Vision Rehabilitation

I. General Policies and Procedures

A. Please describe your qualifications to perform this service.

B. What is your proposed service rate for Vision Rehabilitation Therapy?

$_____ per _____ Describe any additional charges.

C. Describe your policy for notifying ASAP agency of problems encountered that affect, or would affect, completion of the service authorized:

D. Describe your policy for apprising ASAP agency of the outcome of your intervention:

E. Describe your procedure/capacity to respond to emergencies:

II. Personnel Procedure

A. Describe your policy for ensuring that those providing services for ASAP Clients are properly credentialed:

B. Describe your procedure for ensuring staff sensitivity to elders:

C. Please describe your confidentiality policy.

Name of Provider employee who completed this form:

Signature: Date:

Vision Rehabilitation

Please note the documents and records that will be required for the Client files and/or Employee files to be reviewed at the time of On Site Evaluation.

Client Records Review Provider: Date: Monitor:					
Current authorization in file					
ID Info – name; address; phone; DOB					
Emergency contact(s) and phone					
Physician(s) name and phone					
Hospital name and phone					
Medical/ social diagnosis					
Name of current CM/RN					
Date of referral					
Service start date					
Termination: date, if applicable					
Comments					

Vision Rehabilitation

					Vision Rehabilitation Employee Records Review Provider: Date: Monitor:
					Start and Termination Date
					Number of Reference Checks
					Physicals: Date
					TB: Date
					Orientation: Date
					Job Description(s)
					Ongoing training: dates
					Annual Performance Appraisal: Date
					CPR/ First Aid: Dates
					Licenses
					CORI Check[1]
					Comments

[1] M.G.L., Chapter 6, Section 172C