



PHILADELPHIA CORPORATION FOR AGING

*Enriching lives, preserving dignity.™*

## **REQUEST FOR PROPOSAL**

**For**

## **OCCUPATIONAL THERAPY CONSULTATIONS**

**FY 2018**

**(July 1, 2017 – June 30, 2020)**

### **RETURN TO:**

Dorian Harris  
Housing Services Manager  
PCA-Housing Department  
642 North Broad Street  
Philadelphia, PA 19130-3409  
Tele: (215) 282-6585  
Fax: (215) 282-6616  
[dharris@pcaphl.org](mailto:dharris@pcaphl.org)

**Proposals are due by 12:00 PM (noon) on Friday, June 2, 2017 and must be submitted in three (3) complete legible copies. Any proposals arriving after 12:00 (noon) or in less than three complete copies will be rejected without consideration. Faxed proposals are not accepted.**

**PHILADELPHIA CORPORATION FOR AGING**  
**REQUEST FOR PROPOSALS FOR**  
**OCCUPATIONAL THERAPY CONSULTATIONS**

**I INTRODUCTION**

Philadelphia Corporation for Aging (PCA) is a private, non-profit organization serving as Philadelphia County's Area Agency on Aging (AAA) since 1973. One of the region's largest non-profit organizations, PCA is dedicated to improving the quality of life for older Philadelphians or people with disabilities by helping them achieve optimal levels of health, independence and productivity. This mission is carried out through advocacy, fund administration, planning, program development and service coordination.

Serving over 1,200 homes each year, PCA's Housing Department (Housing) performs repairs and modifications in individual homes, engages in advocacy, produces resource materials and participates in related training and research. Part of the modification process is an in-home consultation with an occupational therapist to determine consumer needs and goals, environmental demands and possible solutions.

**II PROGRAM DESCRIPTIONS**

**SENIOR HOUSING ASSISTANCE REPAIR PROGRAM (SHARP)**

SHARP is a minor home repair program for elderly Philadelphia homeowners. SHARP improves the safety and security of homes by making repairs for older persons who can no longer perform such tasks. SHARP also makes home modifications for older people with physical disabilities to enable them to live more independently or to more easily or to safely accomplish important tasks.

**CAREGIVER SUPPORT PROGRAM (CSP)**

CSP provides support to caregivers who have primary responsibility for care of a person with physical and/or mental impairments. Home modifications to ease the burden of caregiving are available to CSP caregivers.

**LONG TERM CARE OPTIONS (LTCO)**

LTCO provides care management and a wide range of services, from personal care and counseling to companionship and home delivered meals for older adults or those with disabilities.

**BRAVO**

Bravo Senior Partners Silver Plan is the Medicare Advantage Plan from Bravo Health Pennsylvania, a for-profit health plan. Bravo's Senior Partners Silver Plan members are eligible for \$1,500 in improvements. However, for a home safety assessment a charge will be directly deducted from the eligible amount.

**Health Partners Plans (HPP)**

Health Partners Plans, a Pennsylvania nonprofit corporation and Pennsylvania-licensed health maintenance organization offers Medicare Advantage in Philadelphia. Health Partners' members are eligible for Medicare Home Safety and Improvement Benefit of \$1,000 per member. A home safety assessment charge will be directly deducted from the eligible amount.

**III SCOPE OF SERVICES**

**A. CONSULTATIONS**

1. All consumers will be referred by Housing Staff
2. The Contractor will visit the homes of consumers in PCA Housing programs. In all cases, the consumer must be present at the time of the evaluation. The purpose of these visits will be:
  - (a) To assess consumers' need(s) for adaptations to the homes to make them safer, more accessible, and usable for consumers in the SHARP program.
  - (b) To address the modifications requested by the care manager for LTCO programs.
  - (c) To make caregiving for the person with a disability easier and/or safer for caregivers in CSP.
  - (d) To assess the home safety needs of members in the BRAVO and Health Partners program.

