# GENERAL POLICIES AND PROCEDURES

* 1. Are you a Medicare Provider? No

Accreditation expiration date:

1. Do you provide a Low Vision Clinic? No
2. What is your proposed service rate: per Describe any additional charges
3. Describe your qualifications to perform this service:
4. Describe procedure and consumer determination of the following: (please attach a copy of each form)

Evaluation

Plan of Care

Training

1. What measures are in place to ensure the consumer can adapt to the recommended plan of care?
2. Describe your policy for notifying ASAP agency of problems encountered that affect, or would affect, completion of the service authorized:
3. Describe your policy and procedure for apprising ASAP agency of the outcome of your intervention:

# PERSONNEL PROCEDURE

* 1. Do you perform the following:
		1. CORI
		2. DPH/Nurse's Registry
		3. Office of the Inspectors General

Yes Yes Yes

How often? How often? How often?

B. Do you employ Certified Low Vision Therapists certified by the Academy for Certification of Vision Rehabilitation

and Education Professionals (ACVREP)?

Yes

If yes, what is your policy to ensure they are properly credentialed and meet continuing education requirements?

1. List the number of employed Occupational therapists who are not certified by ACVREP.
2. What are your requirements of the above employees for additional training, education and in-service training to perform Vision Rehabilitation Therapy?
3. Describe your policy for employee supervision
4. Describe you policy and requirements for employee testing of tuberculosis.
5. Describe your procedure for ensuring staff sensitivity to elders

Employee who completed this form Date: