ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT
Vision Rehabilitation

I. GENERAL POLICIES AND PROCEDURES

A. Are you a Medicare Provider? ☐ No ☐ Yes
Accreditation expiration date:

B. Do you provide a Low Vision Clinic? ☐ No ☐ Yes

C. What is your proposed service rate:
per
Describe any additional charges:

D. Describe your qualifications to perform this service:

E. Describe procedure and consumer determination of the following: (please attach a copy of each form)
Evaluation:

Plan of Care:

Training:

F. What measures are in place to ensure the consumer can adapt to the recommended plan of care?

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

H. Describe your policy and procedure for apprising ASAP agency of the outcome of your intervention:

II. PERSONNEL PROCEDURE

A. Do you perform the following:
1. CORI ☐ No ☐ Yes
How often?

2. DPH/Nurse's Registry ☐ No ☐ Yes
How often?

3. Office of the Inspectors General ☐ No ☐ Yes
How often?

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B. Do you employ Certified Low Vision Therapists certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)? ☐ No ☐ Yes
If yes, what is your policy to ensure they are properly credentialed and meet continuing education requirements?

C. List the number of employed Occupational therapists who are not certified by ACVREP.

D. What are your requirements of the above employees for additional training, education and in-service training to perform Vision Rehabilitation Therapy?

E. Describe your policy for employee supervision:
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F. Describe you policy and requirements for employee testing of tuberculosis.

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

Provider employee who completed this form
Name: Date: