

| Site Visit for County Home Health Agencies   |                                   |                          |
|--|-----------------------------------|--------------------------|
| Date of Site Visit   | Provider Representative           | Time of Visit            |
|  |                                   |                          |
| Provider Information   |                                   |                          |
| Provider Name  | NPI Number                        | Contact Person/Job Title |
|  |                                   |                          |
| Telephone  |                                   |                          |
| Call phone number listed on provider application. Does the phone ring onsite? Y N<br>Comments: |                                   |                          |
| Physical Location/Staffing Information   |                                   |                          |
| Will billing be done onsite? Y N   | List accepted insurance carriers: |                          |
| Confirm business hours from employee:  |                                   |                          |
| Other Information  |                                   |                          |
| List job duties of POC:  |                                   |                          |
| Time POC in current job:   | Previous experience? Y N          |                          |
| Prior to ending visit, representative should:  | Photograph Business               |                          |
| Is it necessary to attach additional documentation for areas of concern during visit? Y N      |                                   |                          |

\_\_\_\_\_  
Provider Representative:

\_\_\_\_\_  
Date

**PL31\_Alabama Site Visit Checklists & Report**

| <b>Site Visit for DME Providers</b>  |                                |   |                                 |                         |
|--|--------------------------------|---|---------------------------------|-------------------------|
| <b>Date of Site Visit</b>  | <b>Provider Representative</b> |   | <b>Time of Visit</b>            |                         |
|  |                                |   |                                 |                         |
| Provider Information (Circle One)  |                                |   |                                 |                         |
| Is the provider:            DME Only            P&O            Both DME and P&O                  |                                |   |                                 |                         |
| <b>Provider Name</b>   | <b>NPI Number</b>              |   | <b>Contact Person/Job Title</b> |                         |
|  |                                |   |                                 |                         |
| <b>Signage</b>   |                                |   |                                 |                         |
| Is a permanent sign present to identify business? Y N If no, receipt to show sign ordered? Y N   |                                |   |                                 |                         |
| Does the name on the sign match the name on the provider file? Y N                               |                                |   |                                 |                         |
| If no, does building allow for a sign? Y N If no, list reason:                                   |                                |   |                                 |                         |
| If in office suite, is a sign present on the door to identify business? Y N Hours Displayed? Y N |                                |   |                                 |                         |
| Is representative satisfied recipients can easily locate business? Y N                           |                                |   |                                 |                         |
| <b>Telephone</b>   |                                |   |                                 |                         |
| Call phone number listed on provider application. Does the phone ring onsite? Y N                |                                |   |                                 |                         |
| Comments: (List phone number)  |                                |   |                                 |                         |
| <b>Physical Location/Staffing Information</b>  |                                |   |                                 |                         |
| Number of employees present at time of visit:  |                                | Total employed at site:   |                                 |                         |
| List DME products sold at this location:   |                                |   |                                 |                         |
| Converse about products. Representative confident employee familiar with products? Y N           |                                |   |                                 |                         |
| Does provider have supplies on hand to fill prescriptions for walk-in recipients? Y N            |                                |   |                                 |                         |
| Does provider have a process for special orders? Y N   |                                | Are refills automatically refilled? Y N   |                                 |                         |
| Does company deliver supplies? Y N   |                                | Is space adequate for conducting business? Y N  |                                 |                         |
| Is space adequate to store supplies? Y N   |                                | Is business license on display? Y N   |                                 |                         |
| HME license Y N N/A  |                                | Does business license name match signage? Y N   |                                 |                         |
| O&P License Certification Y N N/A  |                                | Are business cards/brochures available? Y N   |                                 |                         |
| Mastectomy Only Y N  |                                | How long as DME been open at this location:<br>Other location in past? If yes, where? |                                 |                         |
| Will billing be done onsite? Y N N/A   |                                | If yes, where?  |                                 |                         |
| Confirm business hours from employee:  |                                | List accepted insurance carriers:   |                                 |                         |
|  |                                | Office closed for lunch? If so, list time closed.                                     |                                 |                         |
| <b>Other Information</b>   |                                |   |                                 |                         |
| List job duties of POC:  |                                |   |                                 |                         |
| Time POC in current job:   |                                | Previous experience? Y N  |                                 | If so, list time:       |
| <b>Prior to ending visit, representative should:</b>   |                                |   |                                 |                         |
| Copy or photograph business license  |                                | Copy or photograph HME license (if applicable)  |                                 |                         |
| <b>Photograph-----</b>   | <b>Signage</b>                 | <b>Hours of operation</b>   | <b>Supplies on Hand</b>         | <b>Stored DME items</b> |
|  |                                |   |                                 |                         |
| <b>Is it necessary to attach additional documentation for areas of concern during visit? Y N</b> |                                |   |                                 |                         |

\_\_\_\_\_  
Provider Representative:

\_\_\_\_\_  
Date

| <b>Site Visit for Privately Owned Home Health Providers</b>                                      |  |                                 |
|--|--|---------------------------------|
| <b>Date of Site Visit</b>  | <b>Provider Representative</b>   | <b>Time of Visit</b>            |
| Provider Information   |  |                                 |
| <b>Provider Name</b>   | <b>NPI Number</b>  | <b>Contact Person/Job Title</b> |
|  |  |                                 |
| <b>Signage</b>   |  |                                 |
| Is a permanent sign present to identify business? Y N  |  |                                 |
| If no, does building allow for a sign? Y N If no, list reason:                                   |  |                                 |
| If in office suite, is a sign present on the door to identify business? Y N Hours Displayed? Y N |  |                                 |
| <b>Telephone</b>   |  |                                 |
| Call phone number listed on provider application. Does the phone ring onsite? Y N<br>Comments:   |  |                                 |
| <b>Physical Location/Staffing Information</b>  |  |                                 |
| Number of employees present at time of visit: Total employed at site:                            |  |                                 |
| Obtain a copy of business license Y N (n/a for Home Health)                                      |  |                                 |
| How long has business been open at this location: Other location in past? If yes, where?         | Operated at another location in state? Y N<br>If yes, where?                                 |                                 |
| Will billing be done onsite? Y N   | List accepted insurance carriers:  |                                 |
| Confirm business hours from employee:  | Office closed for lunch? If so, list time closed.  |                                 |
| <b>Other Information</b>   |  |                                 |
| List job duties of POC:  |  |                                 |
| Time POC in current job:   | Previous experience? Y N   |                                 |
| <b>Prior to ending visit, representative should:</b>   | Photograph Signage Photograph Business<br>(signage n/a for ambulance but photo if available) |                                 |
| Is it necessary to attach additional documentation for areas of concern during visit? Y N        |  |                                 |

Provider Representative: \_\_\_\_\_

Date \_\_\_\_\_

| Site Visit for Moderate Risk Providers   |   |                          |
|--|---|--------------------------|
| Date of Site Visit   | Provider Representative   | Time of Visit            |
|  |   |                          |
| Provider Information   |   |                          |
| Provider Name  | NPI Number  | Contact Person/Job Title |
|  |   |                          |
| Signage  |   |                          |
| Is a permanent sign present to identify business? Y N If no, receipts to show sign ordered? Y N  |   |                          |
| If no, does building allow for a sign? Y N If no, list reason:   |   |                          |
| If in office suite, is a sign present on the door to identify business? Y N Hours Displayed? Y N   |   |                          |
| Is representative satisfied recipients can easily locate business? Y N   |   |                          |
| Telephone  |   |                          |
| Call phone number listed on provider application. Does the phone ring onsite? Y N  |   |                          |
| Comments:  |   |                          |
| Physical Location/Staffing Information   |   |                          |
| Number of employees present at time of visit:      Total employed at site:      (If a volunteer fire/rescue, ask number of employees/volunteers) |   |                          |
| Obtain a copy of business license Y N NA (only required for PDN-may also have state license)   |   |                          |
| How long has business been open at this location: Other location in past? If yes, where?   | Operated at another location in state? Y N If yes, where?                                       |                          |
| Will billing be done onsite? Y N   | List accepted insurance carriers:   |                          |
| Confirm business hours from employee:  | Office closed for lunch? If so, list time closed.   |                          |
| Other Information  |   |                          |
| List job duties of POC:  |   |                          |
| Time POC in current job:   | Previous experience? Y N  |                          |
| <b>Prior to ending visit, representative should:</b>   | Photograph Signage Photograph Business (signage n/a for ambulance or PT but photo if available) |                          |
| Is it necessary to attach additional documentation for areas of concern during visit? Y N  |   |                          |

Provider Representative: \_\_\_\_\_

Date \_\_\_\_\_