Patient Care Facility Accreditation Application

Application Type: *Please check the type of application you are submitting for your organization.*

☐ Initial Application ☐ Ownership Change

How did you hear about ABC?

☐ Direct mail ABC flyer or postcard ☐ ABC Accreditation Workshop ☐ Private insurance
☐ Medicare/Medicaid ☐ Internet ☐ Colleague
☐ Other: ____________________

Please complete all fields and include all documentation requested. Your completed application can be mailed or faxed to ABC.
Please make a copy for your records.

SECTION I: Identification of Organization

Legal 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 Code ____________

Phone ____________________ Ext. ______ Fax ____________________

Name/Title of individual who oversees facility operations ____________________

Website ____________________ Email ____________________

SECTION II: Individual Contact for Survey

Primary individual responsible for all aspects of accreditation and future communications

Name: ____________________ Email: ____________________

Office Phone: ____________________ Mobile Phone: ____________________

SECTION III: 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 from Section I)* ____________________

Address 2 *(if different from Section I)* ____________________

City ____________________ State ________ Zip Code ____________

Phone ____________________ Fax ____________________

SECTION IV: Primary Patient Care Facility Information

Employer Identification Number (EIN): ____________ National Provider Identifier (NPI): ____________

CMS Supplier Number/Provider Transaction Account Number (PTAN): ____________

☐ Hospital ☐ Medical Building ☐ Retail Center ☐ Free Standing

☐ Other: ____________

Address 1 ____________

Address 2 ____________

City ____________ State ____________ Zip Code ____________

Phone ____________ Fax ____________

Email ____________

Days & Hours of Operation: *(ex. Monday 9 am – 5 pm)*

Monday: ____________ Tuesday: ____________

Wednesday: ____________ Thursday: ____________

Friday: ____________ Saturday: ____________

Sunday: ____________

Primary Patient Care Personnel: *(Please attach additional pages if necessary)*

Patient Care Providers and Technicians

____
NAME AND CREDENTIAL

____
NAME AND CREDENTIAL

____
NAME AND CREDENTIAL

Billing & Claims Personnel

____
NAME AND CREDENTIAL

____
NAME AND CREDENTIAL

____
NAME AND CREDENTIAL

Scope of Services – Part I

Main Accreditation Programs

(Please check all that apply, refer to the Accreditation Guidance page or the Patient Care Facility Accreditation Guide for additional information.)

☐ Orthotics & Prosthetics
☐ Orthotics
☐ Prosthetics
☐ Pedorthics
☐ Mastectomy
☐ Prefabricated Orthotics
☐ Off-the-Shelf Orthotics
☐ Non-Custom Therapeutic Footwear
☐ Ocular Prosthetics

Additional Accreditation Programs

☐ Durable Medical Equipment
☐ Ancillary Assistive Devices

SECTION IV: Primary Patient Care Facility Information (cont.)

Scope of Services – Part II

Do you rent any of the items checked off below?

☐ Yes *(If Yes, you must apply for DME accreditation.)* ☐ No

Please check all services and items that you currently provide.

Main Accreditation Services

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

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 & 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
☐ 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

Ancillary Assistive Devices

☐ 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
☐ Parenteral 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
☐ Wheelchair Seating/Cushions
☐ Wheelchairs – Standard Manual
☐ Wheelchairs – Standard Manual Accessories
☐ Wheelchairs – Standard Power
☐ Wheelchairs – Standard Power Accessories

SECTION V: Affiliate Location #____ Information

*(You are allowed a maximum of **four** affiliates per primary facility. Print and complete additional pages for each affiliate office. Please refer to the Patient Care Facility Accreditation Guide for affiliate definition and eligibility.)*

National Provider Identifier (NPI):______________________________

CMS Supplier Number/Provider Transaction Account Number (PTAN): ______________________________

☐ Hospital ☐ Medical Building ☐ Retail Center ☐ Free Standing

☐ Other: ______________________________

Address 1 ______________________________

Address 2 ______________________________

City ______________________________ State __________ Zip Code ______________________________

Phone ______________________________ Fax ______________________________

Email ______________________________

Days & Hours of Operation: *(ex. Monday 9 am – 5 pm)*

Monday: ______________________________ Tuesday: ______________________________

Wednesday: ______________________________ Thursday: ______________________________

Friday: ______________________________ Saturday: ______________________________

Sunday: ______________________________

Affiliate Patient Care Personnel *(Please attach additional pages if necessary)*

Patient Care Providers and Technicians

____
NAME AND CREDENTIAL

____
NAME AND CREDENTIAL

____
NAME AND CREDENTIAL

Billing & Claims Personnel

____
NAME AND CREDENTIAL

____
NAME AND CREDENTIAL

____
NAME AND CREDENTIAL

Scope of Services – Part I

Main Accreditation Programs

(Please check all that apply, refer to the Accreditation Guidance page or the Patient Care Facility Accreditation Guide for additional information.)

☐ Orthotics & Prosthetics
☐ Orthotics
☐ Prosthetics
☐ Pedorthics
☐ Mastectomy
☐ Prefabricated Orthotics
☐ Off-the-Shelf Orthotics
☐ Non-Custom Therapeutic Footwear
☐ Ocular Prosthetics

Additional Accreditation Programs

☐ Durable Medical Equipment
☐ Ancillary Assistive Devices

SECTION V: Affiliate Location #____ Information (cont.)

Scope of Services – Part II

Do you rent any of the items checked off below?

☐ Yes *(If Yes, you must apply for DME accreditation.)* ☐ No

Please check all services and items that you currently provide.

Main Accreditation Services

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

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 & 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
☐ 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

Ancillary Assistive Devices

☐ 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
☐ Parenteral 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
☐ Wheelchair Seating/Cushions
☐ Wheelchairs – Standard Manual
☐ Wheelchairs – Standard Manual Accessories
☐ Wheelchairs – Standard Power
☐ Wheelchairs – Standard Power Accessories

SECTION VI: 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 every 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 with your application.

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.

SECTION VII: 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 *Patient Care Facility Accreditation Standards* and *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:

X ______________________________

SIGNATURE OF AUTHORIZED INDIVIDUAL

______________________________ ______________________________

NAME OF AUTHORIZED INDIVIDUAL (PLEASE PRINT) DATE

Patient Care Accreditation Application Guidance

This page is designed to assist your facility with completing your application and is not intended to replace the *ABC Patient Care Facility Accreditation Guide (Guide)*, which is available at abcop.org. For more details regarding the requirements and policies of ABC Patient Care Facility Accreditation, please refer to the *Guide*.

Programs

Some accreditation programs include other programs. Please review the program definitions below to see which programs include others.

Main Accreditation Programs

- **Orthotics & Prosthetics** includes: Orthotic, Prefabricated Orthotic, Off-the-Shelf Orthotic, Pedorthic, Non-Custom Therapeutic Footwear and Prosthetic accreditation programs.
- **Orthotics** includes: Prefabricated Orthotic, Off-the-Shelf Orthotic, Pedorthic, and Non-Custom Therapeutic Footwear accreditation programs.
- **Prosthetics** does not include any other accreditation program.
- **Pedorthics** includes: Non-Custom Therapeutic Footwear accreditation program.
- **Non-Custom Therapeutic Footwear** does not include any other accreditation program.
- **Prefabricated Orthotics** includes Off-the-Shelf Orthotic accreditation program.
- **Off-the-Shelf Orthotics** does not include any other accreditation program.
- **Mastectomy** does not include any does not include any other accreditation program.
- **Ocular Prosthetics** does not include any other accreditation program.

Additional Accreditation Programs

The programs below are **not** stand-alone accreditations. You must apply for a main accreditation program above to be eligible.

- Durable Medical Equipment Accreditation includes: Ancillary Assistive Devices Accreditation Program.
- Ancillary Assistive Device Accreditation does not include any other accreditation program.

Additional Locations

Per the eligibility criteria, you must apply for all patient care locations within your organization. You must also apply for any administrative-only and warehouse offices.

An affiliate is a secondary patient care location that meets the following criteria:

- Shares the corporate structure and utilizes the same policies and procedures of the primary practice
- Shares the same Federal Tax ID number as the primary facility
- Maintain separate NPI and PTAN numbers
- Is located within a 100 mile radius of the primary facility

Each primary location may designate up to four affiliates. Facilities, including renewals, with more than four affiliates must make the fifth affiliate a primary location, which then can list four additional affiliates.

Administrative offices and warehouses are not patient care facilities. If your organization has one or more of these types of facilities, please include a detailed letter describing the activities being conducted or items located at those facilities. Warehouse and administrative offices require an onsite survey and will be assessed the base affiliate fee if within a 100 mile radius. Those located more than 100 miles from the primary location will be assessed the base primary survey fee. Warehouse and administrative office accreditation fees must be submitted with the application.

If you have additional questions regarding the application or payment form, please contact us at accreditation@abcop.org or (703) 836-7114 ext 247.

SECTION VIII: 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 OF AUTHORIZED INDIVIDUAL

____

NAME OF AUTHORIZED INDIVIDUAL (PLEASE PRINT)

____

DATE

FOR ABC USE ONLY

American Board for Certification in Orthotics, Prosthetics & Pedorthics, Inc. (ABC)

____

SIGNATURE

____

NAME

____

TITLE

____

DATE

ABC Patient Care Facility Accreditation – First-Time Applicant Payment Form

Organization Name ____

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. 247.

- ☐ Completed Application
- ☐ Non-refundable Accreditation Fee
- ☐ Copies of all professional staff non-ABC certifications and licenses (if applicable)
- ☐ Legal documentation of ownership (e.g. Articles of Incorporation, IRS tax form)
- ☐ Signed Section VII: Terms of Agreement
- ☐ Signed Section VIII: Business Associate Agreement
- ☐ Narrative of criminal history (if applicable)

See the information at the end of this application for additional guidance.

If your organization **ONLY** provides mastectomy services, please use the **Mastectomy-Only – First-Time Applicant Payment Form**.

Accreditation	Fee	TOTAL
PRIMARY LOCATION – *Main Accreditation Program, choose only one.* ☐ Orthotics & Prosthetics ☐ Pedorthics ☐ Off-the-Shelf Orthotics ☐ Orthotics ☐ Mastectomy ☐ Non-Custom Therapeutic Footwear ☐ Prosthetics ☐ Prefabricated Orthotics ☐ Ocular Prosthetics	$1,825	$1,825
Additional Accreditation Program(s) – *If applicable, check all that apply.* ☐ Pedorthics ☐ Prefabricated Orthotics ☐ Non-Custom Therapeutic Footwear ☐ Mastectomy ☐ Off-the-Shelf Orthotics ☐ Ancillary Assistive Devices	# of services selected: ____ X $250	$
AFFILIATE LOCATION #1 – *Main Accreditation Program, choose only one.* ☐ Orthotics & Prosthetics ☐ Pedorthics ☐ Off-the-Shelf Orthotics ☐ Orthotics ☐ Mastectomy ☐ Non-Custom Therapeutic Footwear ☐ Prosthetics ☐ Prefabricated Orthotics ☐ Ocular Prosthetics	$900	$
Additional Accreditation Program(s) – *If applicable, check all that apply.* ☐ Pedorthics ☐ Prefabricated Orthotics ☐ Non-Custom Therapeutic Footwear ☐ Mastectomy ☐ Off-the-Shelf Orthotics ☐ Ancillary Assistive Devices	# of services selected: ____ X $250	$
AFFILIATE LOCATION #2 – *Main Accreditation Program, choose only one.* ☐ Orthotics & Prosthetics ☐ Pedorthics ☐ Off-the-Shelf Orthotics ☐ Orthotics ☐ Mastectomy ☐ Non-Custom Therapeutic Footwear ☐ Prosthetics ☐ Prefabricated Orthotics ☐ Ocular Prosthetics	$900	$
Additional Accreditation Program(s) – *If applicable, check all that apply.* ☐ Pedorthics ☐ Prefabricated Orthotics ☐ Non-Custom Therapeutic Footwear ☐ Mastectomy ☐ Off-the-Shelf Orthotics ☐ Ancillary Assistive Devices	# of services selected: ____ X $250	$

Accreditation	Fee	TOTAL
AFFILIATE LOCATION #3 – *Main Accreditation Program, choose only one.* ☐ Orthotics & Prosthetics ☐ Orthotics ☐ Prosthetics ☐ Pedorthics ☐ Mastectomy ☐ Prefabricated Orthotics ☐ Off-the-Shelf Orthotics ☐ Non-Custom Therapeutic Footwear ☐ Ocular Prosthetics	$900	$
Additional Accreditation Program(s) – *If applicable, check all that apply.* ☐ Pedorthics ☐ Mastectomy ☐ Prefabricated Orthotics ☐ Off-the-Shelf Orthotics ☐ Non-Custom Therapeutic Footwear ☐ Ancillary Assistive Devices	# of services selected: ____ X $250	$
AFFILIATE LOCATION #4 – *Main Accreditation Program, choose only one.* ☐ Orthotics & Prosthetics ☐ Orthotics ☐ Prosthetics ☐ Pedorthics ☐ Mastectomy ☐ Prefabricated Orthotics ☐ Off-the-Shelf Orthotics ☐ Non-Custom Therapeutic Footwear ☐ Ocular Prosthetics	$900	$
Additional Accreditation Program(s) – *If applicable, check all that apply.* ☐ Pedorthics ☐ Mastectomy ☐ Prefabricated Orthotics ☐ Off-the-Shelf Orthotics ☐ Non-Custom Therapeutic Footwear ☐ Ancillary Assistive Devices	# of services selected: ____ X $250	$
DME ☐ I meet the requirements for DME. (Please review the instruction page for additional guidance.)	$2,000	$
Payments may be tax deductible as business expenses. Please consult your tax advisor.	**Total Enclosed**	**$**

Method of Payment:

Payment Amount: $ ______________________ Check # ______________ *(Make checks payable to ABC)*

Authorizing name as it appears on Check ______________________________

Authorizing Signature as it appears on Check ______________________________

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

Credit Card Number ______________________ Expiration Date__________ Security Code ________

Name as it appears on Card ______________________ Cardholder Signature ______________________

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

Please mail or fax your completed application and all necessary documentation to:

ABC
PO Box 34862
Alexandria, VA 22334-0862
Fax: (703) 842-8027

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

ABC Mastectomy-Only Patient Care Facility Accreditation – First-Time Applicant Payment Form

Organization Name ____

The following items must be included when you submit your organization's application:

- ☐ Completed Application
- ☐ Non-refundable Accreditation Fee
- ☐ Copies of all professional staff non-ABC certifications and licenses (if applicable)
- ☐ Legal documentation of ownership (e.g. Articles of Incorporation, IRS tax form)
- ☐ Signed Section VII: Terms of Agreement
- ☐ Signed Section VIII: Business Associate Agreement
- ☐ Narrative of criminal history (if applicable)

If applying for anything other than Mastectomy Accreditation, please use the **ABC Patient Care Facility Accreditation – First-Time Applicant Payment Form**.

Accreditation	Fee	TOTAL
PRIMARY LOCATION Mastectomy	$1475	$1475
AFFILIATE LOCATION #1	$800	$
AFFILIATE LOCATION #2	$775	$
AFFILIATE LOCATION #3	$775	$
AFFILIATE LOCATION #4	$775	$
	Total	$
	EW Discount	$
	Total Enclosed	**$**

Payments may be tax deductible as business expenses. Please consult your tax advisor.

Members of Essentially Women (EW) are entitled to a $165 discount for the primary location and $50 discount for each affiliate location accredited by ABC. Indicate your EW member number here: ____________.

Please deduct the discount from your total payment.

Method of Payment:

Payment Amount: $ ______________________ Check # ______________ *(Make checks payable to ABC)*

Authorizing name as it appears on Check ______________________________

Authorizing Signature as it appears on Check ______________________________

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

Credit Card Number ______________________ Expiration Date__________ Security Code ________

Name as it appears on Card ______________________ Cardholder Signature ______________________

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

Please mail or fax your completed application and all necessary documentation to:

ABC

PO Box 34862

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