Email form

SELF STUDY CHAP

Organizational Data Sheet - CORE **Agency: _____**

Administrative Profile

	FTE Positions Budgeted	Current FTEs	Vacant Positions	Contract Staff
Executive Staff:	_____	_____	_____	_____
Supervisory Staff:	_____	_____	_____	_____
Support Staff (office/clerical):	_____	_____	_____	_____
Other (Specify)	_____	_____	_____	_____

Turnover Rates for Past Fiscal Year

Category of Positions	*# of Individuals*	*Percent (%)*
Exec/Admin/Management staff	_____	_____
Supervisory staff	_____	_____
Direct care/service staff		
Professional	_____	_____
Paraprofessional	_____	_____
Technical	_____	_____
Support staff (office/clerical)	_____	_____
Other (Specify)	_____	_____
TOTAL	_____	_____

Revenue/Expense:
(Last Fiscal Year)

Total annual revenue: _____

Total annual expense: _____

Insurance coverage maintained:

General liability: _____ Malpractice: _____

Directors & Officers liability:_____ Workers Comp: _____

Property & Casualty: _____ Other (Specify): _____

What is the organization's Governing Body?

Member (Owners): _____

_____

_____

What significant changes have occurred in the organization during the past two years? Please describe.

This agency has been in business since _____ . As of today _____we have in our County _____ active patients, and plan to admit several more upon hospital discharge and coordination. In the last two years we reached new contracts as different Medicaid Programs, waiver services and HMO. We also planned to move the Agency to a new level of care through CHAP accreditation program. **Explain:**

_____

_____

Service Data

Dates of Last Fiscal Year:

Total unduplicated clients in last fiscal year: _____

Total volume services in last fiscal year: _____

Service Description Types of Services/Products Provided by Organization:

Home Health Services: Nursing and Aide services, Therapy Services, Social Workers.
Other: _____

Description of Geographic Service Area: Miami Dade County **or** _____

Service Volume Change Over Previous Three (3) Year Period: _____

_____
New HMO and waiver program contracts, increase therapy services.

E-mail at (DO NOT FAX to US): info@pnsystem.com

* Scan of INSURANCE (**e-mail Insurance coverage**)
* An annual external FINANCIAL review is required **(e-mail copy).**
* Periodic financial statements contain key indicators and show a reasonable match between revenue and expense line items (**e-mail Financial report** show balance between revenue & expense)
* **E-mail** the last Strategic plan executed, and discussed.
* **E-mail** the Last Annual Review/Evaluation

SELF STUDY CHAP

HOME CARE: **Agency: _____**

Current Staffing Profile	FTE Positions Budgeted	Current FTEs	Vacant Positions	Contract Staff
Administrative/Management Staff:	_____	_____	_____	_____
Supervisory Staff:	_____	_____	_____	_____
Support staff (office/clerical):	_____	_____	_____	_____
Direct Care Staff	_____	_____	_____	_____
Registered Nurse:	_____	_____	_____	_____
Licensed/Practical/Vocational Nurse:	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____
Physical Therapy Assistant:	_____	_____	_____	_____
Occupational Therapist:	_____	_____	_____	_____
Occupational Therapy Assistant:	_____	_____	_____	_____
Speech-Language Pathologist/Audiologist:	_____	_____	_____	_____
Social Worker:	_____	_____	_____	_____
Home Health Aide:	_____	_____	_____	_____
Dietitian:	_____	_____	_____	_____
Respiratory Therapist:	_____	_____	_____	_____
Others (specify):	_____	_____	_____	_____

Employee Turnover Rates:

Turnover rates (past fiscal year)	Home Health Staff Positions # of Individuals	Percent (%)
Administrative/management staff:	_____	_____
Supervisory staff:	_____	_____
Direct care staff:		
Professional:	_____	_____
Paraprofessional:	_____	_____
LPN/LVN/COTA,PTA:	_____	_____
Support Staff (Office/Clerical):	_____	_____
Other (specify):_____	_____	_____
Total:	_____	_____

Source Of Revenue (as applicable):

(**Last fiscal year**)	Amount	Percent
Insurance fees:	_____	_____
Privacy Pay:	_____	_____
State funds:	_____	_____
County/City funds:	_____	_____
Grants:	_____	_____
Medicare:	_____	_____
Medicaid:	_____	_____
Investment Income:	_____	_____
Other (list)		
_____	_____	_____
Total annual revenue:	_____	_____
Total annual expense:	_____	_____

Insurance coverage maintained:

General liability: _____ Malpractice: _____

Directors & Officers liability:_____ Surety Bond: _____

Episode Data:

Dates of last fiscal year:_____

Total unduplicated admissions in last fiscal year:_____

Total episodes last fiscal year:_____

Average episodes/patient:_____

Average home visits/episode:_____

Average home visits/discipline/episode:_____

Cost/Episode:_____

Supply cost/episode:_____

Average HHRG reimbursement/episode:_____

Operating Sites/Locations: Please complete the grid below, indicating all locations, subsidiary organizations, branch offices, operating units, joint ventures (arrangements of greater than 50% ownership), and Sub-Units.

Organization Name	City	State	Miles to Parent	Organization Type (Parent, Branch Sub-Unit)	Medicare Provider #	Contact Name	Phone Number	Total Unduplicated Admissions (Last 12 months or FY)

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* Include copies of your organization's 5 OASIS reports (OBQI/OBQM) for the most recent period as an attachment with this self-study (Existing Agencies only, if applicable)
* Current state license
* Medicare number, Medicaid number
* CLIA certification
* The professional advisory group members
* Resume, license of the Administrator

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SCAN AND E-mail ELECTRONIC VERSION OF:

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* CLIA certification
* The professional advisory group members (Names & Titles)
* Resume, license of the Administrator