



# Urgent Care Center Certification Renewal

Use this page as a cover sheet when submitting application | To be completed by an Authorized Representative of the submitting center

**Please check the limited scope of service you are applying for:**

Traditional:  Rural:  Pediatric:  Seasonal:  Pediatric After Hours:  Orthopedic:

**Refer to the following link for eligibility details:**

[http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/certification/2018\\_Types\\_of\\_Certification.pdf](http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/certification/2018_Types_of_Certification.pdf)

## Contact Information

Facility Name \_\_\_\_\_

Facility Address \_\_\_\_\_

Facility Phone Number (\_\_\_\_\_) \_\_\_\_\_

Facility Website \_\_\_\_\_

Facility Owner \_\_\_\_\_

Owner Phone Number (\_\_\_\_\_) \_\_\_\_\_ Owner Email \_\_\_\_\_

Primary Contact Person \_\_\_\_\_

Primary Title \_\_\_\_\_

Primary Email \_\_\_\_\_

Printed Name of Medical Director \_\_\_\_\_

Please check the box if a 3<sup>rd</sup> Party/Consultant/Management Service will be utilized.

**List the Address that the Certificate can be sent to (if different from Facility Address):**

\_\_\_\_\_

## Select Appropriate Category (choose only one)

CATEGORY 1 - MD's or DO's on-site during all hours of operation

CATEGORY 2 - MD's or DO's or NP's or PA's on-site during all hours of operation

## Renewal Certification Application Fees

APPLICATION FEE PER SITE

CLINIC MEMBERS \$349

NON-MEMBERS \$649

## Owner and or Medical Director Initials Required

As the Owner and or Medical Director of this facility, I hereby attest that licenses for all providers at this center have been reviewed and these providers obtain active, unrestricted licenses to practice in the state where this facility is located as of this date.

Initial Here  
Owner

Initial Here  
Medical Director

As the Owner and or Medical Director of this facility, I hereby attest that I have read and this facility agrees to abide by the [Criteria](#) and [Code of Ethics for Certified Urgent Care Centers](#) for the duration of our Certification Term.

Initial Here  
Owner

Initial Here  
Medical Director

# Renewal Certification Application Fees

## APPLICATION FEE PER SITE

**CLINIC MEMBERS ..... \$349**

**NON-MEMBERS ..... \$649**

Fees are paid at application and at three-year renewals. There are no annual fees. **A UCAOA clinic membership is required for the duration of certification to receive the member rate of \$349**, additional fees will apply if membership is not maintained and revocation of certification for unpaid fees.

Applications with incomplete, expired, or incorrect supporting documentation will be returned in full to the applying center so that the application may be correctly re-submitted at a later date. Application fees will not be refunded, and original application deadlines will still apply.

Please review all of your materials carefully prior to submitting. All materials will be kept confidential except if required by law or court proceedings.



Initial Here to acknowledge that you have read and understand pricing structure.

## Other Terms

In consideration of UCAOA's willingness to review this application, applicant agrees to the following provisions:

### INTERPRETATION

UCAOA, as a private not-for-profit organization, reserves sole discretion to interpret and apply the criteria, modify the criteria, and develop and apply additional criteria, from time to time without prior notice.

### DISCLAIMER AND LIMITATIONS OF LIABILITY

UCAOA is providing no assurances that the CUC designation will lead to increased revenues or profits and shall have no liability if increases do not occur or for any other claim or occurrence arising out of applicant's application or the CUC certification program. If applicant is dissatisfied with the program, applicant's sole remedy shall be to decide not to renew or expand its participation. In any event, applicant waives and agrees not to assert any claims against UCAOA (or its officers or directors), based on the CUC certification program or any decision not to grant certification. Without limiting the generality of the foregoing provisions, applicant waives and agrees not to assert any claim that any certification denial violates any federal or state antitrust or restraint of trade laws. IN ANY EVENT, UCAOA'S AGGREGATE TOTAL MONETARY LIABILITY TO APPLICANT UNDER ALL CAUSES OF ACTION AND ALL THEORIES OF LIABILITY (INCLUDING BUT NOT LIMITED TO STATUTORY, TORT, STRICT LIABILITY, WARRANTY, INDEMNITY, CONTRIBUTION, AND CONTRACT THEORIES) WILL BE LIMITED TO THE REFUND OF ALL APPLICATION FEES PAID BY APPLICANT.

