

Facility Accreditation Application



Application Type:

- Initial Application Renewal Service add-on
 Affiliate add-on Location move Ownership Change

Complete application online at www.abcop.org, print out the form and mail or fax to ABC. All fields are required. Make a copy of the completed application for your records.

SECTION I: Identification of Organization

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

Address 1

Address 2 City State Zip

Phone Ext. Fax

Website Email

Federal Tax ID Number _____

Applying for: (Check all that apply, refer to the *Facility Accreditation Guidebook* for more information.)

Orthotics

- Comprehensive Orthotic
 Prefabricated Orthotic
 Off-the-Shelf Orthotics
 Comprehensive Pedorthics
 Non-Custom Therapeutic Footwear

Prosthetics

- Comprehensive Prosthetic

Additional

- Ancillary Assistive Devices
 Durable Medical Equipment
 Post-Mastectomy Patient Care
 Ocular Prosthetic

SECTION II: Ownership Information

Owner Name/Title (List all individuals holding more than 5% of company shares, or provide a current list of your facility's Board of Directors/Trustees. Please attach additional pages if necessary.)

Address 1 (if different than above)

Address 2 (if different than above) City State Zip

Office Phone Fax

SECTION III: Chief Executive Officer

Name/Title (Name of individual to be contacted for further communication regarding this application and accreditation.)

Phone Email

Facility Accreditation Application, cont'd.

SECTION IV: Accreditation Contact Information

Name of chief administrative person responsible for location(s) seeking accreditation and individual who will be contacted for future communication regarding this application and accreditation.

Phone

Cell Phone

Email

SECTION V: Information on Locations (please see *Facility Accreditation Guidebook* for Affiliate Location definition)

Primary Location

Hospital Medical Building Retail Center Free Standing Other: (specify) _____

Address 1

Address 2

City

State

Zip

Phone

Fax

Clinical Director

Office Manager

Affiliate Location #1

Hospital Medical Building Retail Center Free Standing Other: (specify) _____

Address 1

Address 2

City

State

Zip

Phone

Fax

Clinical Director

Office Manager

Affiliate Location #2

Hospital Medical Building Retail Center Free Standing Other: (specify) _____

Address 1

Address 2

City

State

Zip

Phone

Fax

Clinical Director

Office Manager

If more space is required, please make additional copies of this page.

Facility Accreditation Application, cont'd.

SECTION VI: Scope of Services

Please provide the following information for the Primary Location and each Affiliate Location. Please do not leave any boxes blank. Make additional copies as needed.

Apply for ABC accreditation in all services that your facility provides. You must provide at least one Main Accreditation Service to be eligible for ABC accreditation.

	Primary Location	Affiliate Location #1	Affiliate Location #2
Year Opened			
National Provider ID (NPI)			
CMS Supplier Number (PTAN)			
Days & Hours of Operation			

Indicate all services and items provided.
 Do you rent any items indicated below: Yes No (If Yes, you must apply for DME accreditation.)

Main Accreditation Services

- Orthoses: Custom Fabricated
- Orthoses: Custom Fit (non-custom fabricated)
- Orthoses: Off-the-Shelf (non-custom fit)
- Orthoses: Below the ankle
- Limb Prostheses
- Breast Prostheses and Accessories
- Facial Prostheses
- Ocular Prostheses
- Diabetic Shoes/Inserts (custom fabricated)
- Diabetic Shoes/Inserts (non-custom fabricated)
- Somatic Prostheses

- Wheelchair Seating/Cushions
- Wheelchairs-Standard Manual
- Wheelchairs-Standard Manual Accessories
- Wheelchairs-Standard Power
- Wheelchairs-Standard Power Accessories

Ancillary Assistive Devices (AAD)

- Automatic External Defibrillators (AEDs)
- Blood Glucose Monitors and Supplies (mail order)
- Blood Glucose Monitors and Supplies (non-mail order)
- Canes and Crutches
- Commodes/Urinals/Bedpans
- Enteral Nutrients
- Heat and Cold Applications
- Neuromuscular Electrical Stimulators (NMES)
- Osteogenesis Stimulators
- Ostomy Supplies
- Patient Lifts
- Penile Pumps
- Perenteral Nutrients
- Pneumatic Compression Devices (lymphedema pumps)
- Power Operated Vehicles (scooters)
- Seat Lift Mechanisms
- Speech Generating Devices
- Support Surfaces: Pressure Reducing Beds/Mattresses/Pads
- Surgical Dressings
- Tracheostomy Supplies
- Traction Equipment
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Ultraviolet Light Devices
- Urological Supplies
- Walkers

Durable Medical Equipment (DME)