3. The Contractor will recommend the lowest priced modifications that will meet the consumer's needs and program goals.
4. PCA will make every reasonable effort to inform Contractor if a consumer is hospitalized, institutionalized, removed from the home or unavailable for any other reason. Contractor will contact consumers prior to scheduled appointments to confirm appointments. PCA will not reimburse Contractor for consultations and follow up visits not completed for any reason.

**B. FOLLOW UP VISITS**

1. When authorized by PCA, Contractor will make follow up visits to consumers after the provision of assistive technology or home modifications. The purpose of these visits is not to recommend additional technology or modifications, but rather to ensure consumer can safely use modifications and/or equipment provided.

**C. STAIR GLIDE EVALUATIONS**

1. When requested by PCA to assess the home and the consumer for a stair glide, the Occupational Therapist will use the Evaluation Form in Exhibit "A" and the Stair Glide Evaluation Form in Exhibit "C".

**D. RECORDS AND DOCUMENTATION**

1. Written consultation and follow up reports will be completed using forms supplied by PCA (Exhibits "A", "B" and "C"). The information to be provided will include, but not be limited to,
  - (a) Consumer's physical conditions and nature of disability;
  - (b) Obstacles in the home that diminish consumer's ability to use the home safely;
  - (c) Recommended changes, if any, to be made to the house;
  - (d) Recommended technology or equipment, if any;
  - (e) Description of what recommended changes or technology will accomplish
2. Recommendations will be specific, stating location and size of environmental modifications, manufacturer's name and model number for equipment or assistive technology.
3. Contractor will submit completed evaluation reports with an invoice within **ten (10) business days** of consultation to designated Housing staff for SHARP, BRAVO, Health Partners and Caregivers Support Program. For Options consumers, referrals will be faxed up to the 12<sup>th</sup> of the month and must be completed and faxed to our office by the 20<sup>th</sup> of the month.
4. Contractor must maintain a standardized record keeping system. Consumer information must be maintained in a confidential manner. The record for each consumer must include:
  - (a) A copy of the referral form or enrollment list received from Housing
  - (b) A copy of the consultation report
  - (c) Individual documentation signed and dated by consumer or family member/caregiver to document home visit.

**E. AVAILABILITY AND STAFFING**

1. Contractor will have the ability to complete all consultations and follow up visits within **ten (10) business days** of referral by PCA.
2. Contractor will make home visits in all parts of Philadelphia.
3. Contractor will have a method of being contacted during regular business hours.
4. Contractor will not subcontract services under this Agreement without the express written consent of PCA and only to subcontractors who meet all of the requirements in this Agreement.
5. PCA may reject without payment any work which, in PCA's sole discretion, does not meet PCA standards.

6. Contractor may indicate ability to serve a maximum number of consumers. No changes to number of consumers or program(s) served will be accepted after contracts have been awarded.

#### F. SUPERVISION

1. All evaluations will be reviewed by a "Lead" Occupational Therapist prior to submission to PCA.
2. The Contractor will assume responsibility for supervision of its staff as well as subcontracted therapists to assure the delivery of services.

#### G. OCCUPATIONAL THERAPIST STANDARDS

1. Consultations and Follow Up Visits are to be provided by Occupational Therapists currently licensed in the Commonwealth of Pennsylvania. Documentation of such licenses must be provided to PCA.
2. Occupational Therapists for all programs should have a minimum of five years of occupational therapy experience with at least two having been in home modifications. Experience in home modifications should include mobility, sensory and dementia issues.
3. Contractor must submit any request for exceptions to staffing requirements for review by PCA. Requests may be mailed, faxed, or emailed to Mark Myers, Housing Director at [mmyers@pcaphl.org](mailto:mmyers@pcaphl.org). Staff is not to be assigned to provide services to PCA Housing consumers until an exception request has been reviewed and approved.
4. PCA reserves the right to request Contractor to remove individual staff from providing consultations and/or follow up visits to specific consumers or from seeing any PCA consumer.
5. All occupational therapists and supervisors, including both Contractor's and subcontracted staff (if any) **are required to attend a PCA Orientation before they can serve any PCA consumer, unless a waiver is granted by the Housing Department.** Resumes for all professional staff need to be submitted to the Housing Services Manager prior to attending the Orientation.

