

QUICK START GUIDE TO CLIA CERTIFICATION FOR COVID-19 TESTING IN SCHOOLS

MAY 2021



Facility Quick Start Guide to CMS CLIA Certification

The Centers for Medicare & Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) regulates the quality and safety of U.S. clinical laboratories. This guide helps schools and other non-healthcare entities apply for a CLIA Certificate of Waiver to conduct COVID-19 testing. Items that schools must complete are highlighted in yellow, accompanied by directions specific to school COVID-19 testing.



STEP 1: Download and Complete Form CMS-116

- The CLIA application (Form CMS-116) collects information about your facility's (e.g. school) operation to issue a CLIA number.
- Include information based on the date of form completion.
- All applicable highlighted sections/fields must be completed. Incomplete applications cannot be processed.
- Print legibly or type.
- Waived tests are not exempt from CLIA. Facilities that perform only those tests categorized or authorized as waived must apply for a CLIA Certificate of Waiver.



Complete General Information in section I.

If you do not have a CLIA certificate and this is the first time you are applying for a certificate, check "Initial Application."

For all other changes, check "other changes" and provide the effective date of the change. Some examples of "other changes" are address, phone number, or laboratory director.

Facility Name should be specific. NOTE: The information you provide will appear on your certificate. The Facility Name should be specific to the school, school district, county or other controlling organization.

Providing an **Email Address** to receive notifications is optional.

Facility Address is the physical location of a school where the lab testing is performed. It may also be the address of a school district or state responsible for the testing. The address may include a floor, suite, and/or room location, but cannot be a Post Office box or Mail Stop.

For **Name Of Director**, enter the name of the individual responsible for overall operation of the facility, including testing ("Facility Director"). For a Certificate of Waiver, this does not have to be a physician or medical professional.

"Check Certificate of Waiver" for Type of Certificate.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0581

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) APPLICATION FOR CERTIFICATION

ALL APPLICABLE SECTIONS OF THIS FORM MUST BE COMPLETED.

I. GENERAL INFORMATION

☐ Initial Application Anticipated Start Date _____ CLIA IDENTIFICATION NUMBER _____
☐ Survey _____
☐ Change in Certificate Type _____
☐ Other Changes (Specify) _____
Effective Date _____
FACILITY NAME _____ FEDERAL TAX IDENTIFICATION NUMBER _____
EMAIL ADDRESS _____ TELEPHONE NO. (include area code) _____ FAX NO. (include area code) _____
☐ RECEIVE FUTURE NOTIFICATIONS VIA EMAIL _____
FACILITY ADDRESS — Physical Location of Laboratory (Building, Floor, Suite if applicable.) Fee Coupon/Certificate will be mailed to this Address unless mailing or corporate address is specified MAILING/BILLING ADDRESS (if different from facility address) send Fee Coupon or certificate
NUMBER, STREET (No P.O. Boxes) _____ NUMBER, STREET _____
CITY _____ STATE _____ ZIP CODE _____ CITY _____ STATE _____ ZIP CODE _____
SEND FEE COUPON TO THIS ADDRESS SEND CERTIFICATE TO THIS ADDRESS CORPORATE ADDRESS (if different from facility) send Fee Coupon or certificate
PICK ONE: PICK ONE: NUMBER, STREET _____
☐ Physical ☐ Physical CITY _____ STATE _____ ZIP CODE _____
☐ Mailing ☐ Mailing _____
☐ Corporate ☐ Corporate _____
NAME OF DIRECTOR (Last, First, Middle Initial) _____ Laboratory Director's Phone Number _____
CREDENTIALS _____ FOR OFFICE USE ONLY
Date Received _____

II. TYPE OF CERTIFICATE REQUESTED (Check only one) Please refer to the accompanying instructions for inspection and certificate testing requirements)

