The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

Bureau of Health Care Safety and Quality

Division of Health Care Facility Licensure and Certification

67 Forest Street, Marlborough, MA 01752

**Application for Stroke Center Designation**


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**Application for Stroke Center Designation**

**Instructions:** All applicants complete **Part One**. Please complete a separate application for each additional campus.

**Part One**

### Hospital Name: License Number: \_\_\_ \_\_\_ \_\_\_ \_\_\_

**Address:** **Street Name:** **Main Hospital or Campus Location:**

**City/Town:** **State:** **Zip Code:** Parent \_\_\_ \_\_\_ \_\_\_ \_\_\_

**Telephone Number:** (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_-\_\_ \_\_ \_\_ \_\_ Campus \_\_\_ \_\_\_ \_\_\_ \_\_\_

**Hospital Website Address**

**Contact Person**

Designee for Hospital who will serve as the official liaison between the Hospital and the Massachusetts Department of Public Health on Stroke Center Designation (all fields required):

First Name Last Name Title

Telephone Number (\_\_ \_\_ \_\_) \_\_ \_\_ \_\_-\_\_ \_\_ \_\_ \_\_ Fax Number (\_\_ \_\_ \_\_)\_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

E-mail address

**Part Two**

In accordance with the regulations for stroke services as set forth under provisions of 105 CMR 130.1401 through 130.1408, a facility must have a coordinating stroke care agreement with a hospital with primary stroke service or endovascular capable stroke service within their service area to provide appropriate care for acute stroke patients. The coordinating stroke care agreement may include the provision of telestroke services. The undersigned attests that:

* Transfer protocols are in place for the transport and acceptance of stroke patients for stroke treatment therapies which the facility is not capable of providing ; and
* Communication criteria and protocols are in place with one or more facilities, or hospitals with primary stroke service or endovascular capable stroke service, as needed.

**TRANSFER AGREEMENT(S) TO SEND STROKE PATIENTS TO:**

(Attach separate sheets if necessary for additional hospitals)

**Hospital Name:**

Chief of Stroke Service: Medical Director of Emergency Department:

Effective Date: End Date: Name of Signee:

**Hospital Name:**

Chief of Stroke Service: Medical Director of Emergency Department:

Effective Date: End Date: Name of Signee:

**TRANSFER AGREEMENTS(S) TO RECEIVE STROKE PATIENTS FROM:**

(Attach separate sheets if necessary for additional hospitals)

**Hospital Name:**

Chief of Stroke Service: Medical Director of Emergency Department:

Effective Date: End Date: Name of Signee:

**Hospital Name:**

Chief of Stroke Service: Medical Director of Emergency Department:

Effective Date: End Date: Name of Signee:

# DPH Stroke Center Certification Status Report

Pursuant to 105 CMR 130.1402(A), after January 1st, 2026, each hospital with an emergency department and each satellite facility, at a minimum, must provide acute stroke ready services.

Additionally, pursuant to 105 CMR 130.1402(B), a hospital may seek designation to provide primary stroke services or endovascular capable stroke services.

**Instructions:** Facilities seeking designation to provide primary stroke service or endovascular stroke services must complete **Part Three**.

**Part Three**

Massachusetts Department of Public Health designation sought:

Primary Stroke Service

 Endovascular capable stroke service

**If this hospital/campus is currently certified to be a Stroke Center, please check the boxes below as appropriate:**

 **Nationally Recognized Accrediting Body:**

 The Joint Commission (TJC)

 Det Norske Veritas (DNV)

 Accreditation Commission for Health Care (ACHC)

 Not Applicable (for Acute Stroke Ready tier)

 **Stroke Tier – Tier Names Vary by Accrediting Body (TJC/DNV/ACHC):**

 Primary Stroke Center / Primary Stroke Center / Primary Stroke

 Thrombectomy-Capable Stroke Center / Primary Plus Stroke Center / Thrombectomy Ready

 Comprehensive Stroke Center / Comprehensive Stroke Center / Comprehensive Stroke

**Start Date:**

**End Date:**

Please review the application for completeness. Mail this application to:

**ATTN: Walter Mackie**

 **Department of Public Health**

 **Division of Health Care Facility Licensure and Certification**

 **67 Forest Street**

 **Marlborough, MA 01752**

 **Email:** **Walter.Mackie@Mass.Gov**