Personal Care/In Home Respite Services
Attestation Review Form

Provider Name:	
Office Address:	**Phone:**
Agency Owner Name:	**Agnecy Email:**
Exp. Date of Privilege Tax License:	**Location:**
Compliance Officer:	
PCS Supervisor:	**# of PCA staff:**
IHR Supervisor:	**# of IHR staff:**

You must be able to answer YES to each of the following questions to be considered for approval.	**YES/NO**	**Comments**	**Additional Information**
Is business located in a non-residential building zoned for business?			
Is Office/Facility signage present, permanent and visible from the road? If no, provide a copy of the receipt indicating the sign has been ordered.			
Does the name on the sign match the name on the provider file?			
Office/Facility has a dedicated phone and means to transmit secure electronic data, i.e. secure email/facsimile?			
Are office hours 8:00a – 5:00pm, M- F clearly posted in plain sight?			
Is the Office exterior and grounds clean, maintained, accessible, and safe (free of hazards)?			
Is the Office/Facility open and accessible?			
Business is ADA compliant. *Minimum width of 36 inches (ramps, handrails, sufficient door width, stairs, etc.) *Ramps require 1 foot of length for every 1 inch of rise; *Ramps that change direction have 5ft x 5ft turn space; *Threshold ramps between rooms with uneven floors.			
Are parking and arrival/departure areas well-lit, include 1 marked handicap parking space 13' wide, and are free of hazards?			
Is there at least one clearly marked exit?			
Does the Office/Facility have the following documents posted: *Non-Discrimination Notice posted in plain sight; *Applicable business license or permits; and *Organizational chart posted with staff names and positions?			
Are applicable business licenses, permits and or certifications properly displayed?			
The following documents are available for review: *Current DOM Quality Assurance Standards; *Current DOM Administrative Code; and *Agency Policy & Procedures?			
Is the office/facility shared with other businesses? If so, is the other business healthcare related or other? Please specify.			
Does the Provider's business have additional locations? If so, please provide a listing inclusive of name, address and phone number of all other business locations owned by this Provider.			
Is there evidence of office equipment, supplies, locked file storage, computers, hazardous disposals, etc., for the daily operations?			
Restrooms are available for staff. *Restrooms should be within the office and have running water and operable toilet.			
Provider must take a photo of the outside of the office, including business signage.			
Provider must take photo of the parking lot, in particular the designated accessibility markings (i.e. cut burbs, ramps, handrails, etc.)			
Provider must take photo of any business vehicles with the business's advertisement noted on the vehicle.			

***NOTES**

Signature/Title of Reviewer _____ Date _____

Signature/Owner/Administrator _____ Date _____