☐ Certificate of Waiver (Complete Sections I – VI and IX – X)
NOTE: Laboratory directors performing non-waived testing (including PPM) must meet specific education, training and experience under subpart M of the CLIA regulations. Proof of these qualifications for the laboratory director must be submitted with this application.
☐ Certificate for Provider Performed Microscopy Procedures (PPM) (Complete Sections I-VII and IX-X)
☐ Certificate of Compliance (Complete Sections I – X)
☐ Certificate of Accreditation (Complete Sections I – X) and indicate which of the following organization(s) your laboratory is accredited by for CLIA purposes, or for which you have applied for accreditation for CLIA purposes.
☐ The Joint Commission ☐ AAHHS/HFAP ☐ AABB ☐ A2LA
☐ CAP ☐ COLA ☐ ASHI

If you are applying for a Certificate of Accreditation, you must provide evidence of accreditation for your laboratory by an approved accreditation organization as listed above for CLIA purposes or evidence of application for such accreditation within 11 months after receipt of your Certificate of Registration.

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0581. Expiration Date: 03/31/2024. The time required to complete this information collection is estimated to average one hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. *****CMS Disclaimer*****Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact labexcellence@cms.hhs.gov.

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Disclaimer: This guide is a restatement of the law intended to assist people in understanding the basics about the CLIA program, and that the reader should consult the relevant statutes and regulations for the full scope of the CLIA requirements.

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Complete Type of Laboratory in section III.

In section III, select the **Type of Laboratory** that is most descriptive of the location where the laboratory testing is performed. Check 26 School/Student Health for school systems. If you have questions, contact your [State Agency](#).



Complete Multiple Sites in section V

If you are applying for multiple schools, please attach a list of the sites, including each site's name, address, and tests performed. Schools may apply for certification by district, county, state, etc. Please also answer questions 1 – 3 under Section V.

III. TYPE OF LABORATORY (Check the one most descriptive of facility type)

<input type="checkbox"/> 01 Ambulance	<input type="checkbox"/> 11 Health Main, Organization	<input type="checkbox"/> 22 Practitioner Other (Specify)
<input type="checkbox"/> 02 Ambulatory Surgery Center	<input type="checkbox"/> 12 Home Health Agency	
<input type="checkbox"/> 03 Ancillary Testing Site in Health Care Facility	<input type="checkbox"/> 13 Hospice	
<input type="checkbox"/> 04 Assisted Living Facility	<input type="checkbox"/> 14 Hospital	<input type="checkbox"/> 23 Prison
<input type="checkbox"/> 05 Blood Bank	<input type="checkbox"/> 15 Independent	<input type="checkbox"/> 24 Public Health Laboratories
<input type="checkbox"/> 06 Community Clinic	<input type="checkbox"/> 16 Industrial	<input type="checkbox"/> 25 Rural Health Clinic
<input type="checkbox"/> 07 Comp. Outpatient Rehab Facility	<input type="checkbox"/> 17 Insurance	<input type="checkbox"/> 26 School/Student Health Service
<input type="checkbox"/> 08 End Stage Renal Disease Dialysis Facility	<input type="checkbox"/> 18 Intermediate Care Facilities for Individuals with Intellectual Disabilities	<input type="checkbox"/> 27 Skilled Nursing Facility/ Nursing Facility
<input type="checkbox"/> 09 Federally Qualified Health Center	<input type="checkbox"/> 19 Mobile Laboratory	<input type="checkbox"/> 28 Tissue Bank/Repositories
<input type="checkbox"/> 10 Health Fair	<input type="checkbox"/> 20 Pharmacy	<input type="checkbox"/> 29 Other (Specify)
	<input type="checkbox"/> 21 Physician Office	

IV. HOURS OF LABORATORY TESTING (List times during which laboratory testing is performed in HH:MM format) If testing 24/7 Check Here ☐

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

(For multiple sites, attach the additional information using the same format.)

V. MULTIPLE SITES (must meet one of the regulatory exceptions to apply for this provision in 1-3 below)

Are you applying for a single site CLIA certificate to cover multiple testing locations?

