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:

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