Home Health Services

* = required field

- If certified for participation in Medicare, provide your most current certification survey and plans of correction.
  ☐ N/A
  Attachment Name: _____

- Is your agency JCAHO or CHAPS accredited? If so, provide your current accreditation letter.
  ☐ N/A
  Attachment Name: _____

- If your agency is not certified, how will assure the provision of the RN initial assessment and supervision to each HHA consumer according to the Home Health Services Program Instruction?
  ☐ N/A
  Attachment Name:

  _____

I. Service Capacity

A. Is your agency certified for participation in Medicare?*
   ◯ Yes ◯ No

B. Is your agency a MassHealth provider? If so, indicate MassHealth Provider number. *
   ◯ Yes ◯ No
   _____

C. Provide the number of regular full- and part-time employees in the following positions. (Do not duplicate). *
   1) Home Health Aides: Full Time ____ Part Time ____
   2) Registered Nurses: Full Time ____ Part Time ____
   3) Licensed Practical Nurses: Full Time ____ Part Time ____
   4) PTs: Full Time ____ Part Time ____
   5) OTs: Full Time ____ Part Time ____
   6) STs: Full Time ____ Part Time ____

D. Provide the number of per diem contract employees for the following: *
   1) Registered Nurses: ____
   2) Licensed Practical Nurses: ____
   3) PTs: ____
   4) OTs: ____
   5) STs ____

E. Provide an overview of workforce capacity initiatives, recruitment initiatives, workforce adequacy evaluation, and how staffing is managed day-to-day. Include linguistic or other special capabilities, etc.*

_____

F. Provide a detailed description of scheduling for worker absences, ensuring service to Risk Level 1 and 2 as well as other high need consumers, orientation of substitutes, notifications, evening and weekend coverage, etc.*

_____

G. What percentage of HHAs are available to work the following schedules:*

1) Evenings: _____
2) Overnights: _____
3) Weekends: _____

H. Describe your agency process for maintaining a current list of Risk Level 1 and 2 consumers that is accessible in the event of an emergency. *

_____

I. Attach copies of the care plan forms currently in use. (One form for each service being offered, Skilled Nursing, Home Health Aide).*
Attachment Name(s): _____

II. Staff Qualifications

A. Describe in detail the experience and qualifications of the individual responsible for service provision (Home Health Mangers), if different from the information provided in the Administrative Overview.*

_____

B. Describe in detail the qualifications (professional experience, education, licensure, etc.) for the following staff:*

1) Coordinators

_____

2) Field supervisors

_____

III. Training and In-Service Education

A. Your agency provides directly:*
- ☐ Home Health Aide training program
- ☐ Home Health Aide competency evaluation program
- ☐ Both
- ☐ Neither

B. If your agency provides the HHA training program, attach a copy of the curriculum.*
Attachment Name: _____

C. Who in your agency is responsible for overseeing in-service education?*

_____

D. Describe your process for ensuring that all staff understand the requirements of the Department of Public Health 105 CMR 155.00 Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties, and Registry and receives mandatory annual training on the topic. *

_____

IV. Supervision

A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for each position (HHAs, nurses, coordinators, supervisors, etc.).*

_____

B. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized, including telephony, unannounced field visits, quality assurance calls, etc.*

_____

C. Describe the supervisory support available to direct care workers during non-business hours, including how supervisors are contacted, the titles and, as applicable, licensure of available supervisors.*

_____

D. Attach a copy of the field supervision report form currently in use for your employees.*
Attachment Name: _____

Provider employee who completed this form*
Name: _____ Date: _____