Capital BlueCross
INPATIENT SUBSTANCE ABUSE REHABILITATION FACILITY SURVEY

Provider Name: _____
CBC #: _____ **Medicare #:** _____ **Medicaid #:** _____
Accrediting Organization: _____ **Date of most recent accrediting survey:** _____
Person completing survey: _____ **Phone:** _____ **Date:** _____
Contact person (if different than above): _____ **Phone:** _____

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (🗐).

ADMINISTRATION

Number of Beds: _____
Average daily census: _____
Average Length of Stay: _____
Most Frequent Diagnosis: _____
Handicap accessible ☐ Yes ☐ No
Written policy for treatment of minors ☐ Yes ☐ No
Emergency kit/supplies available ☐ Yes ☐ No
Written policy for checking emergency supplies: ☐ Yes ☐ No
Written plan for patient medical emergency ☐ Yes ☐ No
Written plan for patient pyschiatric emergency ☐ Yes ☐ No
Written transfer agreement to acute care ☐ Yes ☐ No
If **yes**, list facilities: _____
_____
_____
Written agreement for emergency transport ☐ Yes ☐ No
If **no**, access to 911 ☐ Yes ☐ No
Written on-call policy ☐ Yes ☐ No
Written confidentiality policy ☐ Yes ☐ No
Smoke-Free Facility ☐ Yes ☐ No

QUALITY MANAGEMENT

Quality Activities

Written Performance Improvement Program ☐ Yes ☐ No
Performance Improvement Committee ☐ Yes ☐ No
Frequency of meetings: _____
Position accountable for Performance Improvement activity: _____
Quality Reports forwarded to the Board of Directors ☐ Yes ☐ No

List two current Quality Studies:
1. _____
2. _____

Written Infection Control policies ☐ Yes ☐ No
If **yes**, includes communicable diseases ☐ Yes ☐ No

Patient Satisfaction

Patient Satisfaction Surveys utilized ☐ Yes ☐ No
Most frequent issues identified:
1. _____
2. _____
Annual return rate for surveys: _____ **%**
Written patient/family complaint process ☐ Yes ☐ No

Clinical Management

Written policy on maintenance and retention of patient records: ☐ Yes ☐ No

Provider Name:

Written admission criteria ☐ Yes ☐ No

Written discharge criteria ☐ Yes ☐ No

Voluntary ☐ Yes ☐ No

Involuntary ☐ Yes ☐ No

Formal level of care criteria utilized for:

Admission ☐ Yes ☐ No

Continued stay ☐ Yes ☐ No

Criteria used:

PCPC ☐ Yes ☐ No

ASAM ☐ Yes ☐ No

Timeframe for completion of physical exam: _____

Written policy on development of treatment plans: ☐ Yes ☐ No

Timeframe for development of initial treatment plan: _____

Timeframe for development of master treatment plan: _____

Frequency of treatment plan updates: _____

Written policy for self-administration of medication: ☐ Yes ☐ No

Written policy for use of medication(s) brought from home ☐ Yes ☐ No

Written restraint policy ☐ Yes ☐ No

Written policy for other agency referrals ☐ Yes ☐ No

Written aftercare plan provided to patient/family ☐ Yes ☐ No

Written policy for patient follow-up ☐ Yes ☐ No

Patient Education/Public Health

Patient/Family education ☐ Yes ☐ No

Education materials distributed to patients/family ☐ Yes ☐ No

Clinical pathways/standardized care plans utilized ☐ Yes ☐ No

Indicate number of pathways/care plans developed: _____

Services for hearing impaired ☐ Yes ☐ No

Services for speech impaired ☐ Yes ☐ No

Services for visually impaired ☐ Yes ☐ No

Bilingual services ☐ Yes ☐ No

Bilingual patient education materials ☐ Yes ☐ No

Languages offered: _____

Data Collection

Transfers to Acute Care ☐ Yes ☐ No

Transfers to Mental Health Facility ☐ Yes ☐ No

Readmissions ☐ Yes ☐ No

Average Length of Stay ☐ Yes ☐ No

AMA Discharges ☐ Yes ☐ No

Others, please list: _____

STAFF

Written policy for credentialing of:

Physicians ☐ Yes ☐ No

Nurses ☐ Yes ☐ No

Allied Health ☐ Yes ☐ No

Written policy for re-credentialing of:

Physicians ☐ Yes ☐ No

Nurses ☐ Yes ☐ No

Provider Name:

Allied Health ☐ Yes ☐ No

Clinical Competency Evaluation ☐ Yes ☐ No

Frequency: _____

Annual performance evaluation of staff ☐ Yes ☐ No

Minimum number of educational programs annually attended by staff: _____

Written policy for verification of licensure/certification of staff ☐ Yes ☐ No

Written policy for verification of education/training of staff ☐ Yes ☐ No

Written policy addressing the following for clinical staff:

Recovery ☐ Yes ☐ No

Abstinence ☐ Yes ☐ No

Relapse ☐ Yes ☐ No

Medical Staff

Medical Director ☐ Yes ☐ No

Name: _____

☐ Full Time ☐ Part Time

☐ Employed ☐ Contracted

Board Certified ☐ Yes ☐ No

Specialty: _____

Physician on-call 24 hrs/day ☐ Yes ☐ No

Nurses available 24 hrs/day ☐ Yes ☐ No

_____ # of Registered Nurses

_____ # of Licensed Practical Nurses

_____ Staff to patient ratio

Minimum of 2 staff members present at all times ☐ Yes ☐ No

Other Staff

Project Director

Name: _____

Degree: _____

Clinical Supervisor

Name: _____

Degree: _____

_____ # of Certified Addiction Counselors

_____ # of Licensed Psychologists

_____ # of Bachelor prepared Counselors

_____ # of Master prepared Counselors

_____ # of Counselor Assistants

_____ # of Mental Health Counselors

_____ # of Licensed Psychiatrists

_____ # of Recreational Therapists

_____ # of Activity Therapists

Bioengineering specialist ☐ Yes ☐ No

Degreed ☐ Yes ☐ No

Trained ☐ Yes ☐ No

List other: _____

Written policy on CPR certfication ☐ Yes ☐ No

Minimum of 2 CPR certified staff present at all times ☐ Yes ☐ No

_____ **%** Direct patient care givers CPR certified

24 hr awake coverage available ☐ Yes ☐ No

Written policy for supervision of clinical staff ☐ Yes ☐ No

SERVICES

Programs for:

Children ☐ Yes ☐ No

Adolescents ☐ Yes ☐ No

Adults ☐ Yes ☐ No

Men ☐ Yes ☐ No

Women ☐ Yes ☐ No

Pregnant women ☐ Yes ☐ No

Geriatrics ☐ Yes ☐ No

Dual Diagnosis ☐ Yes ☐ No

If **yes**, availability of:

Psychiatrist ☐ Yes ☐ No

Licensed psychologist ☐ Yes ☐ No

Psychiatric social worker ☐ Yes ☐ No

Mental health counselor ☐ Yes ☐ No

Other: _____

Provider Name:

Therapies offered:

Individual	☐ Yes ☐ No
Group	☐ Yes ☐ No
Family/Couples	☐ Yes ☐ No

Other: _____

Support services

Laboratory access	☐ Yes ☐ No
7 days/week	☐ Yes ☐ No
Pharmacy access	☐ Yes ☐ No
7 days/week	☐ Yes ☐ No

Other Substance Abuse Services:

	On-Site	Off-Site
Outpatient Detox	☐ Yes ☐ No	☐ Yes ☐ No
Inpatient Detox	☐ Yes ☐ No	☐ Yes ☐ No
Outpatient	☐ Yes ☐ No	☐ Yes ☐ No
Intensive Outpatient	☐ Yes ☐ No	☐ Yes ☐ No
Partial Hospitalization	☐ Yes ☐ No	☐ Yes ☐ No

FACILITY / SAFETY

Written emergency preparedness plan ☐ Yes ☐ No

Plan includes procedures for the following:

Fire	☐ Yes ☐ No
Loss of utilities	☐ Yes ☐ No
Inclement weather	☐ Yes ☐ No

Written policy for safety assessment of equipment / appliances brought from home: ☐ Yes ☐ No

Fire extinguishers available on each unit ☐ Yes ☐ No

Number of fire drills per year: _____

Fire extinguishers checked annually ☐ Yes ☐ No

Fire evacuation plan posted within facility ☐ Yes ☐ No

COMMENTS

_____

_____

_____

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_____

As a reminder, please be sure to include:

- ***Facility Information Sheet***
- ***Name sheet for branch offices***
- ***Affiliate or owned services***
- ***Program Description***

Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.

Branch Offices

Name: _____
Services Provided: _____
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment: _____

Address: _____
City: _____
Phone: _____
Contact Person: _____
Counties Served: _____

Provider Name:

Name: ______________________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment: ________
Address: ____________________________
City: ____________________________
Phone: ____________________________
Contact Person: ______________________
Counties Served: _____________________

Name: ______________________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment: ________
Address: ____________________________
City: ____________________________
Phone: ____________________________
Contact Person: ______________________
Counties Served: _____________________

Name: ______________________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment: ________
Address: ____________________________
City: ____________________________
Phone: ____________________________
Contact Person: ______________________
Counties Served: _____________________

Name: ______________________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment: ________
Address: ____________________________
City: ____________________________
Phone: ____________________________
Contact Person:
Counties Served:

Name: ______________________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment: ________
Address: ____________________________
City: ____________________________
Phone: ____________________________
Contact Person: ______________________
Counties Served: _____________________

Name: ______________________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment: ________
Address: ____________________________
City: ____________________________
Phone: ____________________________
Contact Person: ______________________
Counties Served: _____________________

Name: ______________________________
Services Provided: ______________________
Billing Site Only ☐ Yes ☐ No
Date of Acquisition or Establishment: ________
Address: ____________________________
City: ____________________________
Phone: ____________________________
Contact Person: ______________________
Counties Served: _____________________

Provider Name:

HEALTHCARE FACILITY INFORMATION FORM

Provider Name:_____
Parent:_____
Affiliation:_____
Affiliation:_____

Number of Years in business:_____

Type of Control

- ☐ **Voluntary Nonprofit**
- ☐ **Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)
  - ☐ Individual _____
  - ☐ Partnership_____
  - ☐ Corporation_____
  - ☐ Other_____
- ☐ **Government**
  - ☐ Federal
  - ☐ State
  - ☐ County
  - ☐ Other, explain:_____

Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

- ☐ Yes, explain:_____
- ☐ No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

- ☐ Yes
- ☐ No

If yes, provide a copy to Capital Blue Cross

Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

COMMENTS: _____

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

Provider Name:

Adams ❑
Berks ❑
Centre ❑
Columbia ❑
Cumberland ❑
Dauphin ❑
Franklin ❑
Fulton ❑
Juniata ❑
Lancaster ❑
Lebanon ❑
Lehigh ❑
Mifflin ❑
Montour ❑
Northampton ❑
Northumberland ❑
Perry ❑
Schuylkill ❑
Snyder ❑
Union ❑
York ❑

Other ❑