Assistance and Recovery Program, Inc.

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☙ Provider Evaluation ❧

Date of Site Visit:_____

1. **Provider Information**

   Name of Facility:

   Address:

   Contact Person/Title:

   Telephone Number:

   Fax Number:

   a. Licensure
      1. License Number:
      2. Expiration Date:

   b. Accreditation
      ☐ JCAHO – Expiration Date:
      ☐ CARF – Expiration Date:

   c. Certificate of Liability Insurance

      1. Policy #:
      2. Expiration Date:

2. Program Outline

a. Type of the Facility:

- ☐ Co-Ed
- ☐ Men
- ☐ Women
- ☐ Adolescents

b. Level of Care with Program Outline:

☐ Inpatient:

_____

_____

☐ PHP:

_____

_____

☐ Intensive Outpatient:

_____

_____

☐ Outpatient:

_____

_____

☐ Aftercare:

_____

_____

☐ Recovery Home:

_____

_____

c. Staff Credentials:

_____

d. Medication Management:

1. Physical Security: _____
2. Client Access: _____
   _____
3. Prohibited Medications: _____
   _____

e. Drug Testing Procedures:

_____
_____

f. Additional Program Components/Treatment Modalities:

_____
_____
_____

g. Transportation Limits and Fees:

_____

h. Sample Program Schedule on File:

i. Sample Menu on File:

3. Physical Description

a. Maximum Capacity:

b. Number of Beds per Room:

c. Suitable Accommodation Verified:

1. Bedrooms Yes ☐ No ☐
2. Common Areas Yes ☐ No ☐
3. Counseling Offices Yes ☐ No ☐

d. Handicap Accessible: Yes ☐ No ☐

4. Billing

a. Utilization Review:

☐ Internal ☐ External

Primary Contact:

Name:

Address: Same as above

Phone:

Fax:

b. Claim Processing:

☐ Internal ☐ External

Primary Contact:

Name:

Address:

Phone:

Fax:

5. Additional Information

A. Any lawsuits filed against facility in the last 5 years?

_____

B. Is the facility contracted with any other PPO networks?

_____

_____

C. Is the facility contracted with other unions?

_____

_____

6. Summary

Please include details on:

- **Physical description of the facility**
- **Detox protocol**
- **Client to counselor ratio**
- **Program philosophy**