☐ No. If no, go to section VI. ☐ Yes. If yes, complete remainder of this section.

Indicate which of the following regulatory exceptions applies to your facility's operation.

1. Is this a laboratory that is not at a fixed location, that is, a laboratory that moves from testing site to testing site, such as mobile unit providing laboratory testing, health screening fairs, or other temporary testing locations, and may be covered under the certificate of the designated primary site or home base, using its address?

☐ Yes ☐ No

If yes and a mobile unit is providing the laboratory testing, record the vehicle identification number(s) (VINs) and attach to the application.

2. Is this a not-for-profit or Federal, State or local government laboratory engaged in limited (not more than a combination of 15 moderate complexity or waived tests per certificate) public health testing and filing for a single certificate for multiple sites?

☐ Yes ☐ No

If yes, provide the number of sites under the certificate _____ and list name, address and test performed for each site below.

3. Is this a hospital with several laboratories located at contiguous buildings on the same campus within the same physical location or street address and under common direction that is filing for a single certificate for these locations?

☐ Yes ☐ No

If yes, provide the number of sites under this certificate _____ and list name or department, location within hospital and specialty/subspecialty areas performed at each site below.

If additional space is needed, check here ☐ and attach the additional information using the same format.

NAME AND ADDRESS/LOCATION	TESTS PERFORMED/SPECIALTY/SUBSPECIALTY
NAME OF LABORATORY OR HOSPITAL DEPARTMENT	
ADDRESS/LOCATION (Number, Street, Location if applicable)	
CITY, STATE, ZIP CODE	TELEPHONE NO. (Include area code)
NAME OF LABORATORY OR HOSPITAL DEPARTMENT	
ADDRESS/LOCATION (Number, Street, Location if applicable)	
CITY, STATE, ZIP CODE	TELEPHONE NO. (Include area code)

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As an example:

TEST	TEST KIT	MANUFACTURER
COVID-19	BINAXNOW COVID-19 Ag 2 CARD	ABBOTT

Complete Estimated Total Annual Test

Please add the total number of tests that you think will be performed by all the schools under this CLIA certificate in a year. This number is used to know how many tests you are performing each year.

In the next three sections, indicate testing performed and estimated annual test volume.

VI. WAIVED TESTING *If only applying for a Certificate of Waiver, complete this section and skip sections VII (PPM Testing) and VIII (Non-Waived Testing).*

Identify the waived testing (to be) performed by completing the table below. Include each analyte, test system, or device used in the laboratory.

ANALYTE / TEST	TEST NAME	MANUFACTURER
Example: Streptococcus group A	Ace Rapid Strep Test	Acme Corporation

Indicate the **ESTIMATED TOTAL ANNUAL TEST** volume for all waived tests performed _____

☐ Check if no waived tests are performed

If additional space is needed, check here ☐ and attach additional information using the same format.

VII. PPM TESTING *If only applying for a Certificate for PPM, complete this section and skip section VIII (Non-Waived Testing).*

Listed below are the **only** PPM tests that can be performed by a facility having a Certificate for PPM. Mark the checkbox by each PPM procedure(s) to be performed.

- ☐ Direct wet mount preparations for the presence or absence of bacteria, fungi, parasites, and human cellular elements
- ☐ Potassium hydroxide (KOH) preparations
- ☐ Pinworm examinations
- ☐ Fern tests
- ☐ Post-coital direct, qualitative examinations of vaginal or cervical mucus
- ☐ Urine sediment examinations
- ☐ Nasal smears for granulocytes
- ☐ Fecal leukocyte examinations
- ☐ Qualitative semen analysis (limited to the presence or absence of sperm and detection of motility)

Indicate the **ESTIMATED TOTAL ANNUAL TEST** volume for all PPM tests performed _____

If also performing waived complexity tests, complete Section VI. For laboratories applying for certificate of compliance or certificate of accreditation, also include PPM test volume in the specialty/subspecialty category and the "total estimated annual test volume" in section VIII.

