**QAI CAHSC 202**

**Quality and Accreditation Institute**

**Centre for Accreditation of Health & Social Care**



Change Adapt Improve

**APPLICATION FORM**

**FOR**

**HOME HEALTH CARE**

**Issue No.: 02 Issue Date: August 2019**

**CHANGE HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Doc No.** | **Current Issue No.** | **Revised Issue No.** | **Date of Issue** | **Reasons** |
| 1 | CAHSC 202 | 01 | 02 | August 2019  (20.08.2019) | Removed the fee structure  Terms & condition of maintaining accreditation line edited i.e. certification is added |
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**Information & Instructions for Completing an Application Form**

Quality & Accreditation Institute (QAI)’s Centre for Accreditation of Health & Social Care (**CAHSC**) offers accreditation services to home care organisations.

Application shall be made in the prescribed form QAI CAHSC 202 only. Application form can be downloaded from website as a word file. Applicant organisation is requested to submit the following:

* Three copies of completed application forms
* Self-assessment tool kit along with referenced documents **(soft copy)**
* Prescribed application fees (details given in this section)
* Signed copy of QAI CAHSC 003 ‘Terms and Conditions for Maintaining QAI Accreditation and Certification’

Incomplete application and insufficient number of copies submitted may lead to delay in processing of your application.

The applicant organisation shall provide copy of appropriate document(s) in support of the information being provided in this application form.

Organisation is advised to familiarize itself with QAI CAHSC 002 ‘General Information Brochure and QAI CAHSC 201 Information Brochure for Home Care’ and QAI CAHSC 003 ‘Terms and Conditions for Obtaining and Maintaining Accreditation and Certification’ before filling up this form.

The applicant organisation shall intimate QAI CAHSC about any change in the information provided in this application such as scope applied for accreditation, personnel and location etc. within 15 days from the date of changes.

Completed application may please be sent to:

Quality and Accreditation Institute Pvt. Ltd.

Centre for Accreditation of Health & Social Care

416, Krishna Apra Plaza, Sector 18  
Noida-201301, U.P., India  
Tel.: +91-120 4113234

**DEMOGRAPHIC AND GENERAL DETAILS:**

1. **Applying for (please tick the relevant)**
   1. **Accreditation\* □**

**\*** (Organisation is advised to implement the standards for at least 2 months

before applying)

* 1. **Re-accreditation □**

**Date of 1st Accreditation ……………**

1. **Name of the Organisation:** (the same shall appear on the accreditation certificate) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Contact Details of Organisation:**
3. **Address**-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Website**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
6. **E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
7. **Ownership:**

|  |  |
| --- | --- |
| **□**Private – Corporate | **□**Armed Forces |
| **□**PSU | **□**Trust |
| **□**Government | **□**Charitable |
| **□**Others (Specifiy.........................................................................................) | |

1. **Legal Identity of the organisation with the date of registration**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Name of the Parent Organisation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if organisation is a part of a bigger organisation)

Telephone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Contact person(s):** 
   1. **Senior Management in the Organisation**

Mr. /Ms. /Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. **Person Coordinating with QAI:**

Mr./Ms./Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel./ Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Human Resource**   
   **Details of the staff at head office/regional office**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sl. No. | Name | Designation | Academic and Professional Qualifications\* | Total experience (in years) | Experience in Home Care Organisation |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Details of the field staff (city wise, if applicable)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sl. No. | Name | Designation | Academic and Professional Qualifications\* | Total experience(in years) | Experience in Home Care Organisation |
|  |  |  |  |  |  |
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\* Please clearly indicate the field of specialisation

1. **Total number of patient care episodes for the entire organisation including all locations (monthly)**

|  |  |
| --- | --- |
| No. of patient episode (monthly) | Please Tick |
| Up to 2000 |  |
| 2001-5000 |  |
| 5001-10000 |  |
| 10001-15000 |  |
| >15000 |  |

1. **Name of cities other than head office, if any and number of patient episodes (monthly)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Care Episodes at each city (monthly)** | **Name of city (please write name of city and tick category)** | | | |
| **City 1** | **City 2** | **City 3** | **City 4** |
| Up to 2000 |  |  |  |  |
| 2001-3000 |  |  |  |  |
| 3001-4000 |  |  |  |  |
| 4001-5000 |  |  |  |  |
| >5000 |  |  |  |  |

Note: Pl. add more columns, in case you have more cities.

1. **Scope of Accreditation – Basic services provided by the organisation:**

|  |  |
| --- | --- |
| **Services** | **Service Provided**  **(mention YES or NO)** |
| **Administration of drugs** |  |
| **Care of elderly** |  |
| **Companion Care** |  |
| **Counselling** |  |
| **Diabetic care** |  |
| **Drug Delivery/Pharmacy** |  |
| **Education & Counselling** |  |
| **Feeding (oral/tube)** |  |
| **Infusions** |  |
| **Maternity Care** |  |
| **Medication Reminders** |  |
| **Non-emergency medical transport** |  |
| **Nursing** |  |
| * **Basic** |  |
| * **Geriatric** |  |
| * **Post delivery** |  |
| **Nutritional Consultation** |  |
| **Personal care/hygiene care** |  |
| * **Bathing** |  |
| * **Eye care** |  |
| * **Grooming** |  |
| * **Hair care** |  |
| * **Hot/cold application** |  |
| * **Mobility assistance** |  |
| * **Skin care** |  |
| * **Steam inhalation** |  |
| * **Toileting** |  |
| * **Others (Specify)** |  |
| **Physician visits** |  |
| **Physiotherapy** |  |
| **Post-surgery care** |  |
| **Sample Collection** |  |
| **Speech Therapy** |  |
| **Tele Consultation** |  |
| **Vaccination** |  |
| **Vital monitoring** |  |
| **Wound Management/Dressing** |  |
| **Yoga/Naturopathy** |  |
| **Any Other (specify)** |  |

1. **Scope of Accreditation – Advance services provided by the organisation:**

|  |  |
| --- | --- |
| **Services** | **Service Provided**  **(mention YES or NO)** |
| **Catheterization & catheter care** |  |
| **Critical Care Services** |  |
| **Dialysis** |  |
| **End of life care** |  |
| **Equipment Supply** |  |
| **Home Oncology** |  |
| **Ostomy/colostomy care** |  |
| **Rehabilitation** |  |
| * **Stroke Rehabilitation** |  |
| * **Neuro Rehabilitation** |  |
| * **Post-Surgery Rehabilitation** |  |
| * **Post Organ Transplant Rehabilitation** |  |
| * **Pulmonary Rehabilitation** |  |
| **Ryle’s tube** |  |
| **Skilled hospice support** |  |
| **Special Nursing** |  |
| **Specialist consultation services** |  |
| **Transfusion Services** |  |
| **Any Other (Specify)** |  |

1. **STATUTORY COMPLIANCES**

**Furnish details of applicable Statutory/ Regulatory requirements the organisation is governed by. (Please submit scanned soft copies of all the statutory requirements while submitting the documents)**

|  |  |  |  |
| --- | --- | --- | --- |
| **License/Certificate** | **Number and Date of issue** | **Valid Up to** | **Remarks**  (Please mention if any licenses are pending and how it is being addressed.) |
| **General:** | | | |
| Bio-medical Waste Management and Handling Authorization |  |  |  |
| Registration With Local Authorities |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Facility management:** | | | |
| License to Store Compressed Gas |  |  |  |
| Sanction/ License for Lifts |  |  |  |
| License/registration for medical transport (if any) |  |  |  |
| Pharmacy (for multiple locations, license for each of location is required) | | | |
| Drugs-Bulk license |  |  |  |
| Drugs-Retail license |  |  |  |
| Narcotic license |  |  |  |
| Miscellaneous: | | | |
| Canteen/ F & B license |  |  |  |
| **Any other:** | | | |

1. **Litigation, if any:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Date of last Self-assessment:** ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of implementation of QAI standards:** \_\_\_\_\_\_\_\_\_\_\_\_\_

(Organisation is advised to implement the standards for at least 2 months before applying)

1. **Application Fees**

 Application fees (Rs.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DD/At par cheque number/ bank transfer reference number\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Date Application Completed:** \_\_\_\_\_\_\_\_\_ Day \_\_\_\_\_\_\_ Month \_\_\_\_\_\_\_\_Year
2. **Undertaking**

* We are familiar with the terms and conditions of maintaining accreditation and certification (QAI CAHSC 003), which is signed and enclosed with the application. We also undertake to abide by them.
* We agree to comply fully with the requirements of the standards for the accreditation of organisation.
* We agree to comply with accreditation procedures and pay all costs for any assessment carried out irrespective of the result.
* We agree to co-operate with the assessment team appointed by QAI CAHSC for examination of all relevant documents by them and their visits to those parts of the organisation that are part of the scope of accreditation.
* We undertake to satisfy all national, regional and local regulatory requirements for operating the organisation.
* All information provided in this application is true to the best of our knowledge and ability.

Authorised Signatory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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416, Krishna Apra Plaza, Sector 18

Noida-201301, U.P., India

**Tel**.: +91-120 4113234

**Website**: www.org.in

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