Central Fabrication Accreditation Application

Central Fabrication (non-patient care centers) will provide the following services.

CENTRAL FABRICATION TYPE: *Check all that apply.*

☐ Orthotic (includes Pedorthic) ☐ Prosthetic ☐ Pedorthic (only below ankle items/devices)

PRIMARY LOCATION

Organization Name: _____

(To be used on all identifying documents, including the Certificate of Accreditation. Please provide "dba' if appropriate)

Doing Business As (DBA): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Web Address: _____ Federal Tax ID (EIN): _____

DOCUMENT LOCATION: *Please select one.*

☐ Records are housed at primary location listed above.

☐ Records are housed at a different location.
Records are at the following location:

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Contact Name/Title _____

Cell: _____ Email: _____

Documentation at this location:

☐ Personnel Files ☐ Clinical Records ☐ Financial/Billing ☐ Customer Satisfaction Surveys

OWNERSHIP INFORMATION:

List all individuals holding more than 5% of company shares or provide a current list of your Central Fabrication's Board of Directors or Trustees. Please attach a separate sheet if necessary.

Owner Name: _____ Percentage of Ownership: _____

Owner Name: _____ Percentage of Ownership: _____

DAYS AND HOURS OF OPERATION: Indicate am/pm.

Mon ___–___ Tue ___–___ Wed ___–___ Thu ___–___ Fri ___–___ Sat ___–___ Sun ___–___

Closed for Lunch? ☐ Yes ☐ No If yes, indicate time _____

Hours by Appointment only? ☐ Yes ☐ No If yes, indicate days _____

ON-SITE ACCREDITATION CONTACT:

Name of the individual(s) to be contacted regarding this application and accreditation survey

Primary Contact Name: _____ Title: _____

Cell: _____ Email: _____

Secondary Contact Name: _____ Title: _____

Cell: _____ Email: _____

CERTIFIED/LICENSED INDIVIDUALS:

List all clinical staff serving this location. Please attach a separate sheet if necessary.

Name: _____ Credential Type _____ Position / Title _____ Supervisor ☐ Yes ☐ No

Name: _____ Credential Type _____ Position / Title _____ Supervisor ☐ Yes ☐ No

Name: _____ Credential Type _____ Position / Title _____ Supervisor ☐ Yes ☐ No

Name: _____ Credential Type _____ Position / Title _____ Supervisor ☐ Yes ☐ No

BILLING PERSONNEL:

List all billing personnel. Please attach a separate sheet if necessary.

Name _____ Position / Title _____

CRIMINAL HISTORY

Failure to respond will result in the application being returned. Failure to provide accurate, true and correct information shall constitute grounds for denial of your application, or removal of the credential.

Has any owner or facility personnel ever been charged with a felony and plead guilty to, or been convicted of a lesser charge (e.g. misdemeanor)? ☐ Yes ☐ No

Has any owner or facility personnel ever been prohibited from doing business with any division of the federal government or is on the Office of the Inspector General's (OIG) exclusion list? ☐ Yes ☐ No

TERMS OF AGREEMENT

The undersigned Organization makes application to The American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., for voluntary accreditation of the Organization and certifies that the information recorded in this application and attachments is true and correct. The Organization agrees, at all times, to provide information requested by ABC relevant to the review, evaluation and maintenance of the Organization's accreditation status. Information obtained or generated by ABC in the accreditation process is for the purpose of reviewing the professional service of the Organization. ABC acknowledges that the information obtained or generated by ABC shall be considered confidential between the Organization and ABC, and shall be treated on a confidential basis, except as otherwise provided in ABC's policies or as required by law, a court of law or a governmental agency. ABC will not take possession of any private health information about which it becomes aware during the course of ABC's investigation of this application. The Organization agrees that, if accredited, it will remain in compliance with ABC's accreditation standards and that failure to do so may result in loss of ABC accreditation status. The Organization is responsible for immediately being in compliance with existing, new and/or modified accreditation standards, as and when they are adopted by ABC. The Organization agrees to abide by and be bound by the ABC Code of Professional Responsibility & Rules and Procedures and as they may be modified by ABC. The Organization's failure to abide by these terms and conditions may result in sanctions, including loss of accreditation status, against the Organization.

By initialing and signing my name below, I agree to the following statements:

☐ I have read the Terms of Agreement section above.

☐ I understand that all fees associated with this application are non-refundable.

☐ I understand that my organization must notify ABC in writing within 30 days of all changes in ownership, corporate structure, location, personnel and/or provision of items/devices. Some changes may require submitting a new application, survey and applicable fees.

☐ I attest that all information reported on this application is complete, accurate and true to the best of my knowledge. I understand that falsification of information may result in a revocation of accreditation.

Accepted By:

Organization Name: _____

Printed Name of CEO or Authorized Personnel: _____

Signature: _____Date: _____

BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT is made a part of The American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC) Application for Accreditation (hereinafter, the underlying Agreement) submitted to ABC by _____ (the Surveyed Organization). The underlying Agreement, when accepted by ABC, establishes the terms of the relationship between ABC and the Surveyed Organization.

Whereas, ABC and the Surveyed Organization are parties to the underlying Agreement pursuant to which ABC provides certain accreditation survey and related services to the Surveyed Organization and, in connection with the provision of those services, the Surveyed Organization discloses to ABC certain Protected Health Information (PHI) (as defined in 45 C.F.R. §164.501) that is subject to protection under the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

Whereas, the Surveyed Organization is a Covered Entity as that term is defined in the HIPAA implementing regulations, 45 C.F.R. Part 160 and Part 164, Subparts A and E, the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule);

Whereas, ABC, as a recipient of PHI from the Surveyed Organization, is a Business Associate as that term is defined in the Privacy Rule;

Whereas, pursuant to the Privacy Rule, all Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI; and

Whereas, the purpose of this Agreement is to comply with the requirements of the Privacy Rule, including, but not limited to, the Business Associate contract requirements at 45 C.F.R. §164.501(e).

NOW, THEREFORE in consideration of the mutual promises and covenants contained herein, the parties agree as follows:
1. Definitions. unless otherwise provided in this Agreement, capitalized terms have the same meanings as set forth in the Privacy Rule.

2. Scope of Use and Disclosure by ABC of Protected Health Information

A. ABC shall be permitted to use and disclose PHI that is disclosed to it by the Surveyed Organization as necessary to perform its obligations under the underlying Agreement in accordance with ABC's established policies, procedures and requirements.

B. unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Agreement or required by law, ABC may:

1. use the PHI in its possession for its proper management and administration and to fulfill any legal responsibility of ABC;

2. disclose the PHI in its possession to a third party for the purpose of ABC's proper management and administration or to fulfill any legal responsibilities of ABC; provided, however, that the disclosures are required by law or ABC has received from the third party written assurances that (i) the information will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the third party; and (ii) the third party will notify ABC of any instances of which it becomes aware in which the confidentiality of the information has been breached;

3. aggregate the PHI with that of other Surveyed Organizations for the purpose of providing the Surveyed Organization with data analyses relating to the Health Care Operations of the Surveyed Organization. ABC may not disclose the PHI of one surveyed Organization to another Surveyed Organization without the written authorization of the Surveyed Organizations involved; and

4. de-identify any and all PHI created or received by ABC under this Agreement; provided that the de-identification conforms to the requirements of the Privacy Rule.

3. Obligations of ABC. In connection with its use and disclosure of PHI, ABC agrees that it will:

A. use or further disclose PHI only as permitted or required by this Agreement or as required by law;

B. use reasonable and appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement;

C. To the extent practicable, mitigate any harmful effect that is known to ABC of a use or disclosure of PHI by ABC in violation of this Agreement.

D. Report to the Surveyed Organization any use or disclosure of PHI not provided for by this Agreement of which ABC becomes aware;

E. Require contractors or agents to whom ABC provides PHI to agree to the same restrictions and conditions that apply to ABC pursuant to this Agreement.

F. Make available to the Secretary of Health and Human Services ABC's internal practices, books and records relating to the use and disclosure of PHI for purposes of determining the Surveyed Organization's compliance with the Privacy Rule, subject to any applicable legal privileges;

G. Within 15 days of receiving a request from the Surveyed Organization, make available the information necessary for the Surveyed Organization to make an accounting of disclosures of PHI about an individual;

H. Within 10 days of receiving a written request from the Surveyed Organization, make available PHI necessary for the Surveyed Organization to respond to individuals' requests for access to PHI about them that is not in the possession of the Surveyed Organization, in the event that the PHI in ABC's possession constitutes a Designated Record Set;

I. Within 15 days of receiving a written request from the Surveyed Organization, incorporate any amendments or corrections to the PHI in accordance with the Privacy Rule in the event that the PHI in ABC's possession constitutes a Designated Record Set.

J. Not make any disclosure of PHI that the Surveyed Organization would be prohibited from making.

K. In order to maintain the security of Surveyed Organization's patients' electronic protected health information (E-PHI), Business Associate agrees to:

1. implement administrative, physical and technical safeguards required by the HIPAA Security rule;
2. ensure its subcontractors also agree to implement these safeguards;
3. report to the Surveyed Organization any security incident of which ABC becomes aware.

4. Obligations of the Surveyed Organization. The Surveyed Organization agrees that it:

A. has included, and will include, in the Surveyed Organization's Notice of Privacy Practices required by the Privacy Rule that the Surveyed Organization may disclose PHI for health care operations purposes;

B. has obtained, and will obtain, from Individuals, consents, authorizations and other permissions necessary or required by laws applicable to the Surveyed Organization for ABC and the Surveyed Organization to fulfill their obligations under the underlying Agreement and this Agreement;

C. will promptly notify ABC in writing of any restrictions on the use and disclosure of PHI about Individuals that the Surveyed Organization has agreed to that may affect ABC's ability to perform its obligations under the underlying Agreement or this Agreement;

D. will promptly notify ABC in writing of any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such charges or revocation may affect ABC's ability to perform its obligations under the underlying Agreement or this Agreement;

5. Termination

A. Termination for Breach. The Surveyed Organization may terminate this Agreement if the Surveyed Organization determines that ABC has breached a material term of this Agreement. Alternatively, the Surveyed Organization may choose to provide ABC with notice of the existence of an alleged material breach and afford ABC an opportunity to cure the alleged material breach. In the event ABC fails to cure the breach to the satisfaction of the Surveyed Organization, the Surveyed Organization may immediately thereafter terminate this Agreement.

B. Automatic Termination. This Agreement will automatically terminate upon the termination or expiration of the underlying Agreement.

C. Effect of Termination.

1. Termination of this Agreement will result in termination of the underlying Agreement.

2. upon termination of this Agreement or the underlying Agreement, ABC will return or destroy all PHI received from the Surveyed Organization or created or received by ABC on behalf of the Surveyed Organization that ABC still maintains and retains no copies of such PHI; provided that if such return or destruction is not feasible, ABC will extend the protections of this Agreement to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

6. Amendment

ABC and the Surveyed Organization agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Surveyed Organization to comply with the requirements of the Privacy Rule.

7. Survival

The obligations of ABC under section 5.C (2) of this Agreement shall survive any termination of this Agreement.

8. No Third Party Beneficiaries.

Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

SURVEYED FACILITY

X Signature: _____

Name (Please Print): _____

Title: _____

Date: _____

ABC USE ONLY

AMERICAN BOARD FOR CERTIfiCATION IN ORTHOTICS, PROSTHETICS AND PEDORTHICS, INC. (ABC)

Signature: _____

Name (Please Print): _____

Title: _____

Date: _____

Central Fabrication Accreditation – Payment Form

The following items must be included with your application:

- ☐ Application for Accreditation
- ☐ Signed Business Associate Agreement
- ☐ Non-Refundable Accreditation Fees

Organization Name: _____ Doing Business As (DBA): _____

CENTRAL FABRICATION TYPE: *Check all that apply.*

☐ Orthotic (includes Pedorthic) ☐ Prosthetic ☐ Pedorthic (only below ankle items/devices)

Central Fabrication Accreditaton Fees *Fees are Subject to Change*	Fee
Application Fee	**$150**
Survey Fee	**$950**
TOTAL ENCLOSED	**$1,100**

NON-REFUNDABLE PAYMENT METHOD:

Payment Amount: _____ ❑ Check - CHECK NO: _____

(Make checks payable to ABC)

Authorizing Name as it appears on Check: _____

Authorizing Signature as it appears on Check: _____

By signing my name above, I authorize to pay the total amount shown above

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number: _____ Exp. date: _____ Security Code: _____

Name on Card: _____

Signature of Card Holder: _____

Please mail the application and forms to:

ABC
PO Box 716100
Philadelphia, PA 19171-6100

PLEASE NOTE: The U.S. Postal Service is the only service that can deliver to a PO Box address.