Applicant's Name:	Completed by:	Date:

HOME HEALTH AGENCIES SUPPLEMENTAL APPLICATION

1. If you provide any services to assisted living, independent or long term care facilities, please indicate the percentage of revenue from this business. _____% ☐ N/A

2. What management body oversees the quality of patient care? (i.e. medical director, advisory board, etc.)

   _____

   _____

3. What is the average length of employment or turnover rate? _____

4. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers. Please explain any 'No' answers in the Comments Section.

   a. Physician notification in the event of changes in the patient's condition ☐ YES ☐ NO
   b. Communication to supervisors and team members ☐ YES ☐ NO
   c. Medical emergencies ☐ YES ☐ NO
   d. Patient care/home visits documentation ☐ YES ☐ NO
   e. Patient selection/acceptance into service (type of patient/diagnosis) ☐ YES ☐ NO
   f. Service discontinuation ☐ YES ☐ NO
   g. Safe lifting, transferring and ambulating ☐ YES ☐ NO
   h. Safe use of all equipment ☐ YES ☐ NO
   i. Incident reporting ☐ YES ☐ NO

5. Do all contractors sign an agreement specifying the services they will provide? ☐ YES ☐ NO

6. By state and by job title, indicate the total number of staffing hours expected for the upcoming year. (Attach a separate sheet if indicated).

City, State	Job Title	Staffing Hours

Comments Section:

_____

_____

_____

_____