

# Home Health Agency Survey

Parts A-E

for 1/1/2006-12/31/2006

## Part A: General Agency Information

Georgia Department of Community Health

### 1. Identification:

Due Date: April 13, 2007

Year: 2006

Facility UID	<input type="text"/>			
a. Facility Name	<input type="text"/>	b. County	<input type="text"/>	
c. Street Address	<input type="text"/>	d. City	<input type="text"/>	e. Street Zip
f. Mail Address	<input type="text"/>	g. City	<input type="text"/>	h. Mail Zip
i. Medicaid Provider? <input type="checkbox"/>	Medicaid Number <input type="text"/>	j. Medicare Provider? <input type="checkbox"/>	Medicare Number <input type="text"/>	

### 2. Report Period:

Report data for the full 12-month period, January 1, 2006 through December 31, 2006 (365 days). Do not use a different report period.

Check the box to the right if your facility was NOT operational for the entire year.

If your facility was NOT operational for the entire year, provide the dates the facility was operational below:

## Part B: Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey:

Name	<input type="text"/>	Title	<input type="text"/>
Telephone	<input type="text"/>	Fax	<input type="text"/>
E-mail	<input type="text"/>		

## Part C: Agency Ownership, Operation and Management Information

1. Report as applicable for your agency as of the last day of the report period. Indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the Organization Type for each business category reported. If the category is not applicable, the form requires you only to enter "not applicable" in the legal name field. You must enter something for each category, however.

Category	Full Legal Name (or "Not Applicable")	Organization Type	Effective Date
a. Agency Owner:	<input type="text"/>	<input type="text"/>	<input type="text"/>
b. Owner's Parent Org:	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. Agency Operator:	<input type="text"/>	<input type="text"/>	<input type="text"/>
d. Operator's Parent Org:	<input type="text"/>	<input type="text"/>	<input type="text"/>
e. Mgmt. Contractor:	<input type="text"/>	<input type="text"/>	<input type="text"/>
f. Mgmt's Parent Org:	<input type="text"/>	<input type="text"/>	<input type="text"/>

g. Check the box to the right if your agency has a branch office or branch offices?

2. If your agency operates branch offices please provide the following information on branch locations.

**Part D: Agency Utilization and Patient Caseload Information**

1. For the service disciplines below please report your agency's most current rate per visit and total number of visits for the report period. Please note: Total visits reported here must balance to visits reported elsewhere in the survey.

Service/Discipline	Per Visit Charge	Number of Visits	Service Discipline	Per Visit Charge	Number of Visits
1. Skilled Nursing	0	0	5. Medical Social Services	0	0
2. Physical Therapy	0	0	6. Speech Pathology	0	0
3. Home Health Aide	0	0	7. Other Health-Related Services (Specify)		0
4. Occupational Therapy	0	0			0
			<b>TOTAL:</b>		<b>0</b>

2. Please report the total agency caseload at the end of the business day on December 31,2006.

Total Number of Cases on 12/31

- 2B. Provide the total number of completed Medicare episodes of care during the report year. Include all completed episodes including Low Utilization Payment Adjustments (LUPA).

3. Please report the number of Health-Related patients during the report period using the following race and ethnicity categories.

Patients by Race/Ethnicity							Total
American Indian/ Alaska Native	Asian	Black or African American	Hispanic or Latino	Hawaiian or Pacific Islander	White	Multi-Racial	
0	0	0	0	0	0	0	0

4. Please report the number of patients during the report period by the patient's gender.

	Male	Female	Total
Number of Patients	0	0	0

5. Please report the number of Health-Related visits, unduplicated patients, and the gross and net patient revenue during the report period by each payer. Please note that gross and net patient revenue totals must balance to those reported in Part E.

	Patients	Visits	Gross Revenue	Net Revenue
Medicare	0	0	0	0
Medicaid	0	0	0	0
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	0	0	0	0
Self Pay	0	0	0	0
Other Non-Government	0	0	0	0
<b>Totals</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**Part E: Agency Financial Summary, Indigent and Charity Care Provided, and Patient Point of Origin**

1. Check the box to the right if the agency has a formal written policy or written policies concerning the provision of indigent and/or charity care during 2006?
2. What was the effective date of the policy or policies in effect during 2006?:
3. Please indicate the name and title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.
4. Check the box to the right if the policy or policies include provision for the care that is defined as charity?

Revenue or Expense	Amount	Revenue or Expense	Amount
A. Gross Patient Revenue	0	<b>G. Charity Care</b>	
B. Medicare Contractual Adjustments	0	1. Gross Charity Care	0
C. Medicaid Contractual Adjustments	0	2. Total Compensation (Charity)	0
D. Other Contractual Adjustments	0	<b>3. Uncompensated Charity (Net)</b>	<b>.00</b>
<b>Total Contractual Adjustments</b>	<b>0</b>	H. Other Free Care	0
E. Bad Debt	0	<b>Total Net Patient Revenue</b>	<b>0</b>
<b>F. Indigent Care</b>		<b>Total Net Revenue:</b>	<b>0</b>
1. Gross Charges	0	I. Other Revenue	0
2. Total Compensation (Indigent)	0	J. Total Expenses	0
<b>3. Uncompensated Indigent (Net)</b>	<b>0</b>	<b>Adjusted Gross Revenue</b>	<b>0</b>
		<b>Total Uncompensated I/C</b>	<b>0</b>
		<b>Percent Uncompensated I/C</b>	

5. Report the number of home health care patients who were classified as indigent or charity care cases and for which patient charges were written off to indigent or charity care accounts reported in Part E, Question 4 above.

6. Patient Point of Origin - Report the number of home health care patients who were referred to your agency by each of the following healthcare points of origin.

Point Of Origin	Number Of Patients Referred
Hospitals (via discharge planner)	0
Physicians	0
Other Home Health Agencies	0
All Other Healthcare Providers	0

7. Please provide the names of the hospitals above who referred patients to your agency during the report year along with the number of patients referred from each.

Hospital Name	Patients Referred
x	0

# Home Health Agency Survey      Parts F-H      for 1/1/2006-12/31/2006

*Georgia Department of Community Health*

Year: 2006

Facility UID   
 Facility Name

County: Appling

## Part F : Agency Workforce Information

This information is being collected to support Georgia's healthcare workforce planning activities. Please provide information as of 12-31-2006.

### 1. BUDGETED FTE

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2006. Also include the number of contract or temporary staff (e.g. agency nurses) filling budgeted vacancies as of 12-31-2006.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses	0.00	0.00	0.00
Licensed Practical Nurses (LPNs)	0.00	0.00	0.00
Aides/Assistants:	0.00	0.00	0.00
Allied Health/Therapists:	0.00	0.00	0.00

### 2. FILLING VACANCIES

Please enter the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Time to Fill RN:	<input style="width: 100px;" type="text"/>
Time to Fill LPN:	<input style="width: 100px;" type="text"/>
Time to Fill Aide/Assistant:	<input style="width: 100px;" type="text"/>
Time to Fill Allied Health/Therapists:	<input style="width: 100px;" type="text"/>

## Part G: Monthly Admissions and Readmissions and Utilization by Patient County

1. Provide the number of new admissions and readmissions in each of the months during the report year.

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>New Admissions</b>	0	0	0	0	0	0	0	0	0	0	0	0
<b>Re-Admissions</b>	0	0	0	0	0	0	0	0	0	0	0	0

2. Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2006. Admissions should capture all admissions during the report year. Visits should capture all visits during the report year. Report patients served for the four age cohort groups. The Total Patients column will be automatically calculated. You will not be able to enter data in that column. Also provide patients for ages 60 to 79 in the column provided.

County	Caseload	Admissions	Total Visits	Under 18	18 to 64	65 to 79	80 and Over	Total Patients	I/C Patients

Patients Under 18

Patients 18 to 64

Patients 65 to 79

Patients 80 to Over

Grand Total Patients

Grand Total Visits

Grand Total I/C Patients

-

Patients 60 to 79

**NOTE: You must go to the Signature Form and sign your survey before submitting it. The survey will not be deemed complete without an authorized signature.**

Georgia Department of Community Health

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: [text box]

Date:

Title: [text box]

Comments: [text box]

Summary Data

Utilization: Grand Total Patients 0
Grand Total Visits 0
Average Visit/Patient

Financial:

Total Charges: 0
Net Revenue: 0
Operating Margin: 0
Margin %:

Unresolved Data Issues

Please explain any unresolved data issues in the comments box.