HOME HEALTH AGENCY ANNUAL REPORT
DEFINITIONS AND INSTRUCTIONS

PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ANNUAL REPORT.

THIS REPORT MUST BE SUBMITTED ELECTRONICALLY. PAPER FORMS WILL NOT BE ACCEPTED!

All information given in this Annual Report should be for services rendered to clients in Arkansas. Please do not include data on clients residing in state other than Arkansas.

GENERAL DEFINITIONS

• Agency Name and Address – (reported on page 1) – List only the name and location of the licensed Agency in Arkansas for which this data is reported. Do not list the home office/corporate headquarters if that is not the licensed agency submitting this data.

• Number of Branch Offices – List the total number of branch locations of the Agency as of December 31 of this report year.

• County – (listed on page 1) – Please name the county the report is for. Each county served must have a separate report. (Please do not use County Code)

• Operational days – This is the days of an agency's or facility's operation within the survey year. For an existing facility the value entered is typically 365 days, and this is the maximum expected value. Values of less than 365 days are possible, especially for new facilities.

• Unduplicated Admissions – (reported in, Item II. A. 1,2,3&4). – The number of individuals receiving services by category from this agency during the report year counted only once, regardless of the number of services, frequency of admission, or payor source.

• Intermittent Care (skilled care) is defined as any service delivered by health care professional requiring orders from a physician, podiatrist or licensed practitioner.

• Personal care is defined as medically prescribed health related assistance in activities of daily living, hygiene and grooming for the sick or debilitated.

• Extended care is defined as six or more hours of continuous home health services provided in a 24 hour period by a licensed agency which provides both skilled nursing and other home health services. (Medicaid Personal Care is not included in this.)

• **Admissions – (reported in, Item II.B. 5,6,7,8) – The total of admissions during the report year regardless of the number of individuals involved. For example, the same individual admitted more than once during the reporting period would be counted each time admitted.**

• **Visits or units of service - Direct face-to-face contact with a client for the purpose of delivering service measured in visits regardless of length of time of the visits or payment source. Include all visits made during the report year, including visits for clients already on service at the beginning of the report year.**

• **Medicare Clients – IN ALL APPLICABLE SECTIONS OF THIS FORM, report all Medicare clients in the Medicare column. This includes fee-for-service and Medicare HMO patients.**

ITEM-BY-ITEM INSTRUCTIONS

Section II. A.

ITEMS 1, 2, 3 & 4 UNDUPLICATED ADMISSIONS: Enter the unduplicated admissions by category (the number of individuals receiving service from an agency during the report year counted only once, regardless of the number of services, frequency of admission, or payor source) for the agency from the period January 1 – December 31 of the report year. The totals of this section will not correspond with any other totals reported on this Annual Report.

Section II. B.

ITEMS 1-4 CENSUS ON JANUARY 1: Enter the number of clients receiving services by category at the beginning of the business day on January 1 of the report year. (See definition above for "Admissions.")

ITEMS 5-8 ADMISSIONS: Enter the number of admissions by category – those admitted after the beginning of the business day on January 1 of the report year. (See definition of "admissions" above.)

ITEMS 9-12 DISCHARGES: Enter the number of times services by category to clients were terminated in the report year.

ITEMS 13-16 CENSUS ON DECEMBER 31: Enter the number of clients receiving services by category at the end of the business day on December 31 of the report year. The total of each category equals the Census on 1/1/11 plus the admissions minus the discharges for that category. Eg: 4+8-12=16.

ITEM C. INITIAL CONTACT/REFERRAL SOURCE: Provide information regarding clients who are referred and admitted to the agency. Initial contact refers to the person or agency originating the referral. Enter the number of referrals in the appropriate spaces. (The total (8) will equal the total of Item II. B.8 and F5.

ITEM D. NON-ADMITTED CLIENTS: Provide information regarding the total number of client referrals during the report year for which the agency intended to provide service based on a request for service but the client was not admitted to the agency for the reasons listed on the Annual Report form. Enter in the appropriate space the number of persons with whom an initial contact was made by the agency but who were not subsequently admitted to services. (This does not equal any other section of the report.)

ITEM E. VISITS BY DISCIPLINE & PRINCIPLE PAYOR SOURCE: Include the number of visits made for each discipline and principle payor source listed. Include all visits, made during the report year, including visits for clients already on service at the beginning of the report year. (This does not equal any other section of the report). Report the hours of service for extended care and personal care.

ITEM F. CLIENTS BY AGE: List the number of clients according to age at the time of admission to the agency. Only include admissions made after January 1 and through December 31 of the report year.
The total will equal the total of Items II. B.8.

*** Please check your totals both horizontally and vertically for all sections.**

*** Please check your data base entries after entering to make sure that the system took the information.. You should check the indicators on the Display Data page.**