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| **HOME HEALTH AGENCY SURVEY REPORT**  **(CMS-1572)** | | | | |
| **PART 1: To Be Completed by Facility Staff** | | | | |
| **1. Name of Facility:** | | | | **2. Provider No:** |
| **3. Street Address:** | | | | **4. Telephone:** |
| **5. Name of Administrator:** | | | | **6. Administrator Qualification:**  1 = RN 2 = Physician 3 = Undergraduate degree |
| **7. Type of Control:**    01 = Proprietary 02 = Government Operated  03 = Non-Profit | | | | **8. Has there been a change of ownership of the facility since last survey?**    Yes No |
| **9. Is this home health agency co-located with a separately Medicare-certified Hospice?** YesNo    If yes, provide the hospice Medicare provider number: | | | | |
| **10. Does this home health agency operate any branches locations?** Yes No  If yes, how many branches locations?  Indicate all branch locations below (including official name and full mailing address).    If additional space is needed, attach separate page and check this box. | | | | |
| **Branch No.** | **Branch Name** | **Branch Mailing Address** | | |
| Branch #1 |  |  | | |
| Branch #2 |  |  | | |
| Branch #3 |  |  | | |
| Branch #4 |  |  | | |
| **11. Services Provided:**  For each type of care services provided, indicate how this service is provided:   |  |  | | --- | --- | | **Response** | **Type of Service Provided** | |  | 01 – Skilled Nursing | |  | 02 – Physical Therapy | |  | 03 – Occupational Therapy | |  | 04 – Speech Therapy | |  | 05 – Social Worker | |  | 06 – Home Health Aide | |  | 07 – Pharmaceutical Services | |  | 08 – Infusion Services | |  | 09 – Laboratory Services | |  | 10 – Outpatient Therapy Services |     1 = HHA staff  2 = Under Arrangement  3 = Combination | | | | |
| **12. Staffing - List full-time equivalents (not hours):**   |  |  |  |  | | --- | --- | --- | --- | | **Direct Hire Staff** | **FTE(s)** | **Staff Under Arrangement** | **FTE(s)** | | Registered Nurse |  | Registered Nurse |  | | Licensed Practical Nurse |  | Licensed Practical Nurse |  | | Physical Therapist |  | Physical Therapist |  | | Physical Therapist Assistant |  | Physical Therapist Assistant |  | | Occupational Therapist |  | Occupational Therapist |  | | Occupational Therapist Assistant |  | Occupational Therapist Assistant |  | | Speech-Language Pathologist |  | Speech-Language Pathologist |  | | Social Worker |  | Social Worker |  | | Social Work Assistant |  | Social Work Assistant |  | | Home Health Aide |  | Home Health Aide |  | | | | | |
| **Printed Name of Person Completing Form:** | | | **Title of Person Completing Form:** | |
| **Signature of Person Completing Form:** | | | **Date Form Completed:** | |

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| **PART 2: To Be Completed By The Surveyor** |
| **13. Type of Survey:**  Initial Survey: Recertification:  1 = Standard  2 = Partial Extended  3 = Extended  4 = 1 and 2  5 = 1 and 3  6 = 1, 2, and 3 |
| **14. Survey Data:**  Total Number of Home Visits:  Number of Records Reviewed, No Home Visits: |

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