Application Number: SHSB-YY/<District>/000000

Yukti Yojana – Application form

This application form is also intended to serve as checklist and assessment guide to evaluate the suitability of your clinic/nursing home/hospital (hereinafter referred to as 'site') to provide services under the *Yukti Yojana*.

The District Accreditation Committee (DAC) will assess and evaluate your site's suitability to be accredited under the *Yukti Yojana* based on the information provided by you in this checklist. This information will be revalidated during the subsequent site visit by the members of the DAC.

This checklist has been developed to help you undertake a pre-application assessment of the level of preparedness of your site. The checklist follows a structured format that covers the existing caseload, infrastructure, equipment, drugs and consumables, etc. Each question can be answered with a simple yes or no. In some instances, you will be required to provide information in terms of numbers and/or names, like doctors, nursing staff, beds, etc.

In case any clarifications are needed, please feel free to contact your DAC representative or the office of CMO/CS.

Important Instructions:

1. **The application has to be filled by the applicant**
2. **Write only 1 letter per block and use CAPITAL LETTERS**
3. **In case of submission by hand, please collect the acknowledgement receipt below**

---*TEAR HERE*---

Y U K T I   Y O J A N A

Acknowledgement Receipt

DISTRICT:	**Appl. No.**								

Name of the applicant:

Name of Clinic (Site):

We thank you for your interest in the getting your site accredited under the Yukti Yojana. This is to acknowledge receipt of your application form for the same. Kindly quote the above application number in all future communication with respect to this scheme.

Office of the CMO/CS

District_______________

Date:_________________

Signature of receiving clerk and Stamp

DISTRICT																

Name of the Applicant																

Name of Clinic (Site)																

Complete Postal Address																			
										PIN Code									

Telephone Number (With STD Code)																
	Clinic							-								
	Residence							-								
	Other							-								
	Mobile 1	0	-													
	Mobile 2															

Email Id																		

PAN Number (Self)											
PAN Number (Site)											

Year of Establishment of Site	M	M	/	Y	Y	Y	Y

Enrolled in any other Govt. Health Scheme (Scheme name/enrolled since)	

Please provide the following information about the site:

1. Approval for MTP	Yes/No	Verified (By DAC)
Site is MTP approved		
1.1 for first trimester MTPs	Yes / No	
1.2 for up to second trimester MTPs	Yes / No	
Category Status (to be filled by assessor)		

2. MTP Caseload	Number	Verified (By DAC)
Average monthly MTP cases (past 12 months)		
2.1 First trimester	Number	
2.2 Second trimester	Number	
2.3 Incomplete abortions	Number	
Category Status (to be filled by assessor)		

3. Staff Details	Name/number	Verified (By DAC)
3.1 Number of Ob-Gyn Specialist	Number	
3.1.1 Name of Ob-Gyn Specialist	Name	
3.1.2 Name of Ob-Gyn Specialist	Name	
3.1.3 Name of Ob-Gyn Specialist	Name	
3.2 Number of MBBS doctors	Number	
3.3 Names of MBBS doctors certified MTP service provision		
3.3.1 Name of MBBS doctor	Name	
3.3.2 Name of MBBS doctor	Name	
3.3.3 Name of MBBS doctor	Name	
3.4 Number of nursing staff	Number	
Category Status (to be filled by assessor)		

4. Essential Infrastructure and Equipment	Yes / No/ Number	Verified (By DAC)
4.1 Essential Equipments/ instruments		
4.1.1 Sim's/ Cusco's speculum	Yes / No	
4.1.2 Anterior vaginal wall retractor	Yes / No	
4.1.3 Allis forceps or volsellum (small toothed)	Yes / No	
4.1.4 Sponge holding forceps	Yes / No	
4.1.5 Blunt and sharp curette	Yes / No	
4.1.6 Cheatle's forceps	Yes / No	
4.1.7 Bowl for antiseptic solution	Yes / No	
4.1.8 Proper light source/ torch	Yes / No	
4.1.9 MVA aspirator/ Electric suction machine	Yes / No	
4.1.10 Cannulae of required sizes	Yes / No & number	
4.1.11 Kidney tray or suitable receptacle for emptying the contents of the syringe	Yes / No	
4.1.12 Strainer for tissues	Yes / No	
4.1.13 Plastic bucket	Yes / No	
4.1.14 Equipment for resuscitation		
a. Ambu bag	Yes / No	
b. Oral airway	Yes / No	
c. Oxygen cylinder	Yes / No	
4.1.15 Equipment for infection prevention and sterilization (at least one of the three below)		
d. Autoclave	Yes / No	
e. Boiler	Yes / No	
f. Cidex tray	Yes / No	
4.2 Essential Supplies		
4.2.1 Antiseptic solution: Povidone iodine solution	Yes / No	
4.2.2 Sterile cotton swabs	Yes / No	
4.2.3 Sterile gloves	Yes / No	
4.2.4 Syringe and needle for administration of paracervical block and other drugs	Yes / No	
4.2.5 Sterile saline	Yes / No	
4.2.6 Chlorine solution/ bleaching powder	Yes / No	
4.3 Essential Drugs		
4.3.1 Ampicillin, Amoxicillin Trihydrate, Cephalexin or a suitable alternative	Yes / No	
4.3.2 Paracetamol, Penatazocine, Dicyclomine or a suitable alternative	Yes/No	
4.3.3 Injection Atrophine Sulphate	Yes / No	
4.3.4 Injection Lignocaine 1-2%	Yes/No	
4.3.5 Injection Diazepam	Yes/No	
4.3.6 Injection Oxytocin	Yes/No	
4.3.7 Injection Methylergometrine Maleate	Yes/No	
4.3.8 Dextrose 5%	Yes / No	

