

# **AHRQ Safety Program for Long-Term Care: HAIs/CAUTI Registration Form**

Please take a moment to gather the following information for the registration:

1. Medicare Federal Provider Number (if applicable)
2. Number of staff working at least 8 hours per week (whether contracted or employed)
3. Total number of Medicare and/or Medicaid Federally Certified beds
4. Essential team members for the program (e.g. Team Lead, Survey Coordinator, Data Coordinator, Administrative Champion)
5. All fields are **required**

## **Team Lead Contact Information**

**Team Lead Name:** \_\_\_\_\_

**Team Lead E-mail:** \_\_\_\_\_

**Team Lead Phone Number:** \_\_\_\_\_

## **Facility information**

### **1. Select your Lead Organization:**

- Alabama Quality Assurance Foundation
- Arizona Health and Hospital Association
- Foundation for Healthy Communities (NH)
- Genesis HealthCare
- Grace Living Centers (OK)
- Healthcare Association of New York State
- Healthcentric Advisors (RI)
- HealthInsight (NV, NM, UT)
- Information & Quality Healthcare (MS)
- Massachusetts Senior Care Association
- Missouri Hospital Association
- Oregon Patient Safety Commission
- Pennsylvania Patient Safety Authority
- Presbyterian Manors of Mid-America (KS & MO)
- Professional Nursing Solutions, LLC (AR)

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- Qualidigm (CT)
- Quality Health Associates of North Dakota
- South Carolina Hospital Association
- South Dakota Association of Healthcare Organizations
- South Florida Hospital & Healthcare Association
- Spectrum Health (MI)
- Telligen (IL & IA)
- Tennessee Healthcare Association
- Veteran's Health Administration
- Other (Please Specify) \_\_\_\_\_

**2. State:** \_\_\_\_\_

**3. Facility name:** \_\_\_\_\_

**4. Medicare Federal Provider Number (if applicable):** \_\_\_\_\_

**5. Facility Contact information**

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

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

**Zip:** \_\_\_\_\_

**6. Enter the number of staff in your facility regularly working at least 8 hours per week (whether employed or contracted):**

\_\_\_\_\_

**7. Enter the number of Medicare and/or Medicaid Federally Certified beds in your facility:**

Total Certified Beds: \_\_\_\_\_

**8. Do all staff members have access to computers with internet access during work hours for project use?**

- Yes
- No

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8.1. **If No, comment on staff computer and internet access:**


**AHRQ Program Essential Team Members**

9. **Will the Team Lead have any additional roles in the program? (Select all that apply)**

- Administrative Champion (If selected skip question 16)
- Survey Coordinator (If selected, skip questions 11 – 13)
- Data Coordinator (If selected, skip questions 14 and 15)
- No Other Team Roles

10. **What is the Team Lead's title in the facility? (Select all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Medical Director               | <input type="checkbox"/> Director of Nursing (DON)   |
| <input type="checkbox"/> Infection Control Practitioner | <input type="checkbox"/> Administrator               |
| <input type="checkbox"/> Licensed Nurse                 | <input type="checkbox"/> Certified Nursing Assistant |
| <input type="checkbox"/> Social Worker                  | <input type="checkbox"/> Other (Please specify)      |
- \_\_\_\_\_

11. **Survey Coordinator Contact Information**

**Name:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

12. **What is the Survey Coordinator's title in the facility? (Select all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Medical Director               | <input type="checkbox"/> Director of Nursing (DON)   |
| <input type="checkbox"/> Infection Control Practitioner | <input type="checkbox"/> Administrator               |
| <input type="checkbox"/> Licensed Nurse                 | <input type="checkbox"/> Certified Nursing Assistant |
| <input type="checkbox"/> Social Worker                  | <input type="checkbox"/> Other (Please specify)      |
- \_\_\_\_\_

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**13. Will the Survey Coordinator also be your Data Coordinator?**

- Yes  No  
(Skip questions  
14 and 15)

**14. Data Coordinator Contact Information**

**Name:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**15. What is the Data Coordinator's title in the facility? (Select all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Medical Director               | <input type="checkbox"/> Director of Nursing (DON)   |
| <input type="checkbox"/> Infection Control Practitioner | <input type="checkbox"/> Administrator               |
| <input type="checkbox"/> Licensed Nurse                 | <input type="checkbox"/> Certified Nursing Assistant |
| <input type="checkbox"/> Social Worker                  | <input type="checkbox"/> Other (Please specify)      |

\_\_\_\_\_

**16. Administrative Champion Contact Information**

**Name:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Thank you for your time in completing registration for the AHRQ Safety Program for Long-Term Care: CAUTI.**

**Please contact your Organizational Lead for any additional information about the program**