**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.: 05 Issue Date: December 2023**

**CHANGE HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Sl. No.** | **Doc No.** | **Current Issue No.** | **New Issue No.** | **Date of Issue** | **Reasons** |
| 1 | CAHSC 202 | 01 | 02 | August 2019  (20 August 2019) | * Removed the fee structure * Terms and conditions of maintaining accreditation line edited i.e. certification is added |
| 2 | CAHSC 202 | 02 | 03 | March 2021  (20 March 2021) | * Replaced organisation to facility * Goods and Services Tax (GST) and MSME Registration clause added (6 and 7) * Home Care added in point 2 of clause 19 * Edited authorised signatory and added date |
| 3 | CAHSC 202 | 03 | 04 | October 2021  (22 October 2021) | * Included clause 13 - Name of cities other than head office where the operations are going on, if any and number of patient episodes (monthly) |
| 5. | CAHSC 202 | 04 | 05 | December 2023  (16 December 2023) | * Address added in the last page of the application form * Up to 500 and 501-1000 categories added in clause 11 |
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**Information & Instructions for Completing an Application Form**

1. Quality & Accreditation Institute (QAI)’s Centre for Accreditation of Health & Social Care (**CAHSC**) offers accreditation services to Home Care facilities.
2. Application shall be made in the prescribed form QAI CAHSC 202 only. Application form can be downloaded from website as a word file. Applicant facility is requested to submit the following:

* Soft copy of completed application form (available on website)
* Soft copy of Self-assessment tool kit along with referenced documents
* Prescribed application fees
* Soft copy of signed QAI CAHSC 003 ‘Terms and Conditions for Maintaining QAI Accreditation/ Certification’

1. Incomplete application submitted may lead to delay in processing of your application.
2. The applicant facility shall provide soft copy of appropriate document(s) in support of the information being provided in this application form.
3. Facility is advised to familiarize itself with QAI CAHSC 002 ‘General Information Brochure, QAI CAHSC 201 Information Brochure for Home Care’ and QAI CAHSC 003 ‘Terms and Conditions for Maintaining Accreditation/ Certification’ before filling up this form.
4. The applicant facility 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.

**DEMOGRAPHIC AND GENERAL DETAILS:**

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

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

before applying)

* 1. **Re-accreditation □**

**Date of 1st Accreditation ……………**

1. **Name of the Facility:** (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. **Goods and Services Tax (GST) Number** (Please attach a copy of GST Registration Certificate):

­­­­­­

1. **Micro, Small and Medium Enterprises (MSME) Registration Number** (Please attach a copy of Registration Certificate):

­­­­­­

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 500 |  |
| 501-1000 |  |
| 1001-2000 |  |
| 2001-5000 |  |
| 5001-10000 |  |
| 10001-15000 |  |
| >15000 |  |

1. **Name of the cities where the operations are going on, 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. **Name of the cities from the list above at sl. No. 12 for which accreditation is being sought, 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 facility:**

|  |  |
| --- | --- |
| **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 facility:**

|  |  |
| --- | --- |
| **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/ Transaction ID\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

* We are familiar with the terms and conditions of maintaining accreditation/ 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 Home Care accreditation standards.
* 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 facility 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 (Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Date:

**Quality and Accreditation Institute**

Centre for Accreditation of Health & Social Care

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