

# OPTN Membership Application for Transplant Hospitals

## CERTIFICATION

The undersigned, a duly authorized representative of the applicant, does hereby certify that the answers and attachments to this application are true, correct and complete, to the best of his or her knowledge after investigation. I understand that the intentional submission of false data to the OPTN may result in action by the Secretary of the Department of Health and Human Services, and/or civil or criminal penalties. By submitting this application to the OPTN, the applicant agrees: (i) to be bound by OPTN Obligations, including amendments thereto, if the applicant is granted membership and (ii) to be bound by the terms, thereof, including amendments thereto, in all matters relating to consideration of the application without regard to whether or not the applicant is granted membership.

If you have any questions, please call the UNOS Membership Team at 833-577-9469 or email [MembershipRequests@unos.org](mailto:MembershipRequests@unos.org).

### OPTN Representative

Printed Name	Signature	Email Address
Program Director		
Printed Name	Signature	Email Address
Program Director (if applicable)		
Printed Name	Signature	Email Address
Program Director (if applicable)		
Printed Name	Signature	Email Address

**Program Director (if applicable)**

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<b>Printed Name</b>	<b>Signature</b>	<b>Email Address</b>
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**Proposed Primary Surgeon**

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<b>Printed Name</b>	<b>Signature</b>	<b>Email Address</b>
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**Proposed Primary Physician**

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<b>Printed Name</b>	<b>Signature</b>	<b>Email Address</b>
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**Proposed Primary Pediatric Surgeon**

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<b>Printed Name</b>	<b>Signature</b>	<b>Email Address</b>
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**Proposed Primary Pediatric Physician**

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<b>Printed Name</b>	<b>Signature</b>	<b>Email Address</b>
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## Part 1: General Information

Name of Hospital: \_\_\_\_\_

CMS Provider #: \_\_\_\_\_

OPTN Member Code: \_\_\_\_\_

This application corresponds with what other organ application? (check one) Choose an item.

### Hospital Address

Street: \_\_\_\_\_ Ste: \_\_\_\_\_ Phone #: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax #: \_\_\_\_\_

Hospital Website Address: \_\_\_\_\_

Is this a standalone pediatric hospital?

### Mailing Address (if different from Physical Address)

Street/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Person Completing Form: \_\_\_\_\_ Title: \_\_\_\_\_

Email Address of Person Completing Form: \_\_\_\_\_

Date Form is submitted to OPTN Contractor: \_\_\_\_\_

## Part 2: Designated Transplant Program Requirement

In order to receive organs for transplantation, a transplant hospital member must have current approval as a designated transplant program for at least one organ. A transplant hospital can only have one designated transplant program for each respective organ. Designated transplant programs must meet *at least one* of the following requirements

***Check all that apply***

- The hospital has approval as a transplant program by the Secretary of the U.S. Department of Health and Human Services (HHS) for reimbursement under Medicare.*
  
- The hospital has approval as a transplant program in a Department of Veterans Affairs, Department of Defense, or other Federal hospital.*
  
- The hospital qualifies as a designated transplant program according to the membership requirements of these Bylaws.*

## Part 3: Facilities and Resources

A successful transplant program requires adequate facilities and resources. Read each section and provide the requested documentation with the application.

### Facilities

1. ***Provide an executive summary of your transplant program's physical space. Include operating and recovery room resources, intensive care resources, and surgical beds.***

### Geographic Requirements for Transplant Hospitals (Check yes or no)

**Yes No**

2.   *Is the transplant hospital entirely within a single donation service area (DSA)?*
3.   *Are all operating room facilities used for organ transplantation must be under common executive leadership and governance oversight?*

***Document common executive leadership and governance oversight.***

4.   *Are all the transplant hospital operating rooms where transplants are performed within a geographically contiguous campus?*
5.   *Are all the transplant hospital operating rooms where transplants are performed within a one mile walking distance from the main hospital's physical address?*

### Transplant Hospital Map

6. ***Provide a map that displays and identifies the following:***
  - *The transplant hospital campus and the location of each operating room facility*
  - *Building name(s) and address(es)*
  - *Floor number(s)*
  - *Unit identifier(s)*

### OPO Affiliation

7. ***Provide all letters of agreement or contracts with OPO members per OPTN Bylaws.***

### Histocompatibility Laboratory Affiliation

***Provide a copy of the written agreement with an OPTN approved histocompatibility laboratory to perform the tissue typing of recipients and donors.***

### **Blood Bank Services**

Transplant programs must have access to large quantities of blood and provide proof of extensive blood bank support.

- 8. Provide a list of all local blood bank with whom the transplant hospital interacts.*

### **Additional Laboratory Services**

Transplant programs must have immediate access to microbiology, clinical chemistry, histocompatibility testing, and radiology services, as well as the necessary resources to monitor immunosuppressive medications.

- 9. Provide a list of laboratories with whom the transplant hospital interacts.*

## **Part 4: Quality Assessment and Performance Improvement (QAPI) Requirement**

***By checking the boxes below, the transplant hospital attests to the following for the transplant hospital's Quality Assessment and Performance Improvement (QAPI) program:***

- The transplant hospital has developed, implemented and maintained an ongoing, comprehensive and data-driven QAPI program designed to monitor and evaluate compliance with OPTN requirements and produce measurable process improvement initiatives. The QAPI plan must incorporate all designated transplant programs at the transplant hospital.*
  
- The hospital has documented implementation of all elements of the QAPI plan*

***Provide QAPI plan documentation as an attachment to the application.***

## Part 5: Additional Transplant Program Personnel

Transplant programs must have other support personnel on staff to ensure quality patient care. The sections below provide details of support staff that a transplant program is required to have on staff.

### 1. Clinical Transplant Coordinator

Each transplant program will have on staff at least one Clinical Transplant Coordinator. The Clinical Transplant Coordinator will be a designated member of the transplant team, working with patients and their families to coordinate care, beginning with the evaluation for transplantation and continuing through and after transplantation.

**Name of Clinical Transplant Coordinator:** \_\_\_\_\_

### 2. Financial Coordinator

Each transplant hospital should have on staff a Financial Coordinator who will be responsible for coordinating and clarifying the available financial resources for patient care. The Financial Coordinator will be a designated member of the transplant team, working with patients and their families to coordinate the financial resources required for care, beginning with the transplantation evaluation and continuing after transplantation to ensure continuity of care.

**Name of Financial Coordinator:** \_\_\_\_\_

### 3. Clinical Transplant Pharmacist

Each transplant program should identify at least one Clinical Transplant Pharmacist on staff who will provide pharmaceutical expertise to transplant recipients. The Clinical Transplant Pharmacist should be a member of the transplant team, providing comprehensive pharmaceutical care to transplant recipients.

The Transplant Pharmacist will work with patients and their families, and members of the transplant team, including physicians, surgeons, nurses, clinical coordinators, social workers, financial coordinators and administrative personnel. The Transplant Pharmacist should be a licensed pharmacist with experience in transplant pharmacotherapy.

**Name of Clinical Transplant Pharmacist:** \_\_\_\_\_



#### **4. Medical Expert Support**

The proper care and management of transplant recipients require both physicians and ancillary health professionals. The transplant program must show proof of collaboration with experts in these fields:

***Provide a list of the transplant program collaborators from the following disciplines.***

- *Anesthesiology*
- *Hepatology*
- *Histocompatibility and immunogenetics*
- *Immunology*
- *Infectious disease*
- *Nephrology, including dialysis capability*
- *Pathology*
- *Pediatrics*
- *Physical therapy and rehabilitation medicine*
- *Pulmonary medicine, including respiratory therapy support*
- *Radiology*

#### **5. Mental Health and Social Support**

Each transplant program must have on staff professionals who are designated members of the transplant team and whose primary responsibility is coordinating the psychosocial needs of transplant candidates, recipients, living donors, and their families. These professionals will work with patients and families in a compassionate, culturally sensitive, and thoughtful way to facilitate continuity of care.

***Provide a list of all mental health and social support staff. Include job descriptions for each employed member of this team.***

## Part 6: Donation after Circulatory Death (DCD) Protocols

Each transplant hospital must develop and comply with protocols to facilitate the recovery of organs from DCD donors. Transplant hospital DCD recovery protocols must address the requirements as described in OPTN Policy.

***Provide documentation supporting the transplant hospital's DCD recovery protocols.***

### PUBLIC BURDEN STATEMENT

The private, non-profit Organ Procurement and Transplantation Network (OPTN) collects this information in order to perform the following OPTN functions: to assess whether applicants meet OPTN Bylaw requirements for membership in the OPTN; and to monitor compliance of member organizations with OPTN Obligations. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0184 and it is valid until 08/31/2023. This information collection is required to obtain or retain a benefit per 42 CFR §121.11(b)(2). All data collected will be subject to Privacy Act protection (Privacy Act System of Records #09-15-0055). Data collected by the private non-profit OPTN also are well protected by a number of the Contractor's security features. The Contractor's security system meets or exceeds the requirements as prescribed by OMB Circular A-130, Appendix III, Security of Federal Automated Information Systems, and the Departments Automated Information Systems Security Program Handbook. The public reporting burden for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or [paperwork@hrsa.gov](mailto:paperwork@hrsa.gov).