Quality Insights Renal Network 3

www.qirn3.org

CROWNWeb New Facility Information Sheet

Person Completing Form: _____ _____
Last *First*

Date Facility Opened: _____

CMS Certification Number (If Known): _____

Legal Facility Name: _____

Doing Business As Name: _____

Physical Address: _____
Street Address

_____
Mailing Address (If Different)

_____ _____ _____
City *State* *ZIP Code*

County: _____ **Facility Email Address**: _____

Facility Phone: _____ **Facility Fax:** _____

National Provider identifier Number: _____

Facility Ownership:

DaVita	DCI	FKC	American Renal Associates	Independent	Other
☐	☐	☐	☐	☐	☐

If other, specify name: _____

Profit Type:

Profit	Non-Profit
☐	☐

Services Provided (Check all that apply):

Home ONLY Dialysis	In-Center Hemodialysis	Home Hemodialysis	Peritoneal Dialysis	CAPD/CCPD	Nocturnal Dialysis
☐	☐	☐	☐	☐	☐

Number Stations (Excluding Isolation Stations): _____ **Number of Isolation Stations:** _____

Number of MWF Shifts: _____ Time Facility opens on MWF shifts _____ Time Facility closes on MWF shifts _____

Number of TTS Shifts: _____ Time Facility opens on TTS shifts _____ Time Facility closes on TTS shifts _____

When did you treat your first patient? ____/____/____

Enter Name of Backup Facility _____