FORM DM-1
Revised 8/2012

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2012

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
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MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
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MONTGOMERY AL 36104
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bradford.williams@shpda.alabama.gov

2012 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, 2011, through September 30, 2012*; 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	OPENED IN LAST 12 MONTHS?		DAYS OF WEEK SERVICES AVAILABLE	
	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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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
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**
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