



Interim Facility Site Review (Fax Back)

Site Address: _____ Date of Review: _____
 PCP Name(s): _____ Provider Office Staff Reviewer: _____
 Phone #: _____ County: _____
 Date of Full Scope: FSR: _____ MRR: _____ Health Plan Reviewer: Marcella Young, R.N.

Please complete the self-assessment of your compliance to the Critical Element criteria noted below and return the completed form to:

CenCal Health
 4050 Calle Real
 Santa Barbara, CA 93110
FAX: 805-681-3061
Attn: Provider Services Department

Critical Element	YES	NO	CAP Given (CenCal Use Only)
1. Exit doors and aisles are unobstructed and egress (escape) is accessible.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Emergency Equipment is assessable and checked monthly. Oxygen tank is over ¾ full. Oral airways, nasal cannula or mask, and resuscitator bag is present.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Only trained, qualified staff retrieve, prepare/administer medications.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The Physician reviews (signs) and follows-up on all referral/consultation reports and diagnostic test results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Only lawfully authorized persons (MD/NP/PA) dispense drugs to patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Personal Protective Equipment is readily available for staff use. (Water barrier gown, gloves, masks, eye shield).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Needlestick safety precautions are practiced on site. (Only safety needles on site and sharps log maintained for needlestick injuries).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Blood and/or other potentially infectious materials and Regulated Wastes are placed in appropriate <i>leak proof, labeled</i> containers for collection, handling, processing, storage, transport or shipping.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Spore testing of autoclave/steam sterilizer with documented results are done at least monthly. (If no autoclaving performed on site mark N/A).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Members Initial Health Exam is completed within 120 days Of enrollment to the Health Plan. Or documented within 12 months prior to Plan enrollment (CenCal Health) (New)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

I have completed the Critical Element assessment for the office site on (DATE)_____. I hereby authorize the CenCal Health to furnish the results to any government agencies that have authority over the health plans, and authorized entities in the State of California.

PCP/Representative and Title Signature: _____ **Date:** _____

CenCal Health Use Only	
Interim Review Approved: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date CAP Due: _____
Follow-up required: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Follow-up Due: _____
Nurse Reviewer Signature: _____	Date: _____