SITE INSPECTION FORM

Date: ____________  Inspector: _____________________
Arrival Time: _________  Departure Time:_________

REASON FOR VISIT

□ New Provider  □ Appeal/Revocation  □ Re-Enrollment  □ Renewal
□ Re-Inspection  □ Other
Supplier Name: _____________________________________________________________
Address: ________________________________________________________________
City: __________________________  ST: _______  Zip: _______________________
Phone: ____________________________  Tax ID Number: _______________________

TYPE OF FACILITY AT THIS ADDRESS

1.) □ Storefront  □ Office Suite  □ Private Residence  □ Branch
□ Warehouse  □ P.O. Box  □ Commercial Mailbox
□ Other, (Describe): _____________________________________________________

2.) □ Y  □ N  Is the facility handicapped accessible?  If No, please explain:
________________________________________________________________________
________________________________________________________________________

3.) □ Y  □ N  Is there a visible sign on the front of the facility?  If yes, what information is posted?
□ Hours  □ Business Name  □ Phone Number  □ After Hours Phone Number  □ Other
________________________________________________________________________
________________________________________________________________________

4.) Please list hours of operation:

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RECORDS & TELEPHONE

5.) a) □ Y  □ N  Are the patient records maintained at this location?
     b) □ Y  □ N  Do these records include supplier delivery slips?
     c) □ Y  □ N  Do these records include supplier maintenance records?
d) □ Y □ N Do these records include beneficiary communications (including complaint record/communications, and patient education documentation)? If “No” to any of the above, please explain: ________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

6.)  

a. □ Y □ N Does this location have a business phone number listed in a local telephone directory under the business locations name?
   Confirmed by: □ White Pages □ Phone bill
   □ Yellow Pages □ Directory Assistance
   □ Other: ______________________________________

b. Where are calls from beneficiaries received at?
   □ The number listed above □ Another Number (Explain and list number:)
   ______________________________________
   ______________________________________
   ______________________________________

c. If applicable, how are after hours (emergency) calls handled? ______________________
   ______________________________________
   ______________________________________

d. If Answering Service, List name of Answering Service and Phone Number:
   ______________________________________
   ______________________________________

LICENSING

7.) For this section, inspector is to actually view and note the following requested information. Verify that the information on all licenses/permits are for this location being inspected.
   Expiration Date:

a.) Occupational/Business License ____________________________
b.) State Business License ____________________________
c.) City or County Business License ____________________________
d.) Business Liability Insurance ____________________________
   (Amount of Coverage: ____________________________)
e.) Oxygen Permit (if applicable) ____________________________
   Does this location supply oxygen? □ Y □ N
f.) Elevator Permit (if applicable) ____________________________
   Does this location supply stair lifts, platform lifts or vehicle lifts? □ Y □ N
g.) Orthotics & Prosthetics (if applicable) ____________________________
   Does this supplier custom fabricate or fit prosthetic or orthotic items? □ Y □ N
h.) Other (explain) ____________________________
INTERVIEW OF INDIVIDUALS PRESENT

8.) a.) The first person should be the □ PIC □ Owner □ President □ Mngr. □ Administrator

Last Name: _____________________________ First Name: _____________________________

Home Address: ______________________________________________________________
City, State, Zip: ______________________________________________________________
Home Phone: ___________________________

b.) Others Present: Name: _____________________________

Name: _____________________________
Name: _____________________________

9.) Is this location a branch office, main office, or sole location? □ Branch □ Main □ Sole Location

If Branch Office, complete the following information:

Main Office Address: ______________________________________________________________
Main Office Phone: ___________________________ FAX: ___________________________
PIC for Main Office: _____________________________
How long has Main Office been operating? ___________________________

INVENTORY

10.) □ Y □ N Does the supplier have inventory in stock?

a) □ Y □ N If Yes, is the inventory stored on site?

If No, please provide off site storage address:
Address: ______________________________________________________________
City & State: _____________________________________________________________
Zip Code: ___________________________ Phone: ___________________________

b) □ Y □ N If supplier does not have any inventory in stock, do they have a contract or credit agreement with another company to purchase HME supplies? (Please attach a copy of the contract or invoice)

□ Copy Attached □ If Yes, Identify the Company:
Name: _____________________________
Address: ______________________________________________________________
City & State: _____________________________________________________________
Zip Code: ___________________________ Phone Number: ___________________________

CONTACT WITH BENEFICIARY

11.) □ Y □ N Is a copy of the current Supplier Standards provided to all Medicare beneficiaries? (Provide copy of the way this is documented.)

