ALABAMA BOARD OF HOME MEDICAL EQUIPMENT SERVICES PROVIDERS

Post Office Box 240636
Montgomery, AL 36124-0636
Phone: 334.215.3474
FAX: 334.215.3457
www.homemed.alabama.gov

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:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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

_____

_____

_____

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P.O. Box 240636; Montgomery, AL 36124
Web Site: www.homemed.alabama.gov

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: _____

□ If Site Inspection is Failed: Licensees who fail to pass an 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**.