FORM DM-1 Revised 09/2023 THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2023

### STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

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

#### **2023 ANNUAL REPORT FOR HOME HEALTH AGENCIES**

# SHPDA ID NUMBER FACILITY NAME

Mailing Address:						
Maining Address.	STREET	ADDRESS	CITY	STA	TE ZIP	
Physical Address:				A	L	
	STREET	ADDRESS	CITY		ZIP	
County of Location:						
Facility Telephone:			Facility Fax:			
	(AREA CODE) & TE	ELEPHONE NUMBER		(AREA CODE)	& TELEPHONE NUMBER	
This reporting period is for (	October 1, 2022,	through September	er 30, 2023 *; or for	partial year of oper	ation beginning	
	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 PREPAR		SIGNATURE OF	F PREPARER		DATE	
DIRECT TELEPHONE NUMB	BER	TITLE OF PF	REPARER	E-MAI	IL ADDRESS	
A member of administration MUST 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.  PRINTED NAME OF ADMINISTRATION OFFICIAL SIGNATURE OF ADMINISTRATION OFFICIAL DATE						
DIRECT TELEPHONE NUMB	BER	TITLE OF ADMINIST	RATION OFFICIAL	E-MAI	IL ADDRESS	
		FOR OFFICE I	JSE ONLY			
Facility Verified:		Initial Scan:		Completed	:	
Entered:		Final Scan:		Audited:		

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i Agency Oper	alions		
Days of week services a regularly available	re □ Monday – Frid	lay □ Sunday-Satur	day □ Other (specify)
Days on-call <b>only</b>	☐ Weekends	□ Holidays	☐ Other (specify)
II Ownership			
Corporation Individual Joint Venture	Non-Profit ( Healthcare Governmer	<u> </u>	Partnership LLC Other (specify)
III Branch Office	es		
Does the organization of	your service include a sta	affed satellite or brand	ch office?
YES CITY OF LOCATION	OPENED IN LAST 12 MONTHS?		SERVICES AVAILABLE
	YES NO	REGULAR SCHEDULE	ON-CALL ONLY
			_
IV Drop Sites			
Has this agency received to be a location from wh referrals, advertise, or op- can only be operated in 0	ich supplies <b>only</b> are sto perate in any manner as a	ored. A drop site ma a branch office (CMS	y not be staffed, accept
YES			NO
CITY OF	LOCATION	OPENE YES	D IN LAST 12 MONTHS? NO
		<u> </u>	<del></del>
		<u> </u>	

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#### V Authorized Service Area

List <u>all</u> 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.

<del></del>	
<del></del>	
<del></del>	
TOTALS *	

EQUAL THE TOTAL VISITS IN SECTION VIII.

THIS TOTAL MUST

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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	НМО	Other**
Category Totals											
TOTAL ADMISSIO	NS						*THIS TOTA ADMISSIONS	AL MUST EQUAL S IN SECTIONS V IX-B.	THE TOTAL (II, IX-A, AND	k	
**Please specify "other"	navment soi	irce category:									

**Physicians** 

SOURCE

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:

**NUMBER OF ADMISSIONS** 

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 SECTIONS VI, IX-A, AND IX-B.
VIII. SERVICES OFFERED. List below the tota services provided, for all visits made during the	
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	*
	*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			
TOTALS			*
			*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):	
TOTALS	*
	*THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, VII, AND