☐ Check if no PPM tests are performed

If additional space is needed, check here ☐ and attach additional information using the same format.

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Complete Type of Control in section IX and sign application

IX. TYPE OF CONTROL (CHECK THE ONE MOST DESCRIPTIVE OF OWNERSHIP TYPE)

VOLUNTARY NONPROFIT

- ☐ 01 Religious Affiliation
☐ 02 Private Nonprofit
☐ 03 Other Nonprofit

(Specify)

FOR PROFIT

- ☐ 04 Proprietary

GOVERNMENT

- ☐ 05 City
☐ 06 County
☐ 07 State
☐ 08 Federal
☐ 09 Other Government

(If 09 is selected, please specify the country or the province.)

Does this facility have partial or full ownership by a foreign entity or foreign government?

- ☐ Yes ☐ No

If Yes, what is the country of origin for the foreign entity?

X. DIRECTOR AFFILIATION WITH OTHER LABORATORIES

If the director of this laboratory serves as director for additional laboratories that are separately certified, please complete the following:

CLIA NUMBER	NAME OF LABORATORY

ATTENTION: READ THE FOLLOWING CAREFULLY BEFORE SIGNING APPLICATION

Any person who intentionally violates any requirement of section 353 of the Public Health Service Act as amended or any regulation promulgated thereunder shall be imprisoned for not more than 1 year or fined under title 18, United States Code or both, except that if the conviction is for a second or subsequent violation of such a requirement such person shall be imprisoned for not more than 3 years or fined in accordance with title 18, United States Code or both.

Consent: The applicant hereby agrees that such laboratory identified herein will be operated in accordance with applicable standards found necessary by the Secretary of Health and Human Services to carry out the purposes of section 353 of the Public Health Service Act as amended. The applicant further agrees to permit the Secretary, or any Federal officer or employee duly designated by the Secretary, to inspect the laboratory and its operations and its pertinent records at any reasonable time and to furnish any requested information or materials necessary to determine the laboratory's eligibility or continued eligibility for its certificate or continued compliance with CLIA requirements.

PRINT NAME OF DIRECTOR OF LABORATORY

PRINT NAME OF OWNER OF LABORATORY

SIGNATURE OF OWNER/DIRECTOR OF LABORATORY (SIGN IN INK OR USE A SECURE ELECTRONIC SIGNATURE)

DATE

NOTE: Completed 116 applications must be sent to your local State Agency. Do not send any payment with your completed 116 application.

STATE AGENCY CONTACT INFORMATION CAN BE FOUND AT:

<https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf>

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- Send via mail or email
- Include state-specific paperwork. As your local CLIA contact, the [State Agency](#) can answer your questions on CLIA certificates. They can also advise about any state requirements that apply.



- You will receive a 10-digit alphanumeric CLIA identification number, with the “D” in the third position identifying the provider/supplier as a laboratory certified under CLIA.
- Amount due will be included on Fee Coupon as the Total Payment Due



Pay CLIA certification fees by:

- **Using the U.S. Treasury [online platform](#)**—include the CLIA Identification Number and charge to a debit or credit card; this secure federal government platform applies payments nightly to outstanding fees
- **Writing a check**—include the provider number and allow 10 business days for outstanding fees to be applied



STEP 5: Receive Certificate and Begin Testing

<h2 style="margin: 0;">CLIA Fee Coupon</h2>	
Payment Due Date: 08/07/2020	Total Payment Due: \$180.00
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> Make check payable to: CLIA Laboratory Program </div>	
CLIA ID Number: 22D0981035 STATE UNIVERSITY HEALTH SYSTEM 12345 MAIN STREET 1ST FLOOR SPRINGFIELD, ST 67890	Do not send name or address changes with your remittance
Mail check to:	CLIA LABORATORY PROGRAM P.O. BOX 3056 PORTLAND, OR 97208-3056
21 DRH_062320	
07810350000000000000200623000018000000000000000000000	

