San Francisco Health Plan

FACILITY SITE REVIEW – PRE-AUDIT SURVEY

Facility Name		**Site NPI**	
Address		**Phone**	
Hours of Operation		**Fax**	

1. **Key Contacts, Emails, and Phone Numbers**

Role	Name, Title	Email	Direct Phone Number
Office Manager			
Medical Director			
Admin Lead			

2. **Please indicate number of staff.**
   ___Physician ___NP ___CNM ___PA ___RN ___LVN
   ___MA ___Clerical ___Other

3. **Select all site-specific certifications**
   ☐ AAAHC ☐CPSP ☐FQHC ☐NCQA ☐ TJC ☐ VFC
   ☐ Other

4. **Select all patient types seen by your practice**.
   ☐Adult ☐ Pediatrics ☐ California Children Services (CCS) ☐ Obstetric

5. **What provider types staff your practice?**
   ☐ Family Practice ☐ General Med ☐ Internal Med ☐ Pediatrics ☐ Specialist ☐ Mid-Level

6. **Select all that apply to your practice.**
   ☐Vaccines/immunizations ☐Refrigerator/Freezer ☐Radiology services
   ☐Controlled substances ☐Pharmacy ☐Contaminated laundry
   ☐Sample drugs ☐Lab tests requiring CLIA
   ☐Cold chemical sterilization ☐Autoclave/steam sterilization

7. **Name of EPA approved <u>tuberculocidal</u> disinfectant product or solution used for decontamination of equipment or work surfaces:**

8. **Name of EPA approved <u>tuberculocidal</u> disinfectant product or solution used by housekeeping for cleaning the facility:**

9. **Name of EMR/EHR system (leave blank if paper records only):**

10. **Date of last fire clearance (inspection date on extinguisher):**

11. **Are you registered to CAIR?** ☐Yes ☐No

San Francisco Health Plan

12. Name of Biohazardous Waste Disposal site is contracted with:

13. Language skills on-site staff in addition to English:

14. Is staff proficient in medication translation: ☐Yes. Languages:_____ ☐No

15. Has there been any physical changes to the clinic or building (remodel, major construction) since the last review? ☐Yes ☐No ☐New clinic site

16. Are you registered on SFHP Provider Portal? ☐Yes ☐No

If not, would you like to register? ☐Yes ☐No

17. List names of ALL staff at this site and include the following information below.

First and Last Name	Title (e.g. MD, DO, NP, PA, RN, LVN, MA, Office Manager, etc.)	License # and Expiration Date	NPI#	DEA#	Age Limit	FTE

Please return completed form to SFHP Facility Site Review Team: FSR@sfhp.org or Fax 415-615-4397