### IV PROPOSAL REQUIREMENTS

- A. Proposals must be submitted in three (3) complete copies and include the following documents and sections: ***Business Privilege License, Current Certificate of Insurance, MBEC Certification if applicable.***
- B. Description of applicant organization including:
  1. Primary location;
  2. Applicant's status for federal income tax purposes;
  3. State of incorporation, if applicable,
  4. Year of incorporation or establishment
  5. List of Board of Directors and Officers of applicant agency, if applicable
  6. Organizational table or chart, specifically as it applies to this RFP
  7. Brief description of applicant's history, purpose, goals and objectives
  8. Brief history of applicant's contracting experience with PCA, if any
- C. A complete and detailed description of applicant's experience over the last five (5) years in providing consultation services for home modifications including the types of modifications recommended or provided and population served.
- D. A narrative description of the applicant's capability to provide the required services
- E. A description of applicants proposed workflow for Housing consumers including a description of the process you will use to ensure required timeframes are adhered to;
- F. A description of the paper/electronic system to maintain control of the referrals and documentation;
- G. A description of proposed training and supervision for therapists working on PCA programs;

- H. Key Person data: Name and credentials of the individual directly responsible (if known at application) for review of evaluations prior to submission. Due to state budget requirements, for FY 2016 to 2017, prices cannot be higher than:
- I. Unit Prices for the following:
1. OT Initial Consultation (include stair glide evaluation when requested) \$85.16
  2. OT Follow Up Consultation \$76.66
  3. Hourly rate for meetings requested by PCA (except for initial PCA Orientation) \$71.86
  4. Additional visit rate when the OT consultant has a PCA employee joining him/her for training purposes. \$70.86

**ALL OTHER COSTS SHOULD BE INCLUDED IN UNIT PRICES.**

**V PROPOSAL SUBMISSION**

The total response to all questions should be a maximum of 20 pages, excluding attachments, double spaced with font size no smaller than 12.

Please submit three (3) complete copies of the proposal to:

Dorian Harris, Housing Services Manager  
Philadelphia Corporation for Aging  
642 North Broad Street, 5<sup>th</sup> Floor  
Philadelphia, PA 19130-3409

Proposals will not be accepted by facsimile or electronic transmission.

Proposals must be received by Dorian Harris, by **12:00 P.M (noon) on Friday, June 2, 2017**. PCA will accept no responsibility for failure of the US Postal Service or commercial carriers to deliver proposals by the deadline.

Proposals submitted become the property of PCA.

**Pre-Response Question & Answer Session**

A **mandatory** question and answer session, to allow for clarification of the specifications will be held on **Friday, May 19, 2017 at 2:00 p.m. in the 2<sup>nd</sup> Fl. Classroom** at the address listed above. Applicants are requested to submit questions by **mail, fax, or email to [dharris@pcaphl.org](mailto:dharris@pcaphl.org)** at PCA by **noon on May 15th**, to ensure a complete response. Five (5) points will be deducted from any applicant submitting a proposal who did not attend the mandatory Q&A session.

**VI REVIEW OF PROPOSALS AND NOTIFICATION OF DECISION**

Proposals will be reviewed by a team consisting of the Director of Housing, Housing Supervisor and the Housing Services Manager. Proposals will be scored using the criteria listed below.

**A. EXPERIENCE (40%)**

**Evaluation Criteria**

- Number of years of experience in home modifications
- Type and variety of modifications provided
- Diversity of population served including people with dementia and those with sensory issues.

B. ADMINISTRATION (20%)

Evaluation Criteria

- Proposed workflow for PCA consumers
- Number of consumers proposed
- History of applicant company

C. QUALITY ASSURANCE (20%)

Evaluation Criteria

- Proposed training and supervision for therapists
- Experience / credentials of key therapist

D. FINANCIAL (20%)

Evaluation Criteria

- Unit cost per consultation

PCA reserves the right to reject any and all proposals received as a result of this RFP.

PCA will notify all applicants of award decisions no later than June 30, 2017.

VII **INSURANCE**

1. PCA's insurance requirements for fiscal year 2017-2018 will be substantially as stated below. (A Sample Certificate of Insurance ("COI") is included in this RFP.)

2. Before submitting a response to this RFP, an applicant should verify through its insurance carriers that it would be able to obtain the necessary insurance coverage.

3. A successful applicant must provide PCA with a current COI evidencing compliance with PCA's insurance requirements within fourteen (14) days of receipt of the award letter from PCA or its award status will be in jeopardy.

4. An applicant selected to be a provider will be required to provide a current COI evidencing compliance with PCA's insurance requirements at the time the contract is signed.

**5. Insurance Requirements:**

Contractor shall, at its sole cost and expense, procure and maintain in full force and effect, throughout the term of the Agreement, the following insurance from companies licensed or approved to do business in the Commonwealth of Pennsylvania, or through a qualified self-insurance program approved or registered by or with the Commonwealth and acceptable to PCA, in the forms and on the terms and conditions specified herein. All insurance companies must maintain a Best's Insurance Guide rating of at least "A-" and a financial size of at least Class VII for companies licensed in the Commonwealth or Class X for companies approved but unlicensed in the Commonwealth. Except as specifically provided herein, all such insurance shall be written on an occurrence basis.

A. General liability insurance with no self-insured retention, and with no endorsements excluding or limiting coverage, including, but not limited to, contractual liability coverage, naming PCA and the Commonwealth of Pennsylvania and their directors, officers, employees and agents as additional insureds, with an endorsement stating that the coverage afforded the additional insureds shall be primary and non-contributory to any other coverage available. Such coverage shall have limits of coverage, on a stand-alone basis or in combination with excess or umbrella coverage, of not less than \$1,000,000 combined bodily injury and property damage per occurrence and \$2,000,000 per annual aggregate. All such policies shall expressly include coverage for products-completed operations hazard with limits of at least \$1,000,000 per occurrence and \$2,000,000 in the aggregate. The coverage for products-completed operations hazard shall remain in effect for four (4) years following completion of all work contemplated in the Agreement or the period of the warranty for the work, whichever is longer. Applicants shall evidence coverage for contractor's pollution and/ or lead paint based risk consistent with the scope of work contemplated, in such amounts as PCA may reasonably require, whether by endorsement to the required general liability policy or other means acceptable to PCA.

B. Automobile liability insurance written on the current Insurance Services Office's commercial auto form or its equivalent, with no self-insured retention, naming PCA and the Commonwealth of Pennsylvania and their directors, officers, employees and agents as additional insureds, with an endorsement stating that the coverage afforded the additional insureds shall be primary and non-contributory to any other coverage available, and with limits of coverage, on a stand-alone basis or in combination with excess or umbrella coverage, of not less than \$1,000,000 per occurrence combined single limit for bodily injury and property damage, covering owned, non-owned and hired vehicles;

C. Workers compensation insurance (with statutory limits of coverage and no deductible) and employers liability insurance (with limits of coverage of not less than \$100,000 per accident, \$100,000 per employee by disease and \$500,000 policy limit by disease and no deductible) endorsed for all states in which work is to be performed under the Agreement (including, without limitation, Pennsylvania);

D. Professional liability insurance naming PCA and the Commonwealth of Pennsylvania and their directors, officers, employees and agents as additional insureds (except with respect to Health Care Providers under the Medical Care Availability and Reduction of Error (MCARE) Act), with an endorsement stating that the coverage afforded the additional insureds shall be primary and non-contributory to any other coverage available, and with no endorsements excluding or limiting coverage, as follows:

(1) "Participating Health Care Providers" under the MCARE Act must have statutory limits and must participate in the MCARE Fund;

(2) "Non-participating Health Care Providers" under the MCARE Act and other providers of professional services (including, but not limited to, social and legal services providers and those health care providers who are not "Health Care Providers" under the MCARE Act) must have limits of coverage of not less than \$1,000,000 per occurrence and \$2,000,000 per annual aggregate and no-self insured retention.

(3) Professional liability insurance may be written on a claims-made basis, provided, however, that the policy permits Contractor to purchase extended reporting period coverage ("Tail Coverage") upon termination of the policy.

(a) In the event that insurance is written on a claims-made basis, Contractor hereby agrees to maintain, following termination of such coverage or of the Agreement (whichever is earlier), professional liability insurance, covering claims arising out of occurrences during the term of the Agreement, whether by (i) purchasing additional policies of insurance with no exclusion for prior occurrences and the option of purchasing appropriate Tail Coverage, or (ii) purchasing the appropriate Tail Coverage. Tail Coverage for medical professional liability coverage shall be of unlimited duration. All other Tail Coverage shall be maintained for a period of not less than the greater of six (6) years or as required by law, following termination of the Agreement or of such claims-made coverage (whichever is earlier). In no event shall any such Tail Coverage provide limits of coverage lower than the limits of coverage required herein for professional liability.

(b) In the event that Contractor elects to maintain insurance written on a claims-made basis, these undertakings (and the provision of certificates or policies of insurance evidencing compliance with same, as further specified below) shall survive termination of the Agreement.

E. All-risk or special form property damage insurance, naming PCA and the Commonwealth of Pennsylvania as additional insureds and loss payees, insuring as they may appear the interests of Contractor, PCA and the Commonwealth of Pennsylvania in all personal property, fixtures and improvements to real estate funded or supplied by PCA, whether titled to Contractor or to PCA. Such coverage shall be written for the full replacement value of the property in question without penalty or deduction for coinsurance or deductible greater than \$500.00, and shall be amended as necessary to reflect changes in inventory.

If Contractor has contracted with PCA for any prior period(s) and has in force general liability or, if applicable, excess insurance, written on a claims-made basis, covering claims arising in connection with its performance under contract with PCA during such period(s), Contractor shall maintain said insurance during and for a period of not less than the greater of six (6) years or as required by law, following the term of the Agreement (whether by (i) purchasing additional policies of

insurance with no exclusion for prior occurrences and the option of purchasing Tail Coverage, or (ii) purchasing the appropriate Tail Coverage); provided, however, that all other terms and conditions are otherwise met. In the event that Contractor elects to maintain insurance written on a claims-made basis, as provided in this paragraph, this undertaking (and the provision of certificates or policies of insurance evidencing compliance with same, as further specified below) shall survive termination of the Agreement. Whenever Contractor has insurance written on a claims-made basis, Contractor shall provide PCA with a copy of the policy's declaration page indicating the retroactive date of the coverage.

Contractor shall provide PCA with certificates of insurance evidencing compliance with PCA's insurance requirements prior to performance under the Agreement. All certificates shall evidence the agreement on the part of the insurer to provide PCA with prior written notice of any non-renewal, cancellation or modification of coverage, or of any impairment greater than \$100,000 of the aggregate insurance available as a result of loss no later than the time period for a notice of cancellation as set forth in the policy. Any language on the certificate which states that the insurer will "endeavor to" mail such notice and any language stating "but failure to do so shall impose no obligation or liability of any kind upon the insurer affording coverage, its agents or representatives, or the issuer of this certificate" shall be deleted.





# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
6/30/17

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER XYZ Company 123 Main Street Anytown, USA	~~~~~ SAMPLE ~~~~~	CONTACT NAME:	
		PHONE (A/C, No, Ext):	FAX (A/C, No):
		E-MAIL ADDRESS:	
		INSURER(S) AFFORDING COVERAGE	NAIC #
		INSURER A : CBA12345	
		INSURER B : RST12345	
		INSURER C : XYZ12345	
		INSURER D :	
		INSURER E :	
		INSURER F :	

## COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY						EACH OCCURRENCE \$ 1,000,000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						MED EXP (Any one person) \$ 5,000
							PERSONAL & ADV INJURY \$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE \$ 2,000,000
	<input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG \$ 1,000,000
							\$
A	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
	<input checked="" type="checkbox"/> ANY AUTO						BODILY INJURY (Per person) \$
	<input type="checkbox"/> ALL OWNED AUTOS						BODILY INJURY (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS						PROPERTY DAMAGE (Per accident) \$
							\$
	UMBRELLA LIAB						EACH OCCURRENCE \$
	EXCESS LIAB						AGGREGATE \$
	DED <input type="checkbox"/> RETENTION \$						\$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						<input checked="" type="checkbox"/> WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N						E.L. EACH ACCIDENT \$ 100,000
							E.L. DISEASE - EA EMPLOYEE \$ 100,000
							E.L. DISEASE - POLICY LIMIT \$ 500,000
C	Professional Liability			XYZ12345	7/1/17	6/30/18	Per Occ \$1,000,000/Aggregate \$2,000,000
A	Property-All Risk/Special Form			CBA12345	7/1/17	6/30/18	Per Occ \$1,000,000/Aggregate \$2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

PCA and the Commonwealth of PA and their directors, officers, employees & agents are hereby added as Additional Insureds with an endorsement stating that the coverage afforded the Additional Insureds shall be primary and non-contributory to any other coverage available. Certificate evidences the agreement on the part of the insurer to provide PCA with prior written notice of any non-renewal, cancellation or modification of coverage, or of any impairment greater than \$100,000 of the aggregate insurance available as a result of loss no later than the time period for a notice of cancellation as set forth in the policy.

## CERTIFICATE HOLDER

Philadelphia Corporation for Aging  
642 N. Broad Street  
Philadelphia, PA 19130-3409  
Attn:

## CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE, THEREOF, THE ISSUING INSURER WILL MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT.

AUTHORIZED REPRESENTATIVE

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## EXHIBIT "A"

## Initial Consultation Form

**PHILADELPHIA CORPORATION FOR AGING**  
**HOUSING DEPARTMENT**  
**OCCUPATIONAL THERAPY CONSULTATION**

\_\_\_ Bravo      \_\_\_ CSP  
 \_\_\_ OPT      \_\_\_ SHARP  
 \_\_\_ Other      \_\_\_ Health Partners  
 \_\_\_

Enrollment/Referral Date: \_\_\_\_\_ Evaluation Date: \_\_\_\_\_

Date Rec'd by Provider: \_\_\_\_\_ Consumer's signature \_\_\_\_\_

**1. DEMOGRAPHIC INFORMATION:**

Consumer: \_\_\_\_\_ Phone: \_\_\_\_\_ ZIP: \_\_\_\_\_

Primary Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ PCG: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_

Anticipated Problems serving this household: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

If evaluation is for **stairglide** or  $\frac{1}{2}$  **bath** the following information is needed:

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**2. HOUSEHOLD COMPOSITION & MEDICAL INFORMATION:**

	Age	Relate	Ht/Wt	Arth	DM	CVA	Respir- atory	Orth o	Heart	Mental Status	HTN	Other
Client												

Assistance Available: \_\_\_\_\_

**3. FUNCTIONAL DEFICITS RESULTING FROM MEDICAL PROBLEMS:**

SENSORY Does the client have:	No	Yes	Yes, but compensates	Comment
Vision loss (can't see steps, can't see small print or numbers etc.)				
Hearing loss (can't hear doorbell, telephone, smoke alarm etc.)				

**Consumer name:**

PHYSICAL/ ACTIVITY Can the client...	No	Yes	Yes, but with difficulty	Comment
Grasp (doorknobs, grab bars, cabinet handles, etc.)				
Reach (into cabinets, to open door from w/c etc.)				
Bend (to get into tub, pick up items, or access low cabinets etc.)				
Lift (commode bucket, laundry basket, food tray etc.)				

PHYSICAL/ TRANSFERS What type of transfer does the client perform?	No	Yes	Level	Comment
Stand-Pivot-Sit				
Transfer board/slide				
Dependent lift				
Sit to Stand				

PHYSICAL/ MOBILITY Method of mobility for:	Method	Device used	Comments
Interior of home			
Exterior of home			
Steps in and out of home			
Steps to 2nd floor/bsmt			

ADL and IADL Status What is the level of assistance for each?	I	Min A	Mod A	Max A	D	Comments
Feeding						
Hygiene						
Dressing						
Bathing						
Cooking						
Laundry						
Cleaning						
Shopping						

Consumer name: \_\_\_\_\_

**4. HOME ASSESSMENT:**

Living Situation: \_\_\_\_\_ story \_\_\_\_\_

Condition: G F P

Front Entrance: \_\_\_\_\_

Doorbell: \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_ broken

Can consumer answer door in a timely manner? \_\_\_\_\_ yes \_\_\_\_\_ no

Rear Entrance: \_\_\_\_\_ Used for: \_\_\_\_\_

Bedroom: \_\_\_\_\_ 1st floor \_\_\_\_\_ 2nd floor \_\_\_\_\_ 3rd floor

Bathroom: \_\_\_\_\_ old fashioned tub \_\_\_\_\_ OH shower \_\_\_\_\_ vanity \_\_\_\_\_ std toilet G P

\_\_\_\_\_ modern tub \_\_\_\_\_ HH shower \_\_\_\_\_ sink \_\_\_\_\_ H/C toilet

\_\_\_\_\_ faucets: G P \_\_\_\_\_ stall shower \_\_\_\_\_ no sink

\_\_\_\_\_ faucets: G P

Kitchen: sink faucets: G P

Comments on kitchen set-up/accessibility \_\_\_\_\_ satisfactory \_\_\_\_\_ unsatisfactory

Steps: \_\_\_\_\_ 1st to 2nd \_\_\_\_\_ 2nd to 3<sup>rd</sup>

	straight or curved	wood banister	iron banister	second railing	number of steps	width of steps	condition
Interior							
Interior							
Basement							

Location of Washer: \_\_\_\_\_ 1st floor \_\_\_\_\_ basement \_\_\_\_\_ none

Location of Dryer: \_\_\_\_\_ 1st floor \_\_\_\_\_ basement \_\_\_\_\_ none

Would consumer benefit from relocation of laundry facilities? \_\_\_\_\_ yes \_\_\_\_\_ no

**Consumer name:**

**5. EQUIPMENT CURRENTLY USED:**

Equipment

\_\_\_\_\_ Cane                      \_\_\_\_\_ Wheelchair                      \_\_\_\_\_ Bathroom

\_\_\_\_\_ Walker                      \_\_\_\_\_ Scooter                      \_\_\_\_\_ Commode

\_\_\_\_\_ Crutches                      \_\_\_\_\_ Stairglide                      \_\_\_\_\_ Hospital Bed

\_\_\_\_\_ Other

## 6. INITIAL REQUEST:

☐ Bathroom Mods / Equip      ☐ 1st floor pwr room      ☐ wheelchair lift / ramp  
☐ railings      ☐ 1st floor full bath      ☐ other (specify):  
☐ intercom / door release      ☐ stairglide      \_\_\_\_\_

## 7. PROBLEMS:

Lack of support to safely bathe

Lack of support: front entrance

rear entrance

basement steps

interior steps

**ADDITIONAL COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Consumer name:

**8. RECOMMENDATIONS:**

MEDICAL EQUIPMENT			WROUGHT IRON RAILINGS			
Item #	Price	Description	Location	L Ascend	R Ascend	Comments
			Party Wall			
			Int Step			
			Ext Front			
			Ext Rear			
			Other			

**MODIFICATIONS & MECHANICAL EQUIPMENT:**

\_Bathroom: \_ 18" grab bar \_\_\_\_\_  
\_ 24" grab bar \_\_\_\_\_  
\_\_\_\_\_ HHS \_\_\_\_\_ sliding HHS bar \_\_\_\_\_ hook at seated level \_\_\_\_\_ diverter valve  
\_\_\_\_\_ Tub mat \_\_\_\_\_ check plumbing: \_\_\_\_\_ toilet \_\_\_\_\_ sink \_\_\_\_\_ tub  
\_\_\_\_\_ Shower curtains/rod  
\_\_\_\_\_ Doorbell needed: \_\_\_\_\_ large bell \_\_\_\_\_ regular bell  
\_\_\_\_\_ Intercom: \_\_\_\_\_ # & location of stations Door release: \_\_\_\_\_  
\_\_\_\_\_ Basement wooden rail  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Occupational Therapist, Registered/Licensed