12.) □ Y □ N Does this supplier place stickers (with at least company name and phone number) on their equipment that is put out? (attach sample(s) below or the reverse of this page).

ADDITIONAL COMMENTS

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
SITE INSPECTION RESULT FORM  (Copy to be left with Interviewee)  Date: __________________________

Company Information:

Name: __________________________ Phone #: __________________

Address: __________________________ City: __________________ ST: ______ Zip: __________

Inspector Printed Name __________________________ Signature of Inspector __________________________

Interviewee Printed Name __________________________ Signature of Interviewee __________________________

Results:

Yes □ No □ Site Inspection Completed? If unable to conduct site visit for any reason, explain below: ____________________________________________________________________________________________

Yes □ No □ Site passes inspection? If No, please circle the corresponding number below:

1. Not appropriate location: ____________________________________________________________________________________________

2. Not handicapped accessible: ____________________________________________________________________________________________

3. Not a visible sign on the front of the facility: ___________________________________________________________________________

   Sign does not have required information: _________________________________________________________________________________

4. Hours of operation are not posted or are different than hours listed on application: ____________________________________________________________________________________________

   Emergency information is not posted: _____________________________________________________________________________________

5. a. Patient records are not maintained at facility or appropriate off-site facility: ____________________________________________________________________________________________

   b. Records do not include supplier delivery slips: ____________________________________________________________________________________________

   c. Records do not include supplier maintenance records: ____________________________________________________________________________________________

   d. Records do not include beneficiary communications including complaint and education records: ____________________________________________________________________________________________

6. a. Business phone number is not listed in local directory: ____________________________________________________________________________________________

   b. Other number for beneficiaries is not appropriate: ____________________________________________________________________________________________

   c. Emergency number is not appropriate: ____________________________________________________________________________________________

   d. Answering Service not provided or does not meet requirements: ____________________________________________________________________________________________

7. a. Occupational License not found or expired: ____________________________________________________________________________________________

   b. State Business license not found or expired: ____________________________________________________________________________________________

   c. City or County Business License not found or expired: ____________________________________________________________________________________________

   d. General Liability not found, not enough coverage, or expired: ____________________________________________________________________________________________

   e. Oxygen Permit not found or expired: ____________________________________________________________________________________________

   f. Elevator Permit not found or expired: ____________________________________________________________________________________________

   g. Orthotics & Prosthetics Permit not found or expired: ____________________________________________________________________________________________

   h. Other: ____________________________________________________________________________________________

8. a. PIC, Owner, President, Mngr. Administrator not available for Interview: ____________________________________________________________________________________________

9. Supplies provided at location do not match the items listed on application: ____________________________________________________________________________________________

10. a. Inventory is stored inappropriately: ____________________________________________________________________________________________

    b. Inventory is not in stock and no contract or credit agreement is in place: ____________________________________________________________________________________________

11. Copy of Supplier Standards is not provided to Medicare Beneficiaries: ____________________________________________________________________________________________

12. Supplier Stickers are not placed on equipment with appropriate information: ____________________________________________________________________________________________

Additional Notes: ____________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

□ Yes □ No □ If Site Inspection is Failed: Licensees who fail to pass the site inspection must cease and desist their operations upon receipt of a copy of this Site Inspection Results Form until they have come into compliance with all applicable standards, unless the Board negotiates a written plan for compliance with the licensee and conducts a further inspection for compliance at a time to be determined by the Board. Upon notice of a failure to pass inspection and obtain a license, licensees and applicants have 30 days to file a written appeal regarding the site inspection results and/or request a new inspection (following resolution of the cited deficiencies) or be subject to the penalties provided under Ala. Code § 34-14C-6. Submit all such requests to the Board office on company letterhead and include a $250.00 re-inspection fee.

□ Upon passing the site inspection: Applicants who have passed the site inspection have 60 days from the date of written notification of approval to submit the $250.00 license fee, or the application and fees will be forfeited. Your license will be issued upon receipt of the licensure fee. The Fee Schedule is located under the Rules and Regulations at www.homemed.alabama.gov. Supplier Standards are also available on this site.