## INDEMNITY

To the extent permitted by applicable laws, applicant shall indemnify, hold harmless, defend and reimburse UCAOA and its officers, employees and directors ("Indemnified Parties") from and for any and all claims, losses, damages, liabilities, expenses, penalties, judgments, orders, awards, attorneys' fees and litigation expenses (collectively, "Claims") which arise or are alleged to arise wholly or partly out of or in connection with: (i) any bodily or personal injuries, death, sickness, disease, or any other medical or psychological condition, of any person who visits or seeks to visit applicant's Facility for which UCAOA has provided a CUC designation; (ii) any decision by UCAOA to grant or deny a CUC designation for any of applicant's Facilities; or (iii) any action or omission of applicant or its officers, directors, employees, agents, representatives, contractors or consultants. Without limiting the generality of the foregoing provisions, APPLICANT'S OBLIGATIONS TO INDEMNIFY, HOLD HARMLESS, DEFEND AND REIMBURSE INCLUDE ALL CLAIMS, REGARDLESS OF WHETHER SUCH CLAIMS ARE CAUSED OR ALLEGED TO HAVE BEEN CAUSED WHOLLY OR PARTLY BY UCAOA'S ACTS OR OMISSIONS OR AN INDEMNIFIED PARTY'S NEGLIGENCE; provided, if this provision or any phrase or portion is held void, unenforceable, or prohibited by law, then this provision and any such phrase or portion shall be reasonably reformed (by modifying, adding, or deleting text) to the minimum extent required to carry out the parties' mutual intent that this provision shall provide the broadest obligations to indemnify, hold harmless, defend, and reimburse that are valid, enforceable and permitted by law. Nothing herein shall be deemed to limit or reduce any obligations of any insurers of applicant, except to the extent required for such obligations to be valid, enforceable and permitted by law; provided, applicant hereby waives all rights of its insurers to subrogate against the Indemnified Parties.

\_\_\_\_\_  
**Printed Name of Owner**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Printed Name above**

\_\_\_\_\_  
**Date**

**\*The person signing represents and warrants that the person: (a) has read, understands and agrees With all terms and provisions contained in this entire application and all other UCAOA materials Pertaining to the CUC certification program, on behalf of the applicant, and (b) is authorized to sign This application, make such representations, warranties and agreements on behalf of the applicant**

## Certified Urgent Care Center Eligibility

Refer to the following link for eligibility details:

[http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/certification/2018\\_Types\\_of\\_Certification.pdf](http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/certification/2018_Types_of_Certification.pdf)

Facility must be capable of evaluating walk-in patients of all ages for a broad spectrum of illness, injury and disease during all hours the facility is open to see patients.

- Pediatric specialty centers are exempt from above age requirement IF pediatric-only specialization is included in the name of the facility.

The following must be available during all posted hours of operation for the facility:

- X-ray on site
- **Please Note -- The following changes to the facility X-ray requirement will be effective as of January 1, 2018: On-site radiological equipment (imaging modality to perform chest x-rays, c spines, long bone films, abdomen, extremities, etc) that is easily interpretable and archivable.**
- Phlebotomy services on site
- Licensed provider on site with the appropriate state licenses and resources to:
  - Obtain and read an EKG and x-ray on site
  - Administer PO, IM & IV medications/fluids on site
  - Perform minor procedures (ex. Sutures, cyst removal, incision & drainage, splinting) on site
- The following equipment, and staff trained in its use:
  - Automated external defibrillator (AED) (or more advanced device)
  - Oxygen, ambu-bag/oral airway
  - Drug cart stocked appropriately for patient population (as determined by the facility)
  - Working phone to dial 911
- At least two exam rooms, separate waiting area and restricted access patient restrooms

**Minimum hours of operation (must meet all three criteria):**

- **7 days/week (not including national holidays)**
- **4+ hours each day**
- **3,000 hours per year**

Alternatively, special circumstances will be considered for a facility if all the following are met (see application):

**All facilities, regardless of staffing model, must meet or exceed all of the minimum criteria below.**

- Facility is part of a multi-center system
- Facility is open 5+ days/week (not including national holidays)
- Another facility that is part of the same system meets standard minimum hours of operation criteria [Criteria 3] AND is less than or equal to five miles away

The Certification Committee at its sole discretion may make an occasional exception for “certain religious holidays” only on a “case by case basis,” as long as it does not affect the overall purpose of the facility to be open year round, 7 days a week and accepting walk-in patients of all ages without appointment. Also, we would allow a temporary emergency closure of the facility because of an unforeseen circumstance (or acts of god, flood, hurricane, power outage, etc.)

Facility must have a licensed physician designated as Medical Director for the facility who is responsible for overall clinical quality.

Facility must provide medical care and perform business activities in an ethical manner.

### **RURAL CENTERS ONLY:**

- **Attach verification from the provided website below, showing that the address listed for your center is recognized as rural. Please include with required documents submitted for review by the Committee.**

**Link for rural address verification:** <https://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx>

### **Eligibility**

Certain facilities and practice types are unlikely to meet all of the above minimum criteria and therefore would be excluded from eligibility for certification as an urgent care center. These facilities should use extreme caution when applying, as **fees are not refundable**. Some examples include:

- Retail or similar clinic with limited scope of service located within a pharmacy, supermarket or similar retail facility
- Physician offices with only selected hours for walk-ins
- Chiropractic offices
- Pain clinics

Note: In states with legal restrictions on using the term “urgent care,” facilities will be issued Certified Immediate Care designations.

# Mail Application Materials to: UCAOA – Certified Urgent Care Review: 28600 Bella Vista Pkwy., Ste. 2010, Warrenville, IL. 60555

## **Checklist--Select EITHER to attest OR include the following supporting documentation for each requirement:**

1. Copy of business license for this facility, certificate of occupancy or equivalent.
  - I hereby attest that the facility still meets this requirement/unchanged from last CUC approval; OR
  - The facility has an updated business license/certificate of occupancy (documentation attached).
2. Exterior photo clearly showing the entire facility structure and external signage.
  - I hereby attest that the facility still meets this requirement/unchanged from last CUC approval; OR
  - The facility's exterior structure/signage has been updated (photo attached).
3. Photo of main entry door or sign indicating days and hours of operation to the public.
  - I hereby attest that the facility still meets this requirement/unchanged from last CUC approval; OR
  - The facility's days/hours of operation have changed (photo attached).

### **4. Current copy of ONE of the following x-ray documents (MUST SUBMIT – please attach):**

- Inspection certificate
- State registration
- Licensure

Radiological equipment can perform (check to attest to each):

- Chest x-ray
- C-spines
- Long bone films
- Abdomen
- Extremities

### **5. Copy of current laboratory licensure (MUST SUBMIT – please attach).**

### **6. Organizational chart including names of all current facility staff and providers with credentials (MUST SUBMIT – please attach).**

7. Copy of facility floor plan with clear labels for EACH of the following items: exam rooms, treatment room (if separate), patient restrooms, x-ray, laboratory.

- I hereby attest that the facility still meets this requirement/unchanged from last CUC approval; OR
- The facility's floor plan has changed (documentation attached).

8. Photos of portable defibrillator, oxygen equipment, drug cart, and facility's radiological equipment on site (Fixed or Portable [note: C-arms are not acceptable])

- I hereby attest that the maintenance of the portable defibrillator, oxygen equipment and drug cart is up to date; OR
- The portable defibrillator/AED, oxygen equipment and/or drug cart has been updated since last CUC approval (photos attached).

9. List of all medications and equipment contained in drug cart – should include adult as well as pediatric

- I hereby attest that all meds/equipment is up to date and compliant with requirement; OR
- The list of meds/equipment in the drug cart has changed since last CUC approval (list of meds attached).

### **10. Copy of recent advertisement, flyer or similar marketing piece for this facility (MUST SUBMIT – please attach).**

11. Description of role of Medical Director for this facility.

- I hereby attest that the description of the Medical Director's role is unchanged from last CUC approval; OR
- The description of Medical Director's role has been updated since last CUC approval (attached).

### **12. Copy of active, unrestricted license for center's Medical Director (MUST SUBMIT – please attach).**

13. **RURAL CENTERS ONLY**—Attach verification of rural address through use of the link below:

<https://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx>

It is recommended that centers make a copy of submitted documentation to keep for your records. UCAOA will not provide copies to centers.

## Facility's Demographic Information

1. What services does this site offer?

(please check all that apply)

- Urgent Care
- Occupational Medicine/Worker's Comp
- Telemedicine
- Physical Therapy
- Lab
- X-ray
- CT/MRI
- Physical Exams (School, Sport, Executive, Work, etc)
- Other (please explain): \_\_\_\_\_

2. Radiography Services:

- Plain Film
- Computed Radiography (CR)
- Digital Radiography (DR)

3. Lab Services Offered:

- Waived
- Moderate
- Complex

4. Use of electrocardiogram? (Y/N): \_\_\_\_\_

5. In addition to "Walk-In" Urgent Care patients, do you also have appointments?

- Yes
- No

6. Describe the setting in which this facility is located:

- Urban
- Suburban
- Rural ([per CMS definition](#))
- Resort Area (Seasonal)
- Other (please explain): \_\_\_\_\_

7. Date this facility opened: \_\_\_\_\_

8. Avg. Patient visits per day: \_\_\_\_\_

9. Facility Ownership:

- Corporate entity (i.e. insurance company, private equity or shareholder owned)
- Single physician
- Two or more physicians also working in the center
- Non-physician/provider investors
- Physician investors not practicing in the center
- Hospital-owned or affiliated
- Joint venture with a hospital
- NP/PA ownership
- Other: \_\_\_\_\_

10. Typical Provider Model at this Urgent Care Center (Select one):

- Physicians Only
- Physicians with PA or NP, with physician always on site
- Physicians with PA or NP, with physician NOT always on site
- Exclusively PA and/or NP, with remote physician supervision per state regulations
- Other

11. Total number of days that this Center typically sends receivables to a third-party collection agency: \_\_\_\_\_ days

12. Does this center accept Medicaid?

- Yes
- No

13. Hourly compensation for:

- Full-time Employed Physician
- Full-time Employed PA
- Full Time Employed NP

14. To keep records current, list your organization's contact for membership information:

\_\_\_\_\_