**EXHIBIT "B"**

**Occupational Therapy Follow Up Form**

**PHILADELPHIA CORPORATION FOR AGING  
HOUSING DEPARTMENT  
OCCUPATIONAL THERAPY FOLLOW UP**

Other \_\_\_\_\_ Options \_\_\_\_\_ CSP \_\_\_\_\_ SHARP \_\_\_\_\_ BRAVO \_\_\_\_\_ Health Partners \_\_\_\_\_

Evaluation Date: \_\_\_\_\_ Follow Up Date: \_\_\_\_\_

**1. DEMOGRAPHIC INFORMATION:**

Consumer: \_\_\_\_\_ Phone: \_\_\_\_\_ ZIP: \_\_\_\_\_

Address: \_\_\_\_\_ PCG: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_ CM Phone: \_\_\_\_\_

**2. INITIAL RECOMMENDATIONS:**

\_\_\_\_\_ Bathroom Mods / Equipment \_\_\_\_\_ 1st floor pwdr/bath \_\_\_\_\_ wheelchair lift / ramp

\_\_\_\_\_ railings \_\_\_\_\_ kitchen \_\_\_\_\_ other (specify)

\_\_\_\_\_ intercom / door release \_\_\_\_\_ stairglide \_\_\_\_\_

**3. EQUIPMENT / MODIFICATIONS RECEIVED (if different from recommendations, why?)**

**4. EQUIPMENT/MODIFICATIONS RECEIVED**

Using the above broad categories (section 2), complete a separate section on the next page for each modification category received. Use additional pages as necessary.

**Category #1:** \_\_\_\_\_

- a. Is the consumer using the modification?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_
- b. Is the consumer using the modification safely?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_
- c. Is the consumer having any difficulties using the modification?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_
- d. Does the modification serve the purpose you and the consumer had planned?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_

**Category #2:** \_\_\_\_\_

- a. Is the consumer using the modification?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_
- b. Is the consumer using the modification safely?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_
- c. Is the consumer having any difficulties using the modification?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_
- d. Does the modification serve the purpose you and the consumer had planned?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_

**Category #3:** \_\_\_\_\_

- a. Is the consumer using the modification?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_
- b. Is the consumer using the modification safely?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_
- c. Is the consumer having any difficulties using the modification?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_
- d. Does the modification serve the purpose you and the consumer had planned?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No      why not \_\_\_\_\_



5. ADDITIONAL COMMENTS AND RECOMMENDATIONS:

*Note: Recommendations should only address the specific goals of the initial evaluation.*

---

Consumer's signature/Date

---

Occupational Therapist, Registered/Licensed/ Date

**FOR USE AS NEEDED.....**

*If there is anything in particular that the Program should learn from this case and/or share with other therapists, please indicate below.*

EXHIBIT "C"

Stair Glide Evaluation Form

**OCCUPATIONAL THERAPY EVALUATION  
FOR STAIR GLIDE**

Consumer: \_\_\_\_\_  
Care Giver: \_\_\_\_\_  
Consumer Phone: \_\_\_\_\_

Visit Date: \_\_\_\_\_  
PCA CM: \_\_\_\_\_  
Spoke to: \_\_\_\_\_

**Width of Steps:** Need three (3) measurements – take measurement from inside of molding at each step on both sides of the stairs or from one side to the banister on the other.

1. First Step \_\_\_\_\_ Inches
2. Middle Step \_\_\_\_\_ Inches
3. Top Step \_\_\_\_\_ Inches

**Number of Steps:** \_\_\_\_\_

**Layout of Steps:** \_\_\_\_\_

**Patient's ability to negotiate steps:**

CANNOT do steps independently or with assistance: \_\_\_\_\_

Can do steps with \_\_\_\_\_ assistance.

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If you are recommending a stair glide would it be:**

\_\_\_\_\_ front riding

\_\_\_\_\_ side riding

**Can Patient:**

Safely operate stair glide: \_\_\_\_\_

Transfer safely to and from stair glide: \_\_\_\_\_

Bend leg to almost a 90-degree angle: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Therapist Signature/date