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:

- ○ Advancing Excellence
- ○ Alabama Quality Assurance Foundation
- ○ Arizona Health and Hospital Association
- ○ CAHF (California Association of Health Facilities)
- ○ 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)
- ○ The Joint Commission
- ○ Louisiana eQHealth Solutions, Inc.
- ○ Massachusetts Senior Care Association
- ○ Minnesota Hospital Association

- ○ Missouri Hospital Association
- ○ New Jersey Hospital Association
- ○ North Dakota Quality Health Care Association
- ○ Oregon Patient Safety Commission
- ○ Pennsylvania Patient Safety Authority
- ○ Presbyterian Manors of Mid-America (KS & MO)
- ○ Professional Nursing Solutions, LLC (AR)
- ○ 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

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)

- ☐ Medical Director
- ☐ Infection Control Practitioner
- ☐ Licensed Nurse
- ☐ Social Worker
- ☐ Director of Nursing (DON)
- ☐ Administrator
- ☐ Certified Nursing Assistant
- ☐ 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)

- ☐ Medical Director
- ☐ Infection Control Practitioner
- ☐ Licensed Nurse
- ☐ Social Worker
- ☐ Director of Nursing (DON)
- ☐ Administrator
- ☐ Certified Nursing Assistant
- ☐ Other (Please specify)

_____

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

- ○ Yes (Skip questions 14 and 15)
- ○ No

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)

- ☐ Medical Director
- ☐ Director of Nursing (DON)
- ☐ Infection Control Practitioner
- ☐ Administrator
- ☐ Licensed Nurse
- ☐ Certified Nursing Assistant
- ☐ Social Worker
- ☐ 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