4.3.9 Ringer Lactate solution with IV sets	Yes / No	
4.3.10 Cannulae or scalp vein sets (different sizes)	Yes/No	
4.4 Drugs for treatment of emergencies		
4.4.1 Injection Adrenaline	Yes / No	
4.4.2 Injection Aminophyline	Yes / No	
4.4.3 Injection Sodium-Bi-Carbonate 7.5%	Yes / No	
4.4.4 Injection Calcium Gluconate 10%	Yes / No	
4.4.5 Injection Metclopramide or a suitable alternative	Yes / No	
4.4.6 Injection Promethazine Hydrochloride or a suitable alternative	Yes / No	
4.4.7 Injection Hydrocortisone Succinate	Yes / No	
4.4.8 Injection Frusemide	Yes / No	
4.4.9 Injection Dopamine	Yes / No	
4.5 Drugs required for medical methods of abortion		
4.5.1 Mifepristone	Yes / No	
4.5.2 Misoprostol	Yes / No	
4.5.3 Paracetamol, Ibuprofen or a suitable alternative	Yes / No	
Category Status (to be filled by assessor)		

5. General information	Yes / No/ Number	Verified (By DAC)
5.1 Infrastructure		
5.1.1 Operation theater – major OT	Yes / No & number	
5.1.2 Operation theater – minor OT	Yes / No & number	
5.1.3 Labour room	Yes / No & number	
5.1.4 Pre-operative room / area	Yes / No	
5.1.5 Post OT / recovery room / area	Yes / No	
5.1.6 Number of Rooms/wards	Number	
5.1.7 Total number of Beds	Number	
5.1.8 Electricity backup - Generator / inverter	Yes / No	
5.1.9 Waiting area	Yes / No	
5.1.10 Separate counseling area	Yes / No	
5.2 Client friendly		
5.2.1 Site has prominent signage and can be located easily	Yes / No	
5.2.2 Site is easily accessible	Yes / No	
5.2.3 Site cleanliness – site is neat & clean		
5.2.4 Site cleanliness – site is free from foul odour	Yes / No	
5.2.5 Site cleanliness – toilets are clean	Yes / No	
5.2.6 Running water available in the site	Yes / No	
5.2.7 Client privacy is ensured during counseling	Yes / No	

Name &Signature of applicant & Date

ORIGINAL ASSESSMENT REPORT
(to be retained in the DAC file)

(For use by the Site Assessment Team (SAT) of the District Accreditation Committee for verification during assessment of private site)

Based on the site assessment done of this date (____________________) by the SAT nominated by the DAC of District ______________________, the Private site____ was:

Tick whichever is applicable

found to be fulfilling all required staff & infrastructural requirements stipulated in the guidelines. On this basis, the SAT recommends that the said site be accredited under the Yukti Yojana

OR

found to be lacking in the below mentioned staff and/or infrastructural requirements stipulated in the guidelines. The identified gaps have been brought to the notice of the applicant. On fulfilling these gaps, the applicant may re-submit his/her application to the DAC for being considered for accreditation under the Yukti Yojana

Gaps Identified		
S.No.	**Item number (from Assessment List) in which gap was identified**	**Remarks (If any)**
1		
2		
3		
4		
5		
6		
7		

Name & signature of SAT member	Name & signature of SAT member	Name & signature of Applicant

APPLICANT's COPY of ASSESSMENT REPORT
(to be handed over to the applicant immediately after the assessment)

(For use by the Site Assessment Team (SAT) of the District Accreditation Committee for verification during assessment of private site)

Based on the site assessment done of this date (____________________) by the SAT nominated by the DAC of District ______________________, the Private site____ was:

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2		
3		
4		
5		
6		
7		

Name & signature of SAT member	Name & signature of SAT member	Name & signature of Applicant

(This page– is to be handed over to the applicant immediately after the site assessment)

Final Recommendation of DAC

Private site to be accredited: Yes ☐ No ☐ Comments, if any:

Name, Signature & Date of DAC members:

	First Member of SAT	Second Member of SAT	DPM (if not a member of SAT)
Signature			
Name			
Designation			
Date			

Name & Signature of CMO/CS ______________________________

(Member Secretary – DAC) ______________________________

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Final Approval of Chairperson of DAC

Signature of DM ______________________________

(Chairperson – DAC) ______________________________

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