

Checklist of Requirements for Accreditation of Free Standing Dialysis Clinics

1. Dialysis Clinic:

- | | |
|--|--|
| <input type="checkbox"/> PhilHealth application form properly accomplished and notarized | <input type="checkbox"/> SEC license/ DTI certificate |
| <input type="checkbox"/> DOH licenses for three (3) years or Mayor's permits and proofs of operation for a minimum period of three (3) years | <input type="checkbox"/> Certificate of Acknowledgement of existence of Dialysis Clinic from the Phillipine Society of Nephrology |
| <input type="checkbox"/> Patients' records | <input type="checkbox"/> Current photographs of clinic façade and other facilities |
| <input type="checkbox"/> Sworn testimonies from the parish priest, other religious or community leaders | <input type="checkbox"/> Current photographs of complete Clinic Staff |
| <input type="checkbox"/> Tax returns of the facility for the past three (3) years | <input type="checkbox"/> Memorandum of Agreement with a tertiary hospital (applicable when a medical staff of the clinic is not affiliated with a tertiary hospital the locality). |
| <input type="checkbox"/> Identification of precursor health facility | <input type="checkbox"/> Current standard operating procedure |
| <input type="checkbox"/> Accreditation Fee (P5000.00) by postal money order payable only to Philippine Health Insurance Corporation or cash paid directly to the cashier. The accreditation fee is non-refundable. | <input type="checkbox"/> PhilHealth RF1 |
| | <input type="checkbox"/> Quality Assurance activities |

2. Clinic Staff

a. Medical Staff

1. Clinic Head

- Philippine Society of Nephrology Specialty Board Diplomate Certificate (Head of Medical Staff)
- Photocopy of PhilHealth Accreditation ID

2. Duty Physicians

- Certificate of Residency Training in Internal Medicine
- Certificate of Good Standing as Diplomate/Fellow of the Philippine Society of Nephrology Specialty Board (PSNSB) of the attending or referring physician
- Proof of appointment of at least one (1) physician as a member of the medical staff of a tertiary hospital in the locality (if applicable)
- Photocopy of PhilHealth Accreditation ID

b. Other staff

1. Nursing Staff

- Certificate of post graduate course on dialysis (current year) (for head nurse only)
- Renal Nurses Association of the Philippines Certificate
- IV therapy Certificate
- Photocopy of PRC license
- Certificate of employment for one year from a hospital/clinic

2. Medical technician

- Certificate of dialysis training
- Certificate of one-year experience in dialysis handling

3. Midwives/Nursing attendants

- Certificate of one-year course in nursing aide/attendant
- Diploma of a two-year college course

APPLICATION FOR ACCREDITATION FREE STANDING DIALYSIS CLINICS

 (Date)
THE PRESIDENT
Philippine Health Insurance Corporation
Pasig City, Philippines

SIR:

I, _____, Filipino, of legal age, _____ with address at _____
(Position/Designation)
 _____ and the duly authorized representative to act for and in behalf of _____
 _____, hereby applies for accreditation under Sec. 16 L of R.A. 7875 and its Implementing
(Health Care Institution)
Rules and Regulations thereto. For this purpose, I hereby submit the following pertinent information and documentary

requirements.

Name of Dialysis Clinic: _____			
Complete Address: _____			
Telephone No. _____		Fax No: _____	Zip Code _____
Date Established: _____		Director/Owner _____	
Nature of Ownership: <input type="checkbox"/> Government		<input type="checkbox"/> Private	
Type of Application: <input type="checkbox"/> Initial		<input type="checkbox"/> Renewal	<input type="checkbox"/> Re-accreditation

