at (323) 962-2891. Should you have any questions, please contact Network 18 at (323) 962-2020.

### **Facility Information** (Please print clearly)

Legal Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: CA Zip Code: \_\_\_\_\_

Facility Phone: \_\_\_\_\_ Facility Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

### **Facility Status**

→ Is the facility currently dialyzing patients?  YES or  NO

→ If YES, have you received the CMS Medicare letter:  YES or  NO

**(If yes, Fax letter with this form to (323) 962-2891.) (If no, immediately fax upon receipt)**

→ If NO, is your facility currently under construction:  YES or  NO

→ If YES, approximate construction completion date: \_\_\_\_\_

→ If NO, is your facility awaiting DHS Inspection:  YES or  NO

→ If YES, approximate inspection date: \_\_\_\_\_

→ If NO, explain: \_\_\_\_\_

### **If facility is not open to receive mail or faxes, please provide another address below:**

Attn: \_\_\_\_\_

C/O Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_