

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
www.shpda.alabama.gov

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

2007 ANNUAL REPORT FOR IN-HOME HOSPICES

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, 2006, through September 30, 2007*; 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 _____

A member of administration MUST 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: _____

I. PROGRAM DEMOGRAPHICS

A. Agency Type

- | | |
|--|--|
| <input type="checkbox"/> Free Standing
<input type="checkbox"/> Home Health Based
<input type="checkbox"/> Government/Healthcare Authority Based | <input type="checkbox"/> Hospital Based
<input type="checkbox"/> Nursing Home Based |
|--|--|

B. 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) |

C. Reporting Entity

1. Does this agency have the capability to provide patient information, specific only to this licensed location?

YES NO

2. If no, provide the name of the licensed hospice agency that will be reporting patient information for this entity:

SHPDA ID #:

NAME OF REPORTING HOSPICE:

NAME OF CONTACT:

TELEPHONE NUMBER:

3. Will the information contained in this report include patient information from other licensed hospice agencies, for services offered and performed in the State of Alabama?

YES NO

4. If yes, provide the SHPDA ID # and the name of the licensed hospice agency(ies) for which information is included in this report:

SHPDA ID #:

NAME OF HOSPICE AGENCY

B. PATIENT DAYS BY PAYMENT SOURCE

Provide the number of patient days for all patients including those in hospitals, specialty care assisted living, and nursing facilities, for the reporting period.

HOSPICE PAYMENT SOURCE	NUMBER OF PATIENTS SERVED	DAYS OF ROUTINE HOME CARE	DAYS OF INPATIENT CARE	DAYS OF RESPITE CARE	DAYS OF CONTINUOUS CARE	TOTAL PATIENT CARE DAYS
Hospice Medicare						
Hospice Medicaid						
Private Insurance/ Managed Care (non-Medicare)						
Charity/ Indigent						
Private Pay						
Other (VA, Worker's Comp, etc)						
TOTALS						

C. ADMISSIONS BY DEMOGRAPHICS

Use the patient's age on the first day of admission.

AGE GROUPS	MALE	FEMALE	TOTAL
18 and under			
19 – 34			
35 – 54			
55 – 64			
65 – 74			
75 – 84			
85 years and older			
TOTAL ADMISSIONS			**

**TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A AND II-D.

D. TOTAL ADMISSIONS BY RACE

RACE	ADMISSIONS
a. White/Caucasian	
b. Black/African American/Negro	
c. Hispanic/Spanish/Latino	
d. Asian	
e. American Indian/Alaskan Native	
f. Pacific Islander	
g. India	
h. Middle Eastern	
i. Other	
TOTAL ADMISSIONS	**

**TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A, AND II-C.

III. REVENUES AND EXPENSES (*AMOUNTS DO NOT HAVE TO BE AUDITED*)

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