I. CLINIC FACILITY

A. PHYSICAL PLANT & ENVIRONMENT

1. Building			
<input type="checkbox"/> Concrete	<input type="checkbox"/> Wood	<input type="checkbox"/> Renovated	
<input type="checkbox"/> Semi-concrete	<input type="checkbox"/> Old Structure	<input type="checkbox"/> New Structure	
2. Sanitation and safety			
<input type="checkbox"/> Water supply	<input type="checkbox"/> Electricity	<input type="checkbox"/> Covered garbage containers	<input type="checkbox"/> Toilet facility
<input type="checkbox"/> MWSS	<input type="checkbox"/> Standby Generator	with color-coded segregation	
<input type="checkbox"/> Deep Well	<input type="checkbox"/> Fire Exit	<input type="checkbox"/> Separate receptacle for dispos-	
<input type="checkbox"/> Artesian Well	<input type="checkbox"/> Fire extinguisher	ing pointed or sharp objects	
3. Services			
<input type="checkbox"/> Administrative Service			
<input type="checkbox"/> Lobby	<input type="checkbox"/> Cashier/Billing		
<input type="checkbox"/> Information counter/admitting room	<input type="checkbox"/> Finance/Budget/Auditor		
<input type="checkbox"/> Communication area	<input type="checkbox"/> Toilet facilities		
<input type="checkbox"/> Waiting area			
<input type="checkbox"/> Toilet facilities			
<input type="checkbox"/> Dialysis Service Complex			
<input type="checkbox"/> Dialysis room with air conditioning unit	<input type="checkbox"/> Lavatory		
<input type="checkbox"/> Separate spaces for Hepatitis B and Hepatitis C patients	<input type="checkbox"/> Sterile instrument supply and storage area		
<input type="checkbox"/> Separate spaces for reprocessing	<input type="checkbox"/> Sub-sterilizing room		
<input type="checkbox"/> for Hepatitis B dialysis patients	<input type="checkbox"/> Toilet facility		
<input type="checkbox"/> for Hepatitis C dialysis patients	<input type="checkbox"/> Receiving and releasing area		
<input type="checkbox"/> for regular patients	<input type="checkbox"/> Central sterilization and supply room		
<input type="checkbox"/> Nursing area	<input type="checkbox"/> Sterilizing and work area		
<input type="checkbox"/> Sterile supply storage area			
<input type="checkbox"/> Ambulance service			
<input type="checkbox"/> Transport vehicle for patient's use	<input type="checkbox"/> Contract with providers of such ambulance services		

B. FACILITIES

1. Quality of Water Treatment System				
<input type="checkbox"/> Multi-media	<input type="checkbox"/> Water softener	<input type="checkbox"/> Carbon filter	<input type="checkbox"/> Reverse osmosis system	<input type="checkbox"/> Deionizer and UV sterilization
2. Monitoring requirements				
<input type="checkbox"/> Chemical	<input type="checkbox"/> Bacteriologic-checked:			
	<input type="checkbox"/> Quarterly			
	<input type="checkbox"/> After cluster incidents			
3. Treated water				
<input type="checkbox"/> RO water to prepare dialysate, reprocessing and rinsing, dialyzer disinfectant (less than 200 colonies/cc)				
<input type="checkbox"/> Dialysate water (less than 2000 colonies/cc)				

II. CLINIC STAFF (please use separate sheet if necessary)

	Name	PRC No.	Expiry	Accre. No	Expiry	Signature
1. Medical Staff						
a. Head						
b. Duty physicians	1.					
	2.					
	3.					
	4.					

	Name	PRC No.	Expiry	Signature	Name	Signature
2. Nursing Staff					3. Other Staff	
a. Head					a. Medical technicians	
b. Other nursing staff	1.				b. Midwife/Nursing aide	
	2.				c. Machine Technician	
	3.				d. Admin personnel	
	4.				e. Utility man	

III. EQUIPMENT/INSTRUMENTS/SUPPLIES

<input type="checkbox"/> Dialysis machine	<input type="checkbox"/> Minor surgical instrument set	<input type="checkbox"/> E-cart with emergency medicines
<input type="checkbox"/> Not older than 10 years	<input type="checkbox"/> Instrument table	<input type="checkbox"/> Dopamine IV infusion
<input type="checkbox"/> Number of machines _____ (Machine-patient ratio: 1:8)	<input type="checkbox"/> Treatment table	<input type="checkbox"/> Isosorbide dinitrate tablets
<input type="checkbox"/> Bicarbonate dialysis and biocompatible membranes	<input type="checkbox"/> Patient bed(s) with guard rails or suitable dialysis chair	<input type="checkbox"/> Diazepam (tablets and IV)
<input type="checkbox"/> Dedicated machines for Hepatitis B patients	<input type="checkbox"/> Gooseneck lamp	<input type="checkbox"/> Hydrocortisone IV
<input type="checkbox"/> Dedicated machines for Hepatitis C patients (optional)	<input type="checkbox"/> Stand-by rechargeable light	<input type="checkbox"/> Diphenhydramine maleate 50 mg/amp
<input type="checkbox"/> Back-up machines:	<input type="checkbox"/> Ambu bag	<input type="checkbox"/> Sodium chloride 20% in 50 cc polyampule
<input type="checkbox"/> for every 15 machines	<input type="checkbox"/> Sterilizer	<input type="checkbox"/> D50W 50cc vial
<input type="checkbox"/> for Hepatitis B patients	<input type="checkbox"/> ECG machine	<input type="checkbox"/> Parenteral antihypertensive medications
<input type="checkbox"/> Separate reprocessing machine and/or manual reprocessing	<input type="checkbox"/> Cardiac monitor	<input type="checkbox"/> Others
<input type="checkbox"/> for regular patients	<input type="checkbox"/> Defibrillator	<input type="checkbox"/> Acceptable disinfectants for re-use procedures:
<input type="checkbox"/> for Hepatitis B dialysis patients	<input type="checkbox"/> Suction Machine	<input type="checkbox"/> Formalin (4%)
<input type="checkbox"/> for Hepatitis C dialysis patients	<input type="checkbox"/> Stretcher	<input type="checkbox"/> Peracetic Acid (Hydrogen Peroxide=acetic Acid)
<input type="checkbox"/> Stethoscope	<input type="checkbox"/> Wheelchair	
<input type="checkbox"/> Sphygmomanometer with stand		
<input type="checkbox"/> Examining light		
<input type="checkbox"/> Oxygen unit with guage		

IV. RECORDS

<input type="checkbox"/> Dialysis charts	<input type="checkbox"/> Logbooks
<input type="checkbox"/> Standing order for hemodialysis	<input type="checkbox"/> for complications related to hemodialysis procedure
<input type="checkbox"/> Physician's order	<input type="checkbox"/> for complications related to vascular access
<input type="checkbox"/> Patient's monitoring sheet	<input type="checkbox"/> for complications related to disease process
<input type="checkbox"/> Standing order for medications	<input type="checkbox"/> for dialysis adequacy of each patient
<input type="checkbox"/> Tabulation of laboratories	<input type="checkbox"/> for outcomes
<input type="checkbox"/> Complications during dialysis	
<input type="checkbox"/> Confinements and corresponding dates and hospital	

V. QUALITY ASSURANCE ACTIVITIES

<input type="checkbox"/> Strict observance of universal precautions	<input type="checkbox"/> Dialysis Clinic Monitoring
<input type="checkbox"/> Patient Monitoring	<input type="checkbox"/> Policies on:
Monthly chemistries to include:	<input type="checkbox"/> Procedures
<input type="checkbox"/> Complete Blood Count	<input type="checkbox"/> Management of complications during hemodialysis
<input type="checkbox"/> Blood Urea Nitrogen	<input type="checkbox"/> Hypotension
<input type="checkbox"/> Serum Creatinine	<input type="checkbox"/> Chills
<input type="checkbox"/> Ionized Calcium	<input type="checkbox"/> Chest pains
<input type="checkbox"/> Inorganic Phosphorus	<input type="checkbox"/> Monthly in-house seminar for non-physician personnel
<input type="checkbox"/> Serum albumin to assess nutrition every two (2) months	<input type="checkbox"/> Preventive Maintenance program for machines and water treatment system
<input type="checkbox"/> Hepatitis B and Hepatitis C every 6 months (determination for non-B, non-C patients)	<input type="checkbox"/> Follows the prescribed Standards and Guidelines of Care (from the American Nephrology Nurses Association Universal Hemodialysis Guideline for Care)
<input type="checkbox"/> Monthly Urea Reduction Ratio and/or KTV for dialysis adequacy	
<input type="checkbox"/> Lipid profile every 6 months	

I hereby declare under penalties of perjury that the answers given are true and correct to the best of my knowledge and belief.

