HEALTH PLAN INTERIM FACILITY SITE REVIEW—FAX BACK

Date of Interim: _____

Site Address:	**City:**
PCP Name(s):	**Phone:**
FSR Score ____% on FSR Date:_____ **MRR Score____% on MRR Date:_____**	**Provider Office Staff Reviewer:** **Name: _____Title_____**

Department of Health Care Services requires follow up assessment between cycles for the Primary Care Physician office Facility Site Review. Please have the physician or designee complete the compliance self-assessment of the Critical Element criteria below and fax the form to:
Molina Healthcare of California FSR: 1-888-858-4016 ☐ Check box if site has recently been remodeled or has moved

Critical Element	Yes	No	N/A	Comments
1. Exit doors & aisles are unobstructed and egress (escape) accessible • Accessible pedestrian paths of travel provide a clear circulation path including exit door at all times.	☐	☐		
2. Airway Management • Must have a wall oxygen delivery system or portable oxygen tank that is maintained at least ¾ full with flow meter, oropharyngeal airways, nasal cannula or mask, and Ambu Bag (appropriate sizes).	☐	☐		
3. Qualified personnel prepare/administer medication • There must be a license practitioner (MD, NP, PA, CNM) physically present in the treatment facility during the performance of authorized procedures by the Medical Assistant.	☐	☐		
4. Timely review & follow-up of referral/consultation reports & test results • The office referral process for tracking and follow up includes documentation of physician review.	☐	☐		
5. Authorized persons dispense medications • Drugs are dispensed only by a physician, pharmacist or other persons lawfully authorized to dispense medications upon the order of a licensed physician or surgeon.	☐	☐	☐	Check NA- if no Sample Medications are dispensed
6. Personal protective equipment • PPE is available for staff use on site & includes water repelling gloves, water-resistant gowns, face/e protection (e.g. face shield or goggles), & respiratory infection protection (e.g. mask).	☐	☐		
7. Needle stick precautions are practiced on site •Safety needles are used on site discarded immediately in sharps containers that are secured and inaccessible to patients.	☐	☐		
8. Blood and other infectious materials storage and handling • Containers for blood and other potentially infectious materials (OPIM) are closable, leak proof, and labeled and/or color-coded is a secure location.	☐	☐		
9. Spore testing of autoclave/steam sterilizer • Autoclave spore testing is performed at least monthly.	☐	☐	☐	Check NA- if no autoclave at site

Attestation: I hereby affirm that the information indicated on this form and any documents thereto is true, current, correct and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges or physician participation agreement.

Physician or Designee Signature/Title: _____ Date**:** _____

Health Plan Office Use Only **Interim Review Approved: Yes ☐ No ☐** **Follow-up required: Yes ☐ No ☐ CAP Needed: ☐**	**Date CAP Due:** _____ **Date Follow–up Due:** _____
Health Plan Nurse Reviewer Signature:	**Date:**