

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2014

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

2014 ANNUAL REPORT FOR HOME HEALTH AGENCIES

This report should be typewritten or completed in ink only; no pencil submissions

Mailing Address:

_____ STREET ADDRESS _____ CITY _____ STATE _____ ZIP

Physical Address:

_____ STREET ADDRESS _____ CITY _____ **AL** _____ ZIP

County of Location:

Facility Telephone:

_____ (AREA CODE) & TELEPHONE NUMBER

Facility Fax:

_____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for October 1, 2013, through September 30, 2014*; or for partial year of operation beginning _____ and ending _____ a period of _____ days.

MONTH DAY

MONTH DAY

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this provider.

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS
<i>A member of administration <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and must be separate from the preparer.</i>		
PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS

FOR OFFICE USE ONLY

Facility Verified: _____	Initial Scan: _____	Completed: _____
Entered: _____	Final Scan: _____	Audited: _____

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I Agency Operations

Days of week services are regularly available Monday – Friday Sunday-Saturday Other (specify)

Days on-call **only** Weekends Holidays Other (specify)

II Ownership

_____ Corporation	_____ Non-Profit Organization	_____ Partnership
_____ Individual	_____ Healthcare Authority	_____ LLC
_____ Joint Venture	_____ Government	_____ Other (specify)

III Branch Offices

Does the organization of your service include a staffed satellite or branch office?

_____ YES	_____ NO			
	OPENED IN LAST 12 MONTHS?		DAYS OF WEEK SERVICES AVAILABLE	
CITY OF LOCATION	YES	NO	REGULAR SCHEDULE	ON-CALL ONLY
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

IV Drop Sites

Has this agency received authorization to operate a drop site? NOTE: A drop site is considered to be a location from which supplies **only** are stored. A drop site may not be staffed, accept referrals, advertise, or operate in any manner as a branch office (CMS S&C-05-07). Drop sites can only be operated in CON approved/exempt counties.

_____ YES		_____ NO
CITY OF LOCATION	OPENED IN LAST 12 MONTHS?	
	YES	NO
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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VII. ADMISSIONS BY REFERRAL SOURCE. While it is acknowledged that all patient services are rendered in accordance with a physician's treatment plan, the entity which **initiates** the patient's entry into the Home Health Care System should be indicated below:

SOURCE	NUMBER OF ADMISSIONS
Physicians	
Hospital	
Nursing Home	
Family or Self	
Department of Human Resources	
Public Health or Agency Nurse	
Other (including Social Service Agencies)	
Specify Other _____	
TOTAL ADMISSIONS	*

** THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, IX-A, AND IX-B.*

VIII. SERVICES OFFERED. List below the total number of services provided, broken down by services provided, for all visits made during this reporting period.

SERVICE	VISITS BY SERVICE
Skilled Nursing Services (RN/LPN)	
Home Health Aide	
Homemaker	
Orderly	
Medical Social Service	
Physical Therapy	
Speech Therapy	
Occupational Therapy	
Medical Equipment	
Other (please specify other service offered): _____	
TOTAL VISITS BY SERVICE	*

** THIS TOTAL MUST EQUAL THE TOTAL VISITS ON PAGE 3, SECTION V.*

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IX. PATIENT ADMISSION DEMOGRAPHICS

A. ADMISSIONS BY AGE AND GENDER (Entire Reporting Period)

	MALE	FEMALE	TOTAL
18 & under			
19 – 34 years of age			
35 – 54 years of age			
55 – 64 years of age			
65 – 74 years of age			
75 – 84 years of age			
85 years and older			
TOTALS			*

* THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, VII, AND IX-B.

B. ADMISSIONS BY RACE (Entire Reporting Period)

	TOTAL
White/Caucasian	
Black/African American/Negro	
Hispanic/Spanish/Latino	
Asian	
American Indian/Alaskan Native	
Pacific Islander	
India	
Middle Eastern	
Other (Please specify other race category):	
TOTALS	*

* THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, VII, AND IX-A.

X. REVENUES AND EXPENSES

Only those costs related to Home Health should be reported. These amounts **DO NOT** have to be **AUDITED** prior to reporting.

EXPENSES		REVENUES	
Payroll	\$ <u> .00</u>	Medicare	\$ <u> .00</u>
Non-Payroll	\$ <u> .00</u>	Medicaid	\$ <u> .00</u>
Transportation	\$ <u> .00</u>	Commercial Insurance	\$ <u> .00</u>
Bad Debt	\$ <u> .00</u>	Private Pay	\$ <u> .00</u>
Charity	\$ <u> .00</u>	Other	\$ <u> .00</u>
TOTAL EXPENSES	\$ <u> .00</u>	TOTAL REVENUES	\$ <u> .00</u>