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? Yes No

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:

1 = HHA staff
2 = Under
3 = Combination

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

Arrangement

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:**

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

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14. Survey Data:

Total Number of Home Visits:

Number of Records Reviewed, No Home Visits:

PRA Disclosure Statement

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