

§ 489.3

(2) CMHCs may enter into provider agreements only to furnish partial hospitalization services.

[45 FR 22937, Apr. 4, 1980, as amended at 47 FR 56297, Dec. 15, 1982; 48 FR 56036, Dec. 15, 1983; 51 FR 24492, July 3, 1986; 58 FR 30676, May 26, 1993; 59 FR 6578, Feb. 11, 1994; 62 FR 46037, Aug. 29, 1997]

§ 489.3 Definitions.

For purposes of this part—

Immediate jeopardy means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

Provider agreement means an agreement between CMS and one of the providers specified in § 489.2(b) to provide services to Medicare beneficiaries and to comply with the requirements of section 1866 of the Act.

[48 FR 39837, Sept. 1, 1983, as amended at 51 FR 24492, July 3, 1986; 54 FR 5373, Feb. 2, 1989; 59 FR 56250, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995]

§ 489.10 Basic requirements.

(a) Any of the providers specified in § 489.2 may request participation in Medicare. In order to be accepted, it must meet the conditions of participation or requirements (for SNFs) set forth in this section and elsewhere in this chapter.

(b) In order to participate in the Medicare program, the provider must meet the applicable civil rights requirements of:

(1) Title VI of the Civil Rights Act of 1964, as implemented by 45 CFR part 80, which provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity receiving Federal financial assistance (section 601);

(2) Section 504 of the Rehabilitation Act of 1973, as implemented by 45 CFR part 84, which provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination under any program or activity receiving Federal financial assistance;

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(3) The Age Discrimination Act of 1975, as implemented by 45 CFR part 90, which is designed to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Age Discrimination Act also permits federally assisted programs and activities, and recipients of Federal funds, to continue to use certain age distinctions, and factors other than age, that meet the requirements of the Age Discrimination Act and 45 CFR part 90; and

(4) Other pertinent requirements of the Office of Civil Rights of HHS.

(c) In order for a hospital, SNF, HHA, or hospice to be accepted, it must also meet the advance directives requirements specified in subpart I of this part.

(d) The State survey agency will ascertain whether the provider meets the conditions of participation or requirements (for SNFs) and make its recommendations to CMS.

(e) In order for a home health agency to be accepted, it must also meet the surety bond requirements specified in subpart F of this part.

(f) In order for a home health agency to be accepted as a new provider, it must also meet the capitalization requirements specified in subpart B of this part.

[58 FR 61843, Nov. 23, 1993, as amended at 59 FR 6578, Feb. 11, 1994; 63 FR 312, Jan. 5, 1998]

§ 489.11 Acceptance of a provider as a participant.

(a) *Action by CMS.* If CMS determines that the provider meets the requirements, it will send the provider—

(1) Written notice of that determination; and

(2) Two copies of the provider agreement.

(b) *Action by provider.* If the provider wishes to participate, it must return both copies of the agreement, duly signed by an authorized official, to CMS, together with a written statement indicating whether it has been adjudged insolvent or bankrupt in any State or Federal court, or whether any insolvency or bankruptcy actions are pending.

(c) *Notice of acceptance.* If CMS accepts the agreement, it will return one