Date Accomplished

Owner

Res. Cert. No. _____

Issued at: _____

Issued on: _____

Status of Application:

Approved
Date: _____

Deferred
Date: _____

Denied
Date: _____

Date Received at CO: _____

Date Received at PRO: _____

WARRANTIES OF ACCREDITATION FOR FREE STANDING DIALYSIS CLINICS

A. ELIGIBILITY

1. That it is in operation for at least three (3) years.
2. That it is duly licensed by the Department of Health.
3. That it has a good track record in the provision of health care.
4. That it has the human resources, equipment, physical structure, requirements in conformity with the standards established by the Corporation.
5. That it has an ongoing quality assurance program.
6. That it has a Certificate of Acknowledgement of existence of Dialysis Clinic from the Philippine Society of Nephrology.

B. COMPLIANCE TO PERTINENT LAWS

1. That it shall comply with the provisions of the National Health Insurance Law (RA 7875), its Implementing Rules and Regulations, and the Warranties of Accreditation.
2. That it shall comply at all times with the rules and regulations covering the licensure and regulation of dialysis clinics consistent with E.O. 119, which states that the Department of Health has the power "to regulate the operation of and issue licenses and permits to government and private clinics and dispensaries and other such establishments which by nature of their functions are required to be regulated by the Department" as well as other Administrative Orders.
3. That it shall conform to the formal program on quality assurance as well as payment mechanism and utilization review of the National Health Insurance Program.
4. That its personnel shall strictly adhere and comply at all times with the Code of Ethics of the Medical, Nursing, and Midwife profession.

C. CLINICAL SERVICES

1. That it shall guarantee safe, adequate and standard medical care for all patients.
2. That it shall adopt referral protocols, strictly follow guidelines and health resource sharing arrangements of the Program.
3. That it shall extend without delay chargeable benefits due qualified members and beneficiaries.
4. That it shall not engage in unethical and illegal solicitation of patients for purposes of compensability under the NHI Program.
5. That it shall maintain serviceable equipment and facilities and the required personnel complement.

D. CLINICAL RECORDS AND PREPARATION OF CLAIMS

1. That it shall maintain and accomplish at all times accurate chronological records of all patients, services rendered, health outcomes resulting from such services and health expenditures on patient care.
2. That it shall keep neat and systematic records/file located in a safe but accessible place for easy retrieval.
3. That it shall undertake measures to enter only true and correct data in all patients' records and ensure the filing of legitimate claims within the sixty (60) calendar days after the patient's discharge.
4. That the concerned personnel shall take full responsibility for any omission or commission in the preparation of claims and in the entry of clinical records.

E. MANAGEMENT INFORMATION SYSTEM

1. That it shall give proper information of its accreditation status by posting the PhilHealth Certificate of Accreditation in a very conspicuous place in the said Clinic.
2. That it shall post updated information of the Program's benefits and procedural requirements so provided by PhilHealth at the Billing Section or any conspicuous place of the Clinic and make available the necessary forms for patient's use.
3. That it shall inform PhilHealth within 60 calendar days, in writing of any of the following changes in the Clinic's :
 - a) Location,
 - b) Ownership or management,
 - c) Closure or temporary cessation of clinic operation.

F. INSPECTION/ VISITATION/ INVESTIGATION

1. That it shall recognize the authority of PhilHealth and its duly authorized representative or agents to conduct inspection, visitation, and/or investigation.
2. That it shall cooperate with the duly recognized authorities and make available all pertinent documents required for accreditation.
3. That it shall obey without delay summons, subpoena, or subpoena duces tecum and such other processes as issued by PhilHealth.

Finally, the undersigned hereby affirms that the PhilHealth, pursuant to law may suspend or revoke the accreditation of the clinic if found to have violated any of the provisions of the National Health Insurance Act or its Implementing Rules and Regulations and any of the Warranties of Accreditation after due process.

Administrator/Medical Director

WITNESS MY HAND AND SEAL, this _____ day of _____ 200_ at _____.

Notary Public

Until _____

PTR No. _____

Issued at: _____

Issued on : _____

Doc. No. _____

Book No. _____

Page No. _____

Series of 200_____