

Facility Site Review Policy or Procedure Attestation Form









Facility Name		DHCS ID	
Address		Site NPI	

Instructions: Please review the following and select the checkbox if you have a policy or procedure or practice in place for each item. If any items do not apply, mark as No or NA and add a comment.

Criteria	FSR Item	Yes	No	NA	If No or NA, please explain:
Access D1	Medical emergency personnel plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Access D6	Medication dosage chart for all medications included with emergency equipment (or other method for determining dosage) is kept with emergency medications.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Personnel C2	Only qualified/trained personnel operate medical equipment. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Personnel C4	Procedure for confirming correct patient/medication vaccine/dosage prior to administration. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Personnel E3	Evidence of Non-Physician Medical Practitioner (NPMP) supervision.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office A1, A2	Clinic hours are posted, and provider office hour schedules are available to staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office B1	Process for personnel's management of emergent, urgent, and medical advice telephone calls. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office B2	Protocol for telephone answering machine, voice mail system, or answering service when staff not available. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office C1	Appointments are scheduled according to patient's clinical needs and SFHP timeliness standards. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office C2	Patients are notified of scheduled routine and/or preventive screening appointments. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office C3	Process for verifying follow-up on missed and canceled appointments. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office H2, H3	Procedure to maintain the confidentiality of personal patient information and procedure for medical record release (ROI form with documented expiration date)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office H4	Process of medical records per confidentiality and security standards. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Office H5	Medical records are retained for a minimum of 10 years. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical A5	Written process for dispensing of sample drugs. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical B8	Written plan for vaccine protection in case of power outage or malfunction of equipment. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical B11	Site method(s) for drug and hazardous substance disposal. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical C6	Latest version of Vaccine Information Sheets (VIS) distributed to patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical C8	Site registered to California Immunization Registry (CAIR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Preventive B1, B2, B3	Health education materials and plan specific resource information are readily available, applicable to practice and population, and available in threshold languages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infection A3	Process for effectively isolating infectious patients with potential communicable conditions. 🚫	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Instructions: Please review the following and select the checkbox if you have a log or documented written schedule in place for each item. If any items do not apply, mark as No or NA and add a comment.

Criteria	FSR Item	Yes	No	NA	If No or NA, please explain:
Access D7	Monthly log for checking emergency equipment/supplies (medication kit, O2 tank) for expiration and operating status. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Access E2	Annual maintenance (calibration) of all medical equipment according to equipment manufacturer's guidelines. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Personnel C3	Documentation of education/training for non-licensed medical personnel is maintained on site. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical B4, B5, B6, B7	Daily AM/PM refrigerator &/or freezer temperatures are documented and within normal limits  <i>Refrigerator: 36° - 46° F or 2° - 8° C</i> <i>Freezer: 5° F or - 15° C or lower</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical C1, C2	Monthly log for checking expiration date of all drugs (including vaccines and samples), and infant and therapeutic formulas. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical D4, D5	Monthly log for checking lab supplies & expiration (i.e. vacutainers, culture swabs, test solutions, all lab reagents, hemocult, culture medium and collection system, etc.) 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infection B3	Monthly sharps injury incidents documented Sharp injury incidents are documented. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Infection C2	Written schedule for routine cleaning and decontamination of equipment/work surfaces. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

 = Resource available on SFHP.org, Facility Site Review section

"I attest that these statements of compliance are accurate."

PCP or Representative Signature & Title

Date

HEALTH PLAN USE ONLY	
Attestation Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Received:
Nurse Comments:	
Nurse Reviewer Signature:	Date Approved: