FORM HPCE-2
IN-HOME HOSPICES
09/2009

THIS REPORT MUST BE FILED PRIOR TO OR WITH YOUR CON APPLICATION
2008 REPORT

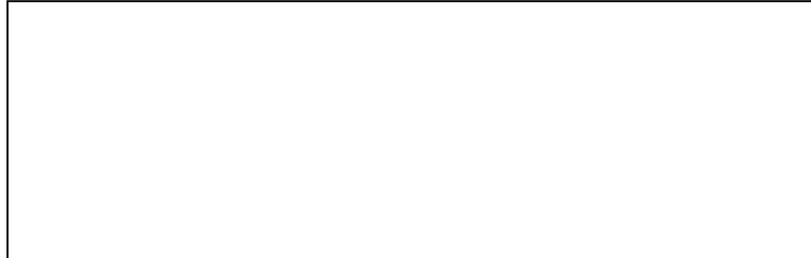
Appendix - C

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

2008 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, 2007, through September 30, 2008*; or for partial year of operation beginning ____________ (MONTH DAY) 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 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: ____________

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I. PROGRAM DEMOGRAPHICS

A. Agency Type

______ Free Standing
______ Home Health Based
______ Government/Healthcare Authority Based
__________ Hospital Based
__________ Nursing Home Based

B. Ownership

______ Corporation
______ Individual
______ Joint Venture
______ Non-Profit Organization
______ Healthcare Authority
______ Government
______ Partnership
______ LLC
______ 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

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II. ADMISSIONS

A. ADMISSIONS BY COUNTY OF RESIDENCE

(This data should reflect all patients served during the reporting period, including those in nursing facilities. Information should be provided by county of residence. Attach additional sheets as necessary.)

COUNTY	NUMBER OF ADMISSIONS	NUMBER OF DEATHS	NUMBER OF NON-DEATH DISCHARGES	NUMBER OF PATIENTS SERVED (include carryover from the prior year)	ROUTINE HOME CARE DAYS	CONTINUOUS CARE DAYS	INPATIENT CARE DAYS	RESPITE CARE DAYS	TOTAL CARE DAYS (sum of routine home, continuous, inpatient & respite care days
TOTALS	**								

**TOTAL NUMBER OF ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-C, AND II-D.

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B. PATIENT DAYS BY PAYMENT SOURCE

Provide the number of patient days for all patients including those in hospital, specialty care assisted living or 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