

CALIFORNIA CHILDREN SERVICES

ORTHOTIC AND/OR PROSTHETIC FACILITY APPLICATION

A CCS approved Orthotic and/or Prosthetic Facility must: (1) Be accredited by the American Board for Certification in Orthotics and Prosthetics (ABC) or the Board for Orthotist/Prosthetist Certification (BOC) OR (2) Meet all criteria in Section B of this application.

In addition:

Have a **minimum** of one CCS paneled practitioner on staff of the specialty in which the facility is applying (Orthotics, Prosthetics or both).

(Please type or print in ink

APPLICATION IS BEING MADE FOR:

Orthotic facility _____ Prosthetic facility _____ Orthotic and Prosthetic facility _____
.....

NAME OF FACILITY _____

ABC ACCREDITATION

NUMBER _____

(Attach copy of Certificate

MEDI-CAL NUMBER _____

ADDRESS _____

CITY _____ ZIP CODE _____ COUNTY _____

TELEPHONE: AREA CODE _____ NUMBER _____ EXTENSION _____

NAME OF PERSON IN CHARGE AT THIS ADDRESS _____

LAST FIRE DEPARTMENT INSPECTION WAS MADE _____
MONTH _____ YEAR _____

WRITTEN REFERENCE IS BEING SUBMITTED BY DOCTOR(S) _____

DOES THE FACILITY HAVE ANY BRANCH OFFICES? YES NO

IF YES, LIST NAMES AND ADDRESS FOR EACH LOCATION. LIST P&O PROCEDURES CARRIED OUT IN BRANCH OFFICE (FULL SERVICE; PARTIAL SERVICE). USE SEPARATE SHEET IF NECESSARY.

SECTION A (Facility Personnel)

List names and certificate numbers (Use separate sheet if necessary.)

- | | | |
|----------------------------|-------|-----------------|
| 1. Certified Practitioners | Name | Certificate No. |
| | _____ | |
| | _____ | |
| | _____ | |
| 2. Registered Assistants | Name | Certificate No |
| | _____ | |
| | _____ | |
| | _____ | |
| 3. Registered Technicians | Name | Certificate No |
| | _____ | |
| | _____ | |
| | _____ | |

SECTION B (Physical Plant)

1. The facility is located in a:

Store Building _____ Office Building Hospital Other _____

- | | EXPLAIN ALL "NO" ANSWERS | |
|--|--------------------------|----------|
| | YES | NO |
| 2. Is the exterior and interior of the facility neat and clean? | YES _____ | NO _____ |
| 3. Does the facility have adequate parking space for handicapped persons? | YES | NO |
| 4. Is there easy access to the facility for wheelchair and other disabled patients (i.e., no steps; solid handrails for ramps; doors wide enough, etc.)? | YES | NO |
| 5. Does the facility provide a separate waiting area adequate for the patient load? | YES | NO |
| 6. Are the reception and patient management areas separated from the laboratory area by a floor to ceiling partition? | YES | NO |
| 7. How many rest rooms are located in the facility? | | |
| 8. Can wheelchair patients use the rest rooms? | YES | NO |
| 9. Are grab bars provided for safety in the rest rooms? | YES | NO |
| 10. How many fitting rooms are there in the facility? | | |

- | | | |
|--|-----|----|
| 11. Is there a sturdy set of parallel bars at least eight feet long? | YES | NO |
| 12. a. Is there a full length mirror installed at one end of the parallel bars? | YES | NO |
| b. Are the parallel bars easily accessible from at least one of the fitting rooms for wheelchair patients? | YES | NO |
| 13. Can wheelchair patients navigate through: | | |
| a. halls? | YES | NO |
| b. doorways? | YES | NO |
| 14. Does a certified orthotist or prosthetist do the actual measuring, casting, and fitting of patients? | YES | NO |
| 15. Is the laboratory adequately equipped to perform routine services for orthotic and/or prosthetic patients? | YES | NO |
| 16. Is there an adequate inventory of components and repair parts and finished goods to provide routine P and/or O services for the extent and type of services the facility is providing? | YES | NO |
| 17. Are adequate fire precautions taken in the laboratory? | YES | NO |
| 18. Are adequate provisions made for the collection of dust and fumes in the laboratory? | YES | NO |
| 19. Is the responsible individual for the facility aware of the Occupational Safety and Health Act (OSHA)? | YES | NO |
| 20. Do you think adequate precautions have been taken to ensure the safety of the employees and patients? | YES | NO |

Please explain

I certify that the information I have provided above is true and correct to the best of my knowledge.

I understand that P & O devices and services require prior authorization.

I agree to:

- a. Bill insurance first (within two [2] months of the month of service[s]).
- b. Bill CCS within two (2) months of the month of service, insurance payment or insurance rejection. (Bill CCS within twelve [12] months of date of service if insurance fails to respond.)

- c. Accept payment in accordance with State regulations as payment in full; not bill families in whole or part for any CCS covered benefit; not question families regarding their ability to pay for CCS covered benefits.
 - d. Accept Medi-Cal patients authorized by CCS
 - e. Serve CCS patients regardless of race, color, religion, national origin or ancestry.
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Signature

Title

Date

PLEASE RETURN TO:

California Children's Services
Provider Services Unit
MS 8105
P.O. Box 997413
Sacramento, CA 95899-7413