

**THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2018**

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2018 ANNUAL REPORT FOR HOME HEALTH AGENCIES

**SHPDA ID NUMBER**  
**FACILITY NAME**

<b>Mailing Address:</b>	STREET ADDRESS	CITY	STATE	ZIP
<b>Physical Address:</b>	STREET ADDRESS	CITY	<b>AL</b>	ZIP
<b>County of Location:</b>				
<b>Facility Telephone:</b>		<b>Facility Fax:</b>		
	(AREA CODE) & TELEPHONE NUMBER			(AREA CODE) & TELEPHONE NUMBER

This reporting period is for **October 1, 2017**, through **September 30, 2018** \*; 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
<b><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></b>		
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**

<input type="checkbox"/> Corporation	<input type="checkbox"/> Non-Profit Organization	<input type="checkbox"/> Partnership
<input type="checkbox"/> Individual	<input type="checkbox"/> Healthcare Authority	<input type="checkbox"/> LLC
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Government	<input type="checkbox"/> 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### 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
<b>TOTALS</b>	*	

\*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**
<b>Category Totals</b>											

**TOTAL ADMISSIONS**

*\*THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VII, IX-A, AND 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:

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

*\*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.

<b>SERVICE</b>	<b>VISITS BY SERVICE</b>
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): _____	_____
<b>TOTAL VISITS BY SERVICE</b>	*

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

**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			
<b>TOTALS</b>			*

\* 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):	
<b>TOTALS</b>	*

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