- Continuous Passive Motion (CPM)
- Continuous Positive Air Pressure (CPAP)
- Contracture Treatment Devices: Dynamic Splint
- Enteral Equipment and Supplies
- External Infusion Pumps and Supplies
- Gastric Suction Pumps
- Hemodialysis Equipment and Supplies
- High Frequency Chest Wall Oscillation (HFCWO) Devices
- Home Dialysis Equipment and Supplies
- Hospital Beds-Electric
- Hospital Beds-Manual
- Implanted Infusion Pumps and Supplies
- Infrared Heating Pad Systems
- Insulin Infusion Pumps and Supplies
- Intermittent Positive Pressure Breathing (IPPB) Devices
- Intrapulmonary Percussive Ventilation Devices
- Invasive Mechanical Ventilation Devices
- Mechanical In-Exsufflation Devices
- Nebulizer Equipment and Supplies
- Negative Pressure Wound Therapy Pumps and Supplies
- Neurostimulators and Supplies
- Oxygen Equipment and Supplies
- Parenteral Equipment and Supplies
- Respiratory Assist Devices
- Respiratory Suction Pumps
- Ventilators Accessories/Supplies
- Wheelchairs-Complex Rehab. Manual Chair
- Wheelchairs-Complex Rehab. Manual Chair Accessories
- Wheelchairs-Complex Rehab. Power Chair
- Wheelchairs-Complex Rehab. Power Chair Accessories

Facility Accreditation Application, cont'd.

ORGANIZATIONAL PERSONNEL (Please list all patient care and billings/claims personnel. Attach separate sheet if necessary.)

Primary Location

Patient Care Supervisors:

Name and Credentials	Position/Title
Name and Credentials	Position/Title
Name and Credentials	Position/Title

Patient Care Providers and Technicians:

Name and Credentials (if applicable)	Position/Title
Name and Credentials (if applicable)	Position/Title

Billing/Claim Personnel:

Name and Credentials (if applicable)	Position/Title
Name and Credentials (if applicable)	Position/Title

Affiliate Location #1

Patient Care Supervisors:

Name and Credentials	Position/Title
Name and Credentials	Position/Title
Name and Credentials	Position/Title

Patient Care Providers and Technicians:

Name and Credentials	Position/Title
Name and Credentials	Position/Title
Name and Credentials	Position/Title

Billing/Claim Personnel:

Name and Credentials	Position/Title
Name and Credentials	Position/Title

Facility Accreditation Application, cont'd.

Affiliate Location #2

Patient Care Supervisors:

Name and Credentials	Position/Title
Name and Credentials	Position/Title
Name and Credentials	Position/Title

Patient Care Providers and Technicians:

Name and Credentials	Position/Title
Name and Credentials	Position/Title
Name and Credentials	Position/Title

Billing/Claim Personnel:

Name and Credentials	Position/Title
Name and Credentials	Position/Title

SECTION VII: Criminal History

In an effort to better serve the public trust, ABC reserves the right to perform a criminal history background check and to deny an application or remove a credential based on the commission of a felony by the facility owners or organizational personnel.

Answers to the following questions are mandatory.

Failure to respond to each question 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.

1. Has any owner or facility personnel ever been convicted of, or plead guilty or nolo contendere to a felony or a crime involving a patient? Yes No
2. 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
3. Has any owner or facility personnel ever been charged with a felony which has yet to be dismissed? Yes No
4. 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

If you answered 'Yes' to any of the above questions, you must submit the following before your application will be considered complete:

A complete written explanation of the circumstances surrounding the charge(s) that were filed against such individual, which includes a narrative describing:

- A description of the incident.
- Where the incident occurred.
- The date the incident occurred.
- The outcome of the charge(s) that were filed against the individual (e.g. verdict).
- Any penalty/sentence associated with charges that have been filed against the individual.
- When the sentence was or will be completed.
- Court case headings regarding the incident.

Copies of court documents are also required. If the documents are not available, indicate the jurisdiction in which the charge(s), conviction or plea occurred and why the documents are not available.

All application materials that are submitted are only released to ABC and its contractors and as required by law. The more information that you provide, the less time will be needed to review your eligibility status. If all the appropriate information is not provided, the processing of your application will be delayed and your application will be considered incomplete.

Facility Accreditation Application, cont'd.

SECTION VIII: Application Checklist

Please note that the following items must be included with the submission of your application. Any omission will delay the application process. If you have any questions regarding these items, please contact ABC at 703-836-7114, ext. 200 or 205.

- Business Associate Agreement
- Non-Refundable Application Fee
- Copy of any non-ABC individual certificates and licenses (if you practice in a licensure state)
- Legal documentation of ownership (e.g. Articles of Incorporation, IRS tax form)

Section IX: 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, and the quality of care provided or arranged by, 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 understands that all fees associated with this application are non-refundable and agrees that it is solely responsible for being aware of and understanding ABC's accreditation standards, which are readily available from ABC. 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 must notify ABC in writing of any changes to this application.

