HealthCare Partners, IPA
HealthCare Partners, Management Services Organization
501 Franklin Avenue, Suite 300, Garden City, New York 11530 (516) 746-2200 Fax (516) 515 - 8843

SITE ASSESSMENT TOOL

Please complete a form for <u>each</u> ACTIVE office location

(Be sure to make additional copies, one for each location)

Practice Name: _____
Street: _____
City/State/Zip Code: _____
Office Phone#: _____ Office Fax#: _____
Please list the hours the "Provider" is at this location:
M ___-___ **T** ___-___ **W** ___-___ **TH** ___-___ **F**___-___ **SAT** ___-___ **SUN** ___-___

NOTE: For any **NO** response, please provide an explanation on a separate sheet of paper.

<u>AMERICAN DISABILITY ACT</u> (view at **ada.gov/racheck.pdf**)

1. Does this office meet ADA accessibility requirements? □ **YES** □ **NO**

<u>PHYSICAL ACCESSIBILITY</u>

2. Facility entry is handicapped accessible? □ **YES** □ **NO**
3. Bathrooms are handicapped accessible? □ **YES** □ **NO**
4. Exam Tables are handicapped accessible? □ **YES** □ **NO**
5. Office Hours are posted in office? □ **YES** □ **NO**

<u>PHYSICAL APPEARANCE</u>

6. Floors, walkways, rooms, entrances and exits are clean and free of clutter? □ **YES** □ **NO**
7. Bathrooms and hand washing areas have hot water, soap and paper towels/air dryers? □ **YES** □ **NO**
8. Sufficient lighting (indoors and outdoors)? □ **YES** □ **NO**
9. Fire extinguishers, smoke detectors and sprinklers are present, accessible and in working order? □ **YES** □ **NO**
10. Evacuation plan is displayed? □ **YES** □ **NO**

<u>ADEQUATE SPACE IN WAITING AREA AND EXAM ROOMS</u>

11. Adequate seating in waiting room (3 chairs per physician)? □ **YES** □ **NO**
12. Exam room equipped with adequate space/privacy? □ **YES** □ **NO**

<u>ADEQUACY OF MEDICAL/TREATMENT RECORD KEEPING</u>

13. Medical records are filed securely, easily accessible and limited to authorized personnel? □ **YES** □ **NO**
14. All entries are legible, signed and dated? □ **YES** □ **NO**
15. HIPAA Privacy Notice is visibly displayed and distributed to all patients? □ **YES** □ **NO**

I, the undersigned, attest that the information on this form is complete and accurate.

_____ _____
Signature and Title of Authorized Personnel **Date**

SCORE: _____