AMERICANS WITH DISABILITIES ACT (ADA) PROVIDER SURVEY

Provider Name:						**Office ID#:**	
Address:						**Office Phone:**	
City:		**State:**		**Zip:**		**Office Fax:**	

- Complete a separate survey form for each office location or attach a copy on group letterhead stating each physician's name and practice addresses.
- If you have already completed an ADA Provider Survey Form previously for another healthcare company, please send a copy of this already completed survey.

Part I.

1.	Number of staff members (include all medical professionals, members or partners of the professional association, technicians and support staff) employed at this office:	
2.	Year when the building in which provider's office is located was constructed:	
3.	Floor(s) of building on which provider's office is located:	
Please answer the following questions regarding architectural accessibility to the provider's office:		
4.	Is handicap parking available?	
5.	Is the path of travel from the parking lot to the entrance of the building in which the provider's office is located barrier-free?	
6.	Is there street-level access or an accessible ramp into the building in which the provider's office is located?	
7.	If the provider's office is not on the first floor, is the office served by a working elevator which is accessible by wheelchair and motorized scooter?	
8.	Are the provider's office and other patient areas accessible by wheelchair and motorized scooter?	
9.	Are the examination rooms accessible by wheelchair and motorized scooters?	
10.	Are the examination rooms accessible by wheelchair and motorized scooters?	

- If you answered "Yes" to every Question 4 through 10 above, please skip the remaining questions and sign the attached certification.
- If you answered "No" to any Questions 4 through 10, and:

AMERICANS WITH DISABILITIES ACT (ADA) PROVIDER SURVEY

1. The building in which the provider's office is located was built **before January 1992 and structural alterations were made to the building after January 1992**, please answer the questions in Part II and sign the attached certification;

2. The building in which the provider's office is located was built **before January 1992, no alterations were made after that date and 15 or more staff are employed** at the provider's office, please answer questions in Part III and sign the attached certification, or

3. The building in which the provider's office is located was **built before January 1992, no alterations were made to it after that date and fewer than 15 staff are employed** at the provider's office, please answer the questions in **Part IV** and sign the attached certification.

Part II. **Building constructed before January 1992 with structural alterations made to building after that date.**

1.	What alterations were made to the building?	
2.	If the altered portions of the building affected the usability of the facility, are the altered portions of the office readily accessible to and usable by mobility impaired and disabled individuals	
3.	If the answer to Question 2 is "No", explain:	

Part III. **Building constructed before January 1992 with no alterations made to the building after that date. Provider has 15 or more staff employed at that location.**

1.	Does the provider or group have an alternate accessible location where services can be provided to mobility impaired or disabled individuals?	
2.	If the answer to Question 1 is "Yes", please describe the facility, including its location and distance from the provider's office:	
3.	If the answer to Question 1 is "No", will the provider accommodate mobility impaired and disabled individuals through home visits?	

AMERICANS WITH DISABILITIES ACT (ADA) PROVIDER SURVEY

Part IV. Building constructed before January 1992 with no alterations made to building after, that date. Provider has fewer than 15 staff employed at thatlocation.

If you determine after conferring with a mobility-impaired or disabled individual, that you are unable to see the individual in your office without making significant architectural alterations to the building or office, are you, the provider, willing to see the patient at a mutually acceptable and appropriate accessible location?

THE INDIVIDUAL COMPLETING THIS FORM MUST SIGN THE ATTACHED

CERTIFICATION OF ADA COMPLIANCE

I hereby certify that I have reviewed the Americans with Disabilities Act (ADA), requirements which are set out on the attached sheet, that I have answered the above questions truthfully and to the best of my knowledge and that this (office/group practice) as well as the building in which it is located, meets the requirements of the ADA.

Provider Name

Office ID#

Signature of Provider/Authorized Practice Designee

Date

Submit Form