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.

Accepted By:

Name of Chief Executive Office (Please print)

X

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.

Business Associate Agreement, cont'd.

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;

Business Associate Agreement, cont'd.

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

ABCOP USE ONLY	
American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC)	
_____	Signature
_____	Name
_____	Title
_____	Date

ABC Renewal Accreditation Application Payment Form

Organization Name (From page 1)

The following items must be included in your organization's application: Application for Accreditation; Business Associate Agreement; Non-refundable Application Fee.

NOTE: Due to the increased cost of surveying more complex businesses, organizations providing "DME" (See Section II in the "Accreditation Guide") are assessed a surcharge of **\$1,500 per survey day** for survey services. This fee is in addition to the fees calculated below.

Application & Survey Fees:	Fee	Total
PRIMARY LOCATION Main service, choose only one. <input type="checkbox"/> Comprehensive Orthotics & Prosthetics <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Comprehensive Orthotics <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Comprehensive Prosthetics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Ocular Prosthetics	\$825.00	\$825.00
Additional Service(s) If applicable, check all that apply. <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Ancillary Assistive Devices	# of services selected: ____ X \$200.00 =	\$ _____
AFFILIATE LOCATION #1 Main service, choose only one. <input type="checkbox"/> Comprehensive Orthotics & Prosthetics <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Comprehensive Orthotics <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Comprehensive Prosthetics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Ocular Prosthetics	\$600.00	\$ _____
Additional Service(s) If applicable, check all that apply. <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Ancillary Assistive Devices	# of services selected: ____ X \$200.00 =	\$ _____
AFFILIATE LOCATION #2 Main service, choose only one. <input type="checkbox"/> Comprehensive Orthotics & Prosthetics <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Comprehensive Orthotics <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Comprehensive Prosthetics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Ocular Prosthetics	\$600.00	\$ _____
Additional Service(s) If applicable, check all that apply. <input type="checkbox"/> Comprehensive Pedorthics <input type="checkbox"/> Post-Mastectomy <input type="checkbox"/> Prefabricated Orthotics <input type="checkbox"/> Non-Custom Therapeutic Footwear <input type="checkbox"/> Off-the-Shelf Orthotics <input type="checkbox"/> Ancillary Assistive Devices	# of services selected: ____ X \$200.00 =	\$ _____
DME <input type="checkbox"/> I meet the requirements for DME. (See Section II in the "Accreditation Guide")	\$1,500.00	\$ _____
Payments may be tax deductible as business expenses. Please consult your tax advisor.	Total Enclosed	\$ _____

Method of Payment:

- Check # _____
 Visa
 MasterCard
 American Express
 Discover

Card Number

Expiration Date

Name on Card

X
Signature

Please mail application and forms to:

American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., PO Box 34862, Alexandria, VA 22334-0862
 (703) 836-7114 ext. 200 or 205 • Fax: (703) 836-0838

Please note: The U.S. Postal Service is the only service that can deliver to a "PO Box" address.

ABC Post-Mastectomy Renewal Accreditation Application Payment Form

ORGANIZATION NAME _____

The following items must be included with your application: Application for Accreditation; Business Associate Agreement; Non-refundable Application Fee.

Application & Survey Fees:	Fee	Total
PRIMARY LOCATION <input type="checkbox"/> Post-Mastectomy If applying for additional services, please see Facility Accreditation Application.	\$825	\$ _____
AFFILIATE LOCATION #1 <input type="checkbox"/> Post-Mastectomy If applying for additional services, please see Facility Accreditation Application.	\$600	\$ _____
AFFILIATE LOCATION #2 <input type="checkbox"/> Post-Mastectomy If applying for additional services, please see Facility Accreditation Application.	\$600	\$ _____
Payments may be tax deductible as business expenses. Please consult your tax advisor.		Total: \$ _____ EW Discount \$ _____ Total Enclosed: \$ _____

Members of Essentially Women are entitled to a \$162.50 discount for a primary location and a \$50 discount for each affiliate location accredited by ABC. Indicate your EW member number here _____.

Please check all that apply: PRIMARY LOCATION AFFILIATE LOCATION #1 AFFILIATE LOCATION #2

The discount will be deducted from your total payment.

Method of Payment:

Check # _____

Visa Card Number _____
 MasterCard Expiration Date _____
 American Express Name on Card _____
 Discover Signature **X** _____

Please mail application and forms to:

American Board for Certification in Orthotics,
 Prosthetics and Pedorthics, Inc.
 PO Box 34862, Alexandria, VA 22334-0862
 (703) 836-7114 ext. 200 or 205 • Fax: (703) 836-0838
*Please note: The U.S. Postal Service is the only service
 that can deliver to a "PO Box" address.*