FORM APPROVED
OMB N0. 0938-0355

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 = Undergrad degree 4=Other

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 branch locations? Yes No

If yes, how many branch 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 Arrangement

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

12. Staffing - List full-time equivalents (not hours):

Direct Hire Staff	FTE(s)	Staff Under Arrangement	FTE(s)
Registered Nurses		Registered Nurses	
Licensed Practical Nurses		Licensed Practical Nurses	
Physical Therapists		Physical Therapists	
Physical Therapist Assistants		Physical Therapist Assistants	
Occupational Therapists		Occupational Therapists	
Occupational Therapist Assistants		Occupational Therapist Assistants	
Speech-Language Pathologists		Speech-Language Pathologists	
Social Workers		Social Workers	
Social Work Assistants		Social Work Assistants	
Home Health Aides		Home Health Aides	

Name and Title 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

14. Survey Data:

Total Number of Home Visits:

Number of Records Reviewed, No Home Visits:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0355. The time required to complete this information collection is estimated to average **30 minutes** per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*****CMS Disclaimer*****

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact hhasurveyprotocols@cms.hhs.gov. OMB approval expiration date: 07/31/2024