**FORM DM-1**
**Revised 8/2011**

**THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2011**

# STATE HEALTH PLANNING AND DEVELOPMENT AGENCY


*MAILING ADDRESS (U.S. Postal Service)*
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## 2011 ANNUAL REPORT FOR HOME HEALTH AGENCIES

**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, 2010, through September 30, 2011*; or for partial year of operation beginning

_____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*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 |

***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.***

| 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 _____

Days on-call only _____

## 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

| CITY OF LOCATION | MONTH/DAY/YEAR OPENED | DAYS OF WEEK SERVICES AVAILABLE | |
|---|---|---|---|
| | | REGULAR SCHEDULE | ON-CALL ONLY |
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## 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 | MONTH/DAY/YEAR OPENED |
|---|---|
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## V Authorized Service Area

List **all** counties for which your agency and branch offices are approved to provide services, number of visits, and number of persons (unduplicated) served during this reporting period. If no visits were made in an approved county, list "0" for the number of visits and persons served. A contiguous county is not considered to be "authorized" until the home health provider has accepted the first referral and has sent the required notification to SHPDA. A person receiving services during this reporting period should be counted only once, regardless of whether the person was admitted more than once and/or received more than one service. Attach additional sheets as necessary.

| COUNTY | VISITS | PERSONS SERVED |
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| **TOTALS** | * | |

* *THIS TOTAL MUST EQUAL THE TOTAL VISITS IN SECTION VIII.*

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**VI. ADMISSIONS BY SOURCE OF PAYMENT.** List below the total number of admissions, broken down by county of residence, for each payment source category during this annual reporting period. Since a patient may be discharged and readmitted several times during an annual reporting period, and payment source may vary for subsequent readmission(s), most agencies will show more admissions than patients served. Attach additional sheets if necessary.

| County of Residence | Self-Pay | Workman Comp | Medicare | Medicaid | Tricare | Blue Cross | All Kids | Other Ins. | Charity | HMO | Other** |
|---|---|---|---|---|---|---|---|---|---|---|---|
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| **Category Totals** | | | | | | | | | | | |

**TOTAL ADMISSIONS** *

***** *THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTION VII, SECTION IX-A, AND SECTION IX-B.*

****Please specify "other" payment source category.** _____

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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 SECTION VI, SECTION IX-A, AND SECTION IX-B.*

**VIII. SERVICES OFFERED.** List below the total number of services provided, broken down by the 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 SECTION VI, SECTION VII, AND SECTION 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 SECTION VI, SECTION VII, AND SECTION 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 | $ .00 | Medicare | $ .00 |
| Non-Payroll | $ .00 | Medicaid | $ .00 |
| Transportation | $ .00 | Commercial Insurance | $ .00 |
| Bad Debt | $ .00 | Private Pay | $ .00 |
| Charity | $ .00 | Other | $ .00 |
| **TOTAL EXPENSES** | $ .00 | **TOTAL REVENUES** | $ .00 |