Arkansas Health Services Permit Agency

HOME HEALTH AGENCY ANNUAL REPORT FORM

There are 8 steps to go through to complete one entry. All 8 steps need to be completed for each county. Please be sure to completely read all instructions accompanying this Annual Report form. You may download the instructions and report form at the links above. A separate report must be submitted for each county served by your agency. Please submit completed electronic form by XXXX XX, XXXX.

Agency Name:

Address:

City:

State:

Phone:

Name of Owner:

Email address of person filling out this report:

Name of person filling out this report:

County:

Do you have an office in this County?: **Yes, No**

If no, from which office do you serve this county?:

License Type: **A, B, A and B**

Type of Care:
- ☑ **Personal Care,**
- ☑ **Skilled Care,**
- ☑ **Extended Care**

Serves (**W**)hole County, (**P**)artial County, or (**N**)ot Licensed for this County:

Did you serve patients in this County?: **Yes, No**

Enter the number of patients served for this County:

Branches as of 12/31/20XX:

Operational days (see instructions):

Administrator:

Profit Status: **For Profit, Not For Profit**

Agency Type:

Privately Owned
Hospital Based
Government Based
Chain Affiliate

Agency Accreditation and membership (Please enter all that apply)

a. Joint Commission on Accreditation of Health Care Organization

b. National League of Nursing
c. National Home Caring Council
d. Membership in Arkansas Home Care Association
e. Member National Association for Home Care

f. CHAP
g. Medicare Certified
h. Medicaid Certified

Please enter all letters that apply

Staffing Information (Unduplicated count of staff on 12/31/20XX in this county) or contract (Yes or No). *If you use a position such as a nurse in more than one county, please count that position only once in you major county)*

	Number of Full Time Staff on 12/31/20XX	Number of Part Time Staff on 12/31/20XX	Retained on Contract on 12/31/20XX
RNs			
LPNs			
Physical Therapist			
Speech Therapist			
Occupational Therapist			
Medical Social Worker			
Home Health Aides			
Personal Care Aides			
Clerical Staff			
TOTAL:			

II. Patient / Client Data

A. Unduplicated Admissions (See Instructions for each)

	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
1.Unduplicated Intermittent Admissions						
2.Unduplicated Personal Care Admissions						
3.Unduplicated Extended Care Admissions						
4.Total Unduplicated Admissions						

II. Patient / Client Data

B. Census

	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
1.Intermittent Census on 1/1/20XX						
2.Personal Care Census on 1/1/20XX						
3.Extended Care Census on 1/1/20XX						
4.Total Census on 1/1/20XX (Total of 1, 2 and 3)						

	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
5.Intermittent Admissions						
6.Personal Care Admissions						
7.Extended Care Admissions						
8.Total Admissions (Total of 5, 6 and 7) Equals II C8, F7						

	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
9.Intermittent Discharges						
10.Personal Care Discharges						
11.Extended Care Discharges						
12.Total Discharges (Total of 9, 10, 11)						

	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
13.Intermittent Census on 12/31/20XX						
14.Personal Care Census on 12/31/20XX						
15.Extended Care Census on 12/31/20XX						
16.Total Census						

II. Patient / Client Data

C. Initial Contact/Referral Source (Clients Admitted to Agency)

	Intermittent	Personal Care	Extended Care	Total
1. Hospital				
2. Rehab Facilities				
3. Physician				
4. Payor (HMO, PPO, etc.)				
5. Family / Friend / Self				
6. Nursing Home				
7. Other				
8. Total				

II. Patient / Client Data

D. Non-Admitted Clients and Reasons(Clients Referred but Not Admitted to Agency)

	Intermittent	Personal Care	Extended Care	Total
1.Service Not Available				
2.Admitted to Acute or or Intermediate Care Facility				
3.Admitted to Long-Term Care Facility				
4.Client does not Meet Admission Criteria				
5.Client Refused Services				
6.Client Deceased				
7.Client Chose Different Agency				
8.Unsafe Environment				
9.Does not Meet Insurance Criteria				
10.Staffing				
11.Licensure				
12.Out of Service Area				
13.Unable to Locate				
14. Total				

II. Patient / Client Data

E. Visits by Professional Discipline and Principal Payor Source

	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
1. Skilled Nursing Visits						
2. Physical Therapy Visits						
3. Speech Pathology Visits						
4. Occupational Therapy Visits						
5. Medical Social Services Visits						
6. Home Health Aide Visits						
7. Other Visits						
8. Total Visits						
9. Extended Care Hour(s)						
10. Personal Care Hour(s)						
11. Total Hour(s)						

II. Patient / Client Data

F. Clients by Age (at time of admission) (do not include census on January 1, 20XX)

	Intermittent	Personal Care	Extended Care	Total
1. 0 - 1 years old				
2. 1 - 18 years old				
3. 19 - 64 years old				
4. 65-74 years old				
5. 75-84 years old				
6. 85+ years old				
7. Total				

1 | 2 | 3 | 4 | 5 | 6 | 7 | 8

Comments and Explanations

Please comments on any responses that you left not complete or responses that require clarification.

Thank you for your cooperation in completing this survey.

If there are any questions about your responses to this survey, who should be contacted?

Name: Phone: Email:

Name: Phone: Email: