

Section 2

OSHPD Facility ID No. _____

LICENSEE TYPE OF CONTROL

Line No.		(1)
1	From the list below, select the ONE category that best describes the licensee type of control of your home health agency and enter the number which appears next to that category.	

LICENSEE TYPE OF CONTROL CODES

1	City and/or County	6	Investor - Individual
2	District	7	Investor - Partnership
3	Non-profit Corporation (incl. Church-related)	8	Investor - Limited Liability Company
4	University of California	9	Investor - Corporation
5	State		

MEDICARE/MED-CAL CERTIFICATION

Line No.	
5	Select certification: (1) Medicare <input type="checkbox"/> (2) Medi-Cal <input type="checkbox"/>

AGENCY ACCREDITATION STATUS (Check all applicable ones.)

Line No.	
10	Accredited by ACHC (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/>
11	Accredited by CHAP (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/>
12	Accredited by JCAHO (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/>
13	Accredited by other: (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/>

HOME INFUSION THERAPY/PHARMACY ONLY

Line No.		(1)
15	Is your agency a licensed Pharmacy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
16	Do you have a Registered Nurse on staff who makes hom visits?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Note: If the agency is a licensed pharmacy that provides **only** home infusion therapy equipment then there is no need to complete the remainder of the report.

SPECIAL SERVICES (Check all that apply.)

Line No.		(1)	Line No.		(1)
20	AIDS Services	<input type="checkbox"/>	25	Pediatric	<input type="checkbox"/>
21	Blood Transfusions	<input type="checkbox"/>	26	Psychiatric Nursing	<input type="checkbox"/>
22	Enterostomal Therapy	<input type="checkbox"/>	27	Respiratory/Pulmonary Therapy	<input type="checkbox"/>
23	IV Therapy (Includes Chemo & TPN)	<input type="checkbox"/>	28	Other	<input type="checkbox"/>
24	Mental Health Counseling	<input type="checkbox"/>			

PATIENT INFORMATION

Line No.		(1)
30	Enter the number of unduplicated patients seen by your agency during the reporting year.	

Section 2 (Cont'd)

OSHPD Facility ID No. _____

HOME HEALTH CARE

Line No.	Other Home Health Visits	No. of Visits (1)
31	Pre-Admission Screening / Evaluations	
32	Outpatient Visits	
33	Other	
34	TOTAL	

OTHER HOME HEALTH SERVICES (Home Care Service, e.g. Continuous Care)

NOTE: Do not complete Lines 50-54 if these services were provided by an organization other than your licensed agency.

Line No.		(1)
40	Did your agency perform other Home Care Services?	Yes <input type="checkbox"/> No <input type="checkbox"/>
41	How many total hours of other Home Care did your agency provide?	

Other Home Care Services, Staff, and Functions (Check all that apply.)

Line No.		(1)
50	Certified Nurse Assistant (CNA)	
51	Home Health Aide	
52	Homemaker Services	
53	Non-intermittent Nursing (RN / LVN)	
54	Other	

**HOME HEALTH AGENCY PATIENTS
AND VISITS**

ANNUAL UTILIZATION REPORT OF HOME HEALTH AGENCIES - 2003

OSHDP Facility ID No. _____

Section 3

PATIENTS AND VISITS BY AGE

Line No.	Age	Patients (1)	Visits (2)
1	0-10 Years		
2	11-20 Years		
3	21-30 Years		
4	31-40 Years		
5	41-50 Years		
6	51-60 Years		
7	61-70 Years		
8	71-80 Years		
9	81-90 Years		
10	91 Years and Older		
15	TOTAL		

ADMISSIONS BY SOURCE OF REFERRAL

Line No.	Source of Referral	Admissions (1)
21	Another Home Health Agency	
22	Clinic	
23	Family / Friend	
24	Hospice	
25	Hospital (Discharge Planner, etc.)	
26	Local Health Department	
27	Long Term Care Facility (SN / IC)	
28	MSSP	
29	Payer (Insurance, HMO, etc.)	
30	Physician	
30	Self	
32	Social Service Agency	
34	Other	
35	TOTAL	

**HOME HEALTH AGENCY PATIENTS
AND VISITS**

ANNUAL UTILIZATION REPORT OF HOME HEALTH AGENCIES - 2003

OSHDP Facility ID No. _____

Section 3 (Cont'd)

DISCHARGES BY REASONS

Line No.	Reason for Discharge	Discharges (1)
41	Admitted to Hospital	
42	Admitted to SN / IC Facility	
43	Death	
44	Family / Friends Assumed Responsibility	
45	Lack of Funds	
46	Lack of Progress	
47	No Further Home Health Care Needed	
48	Patient Moved out of Area	
49	Patient Refused Service	
50	Physician Request	
51	Transferred to Another HHA	
52	Transferred to Home Care (Personal Care)	
53	Transferred to Hospice	
54	Transferred to Outpatient Rehabilitation	
59	Other	
60	TOTAL	

VISITS BY TYPE OF STAFF

Line No.	Type of Staff	Visits (1)
71	Home Health Aide	
72	Nutritionist (Diet Counseling)	
73	Occupational Therapist	
74	Physical Therapist	
75	Physician	
76	Skilled Nursing	
77	Social Worker	
78	Speech Pathologist / Audiologist	
79	Spiritual and Pastoral Care	
84	Other	
85	TOTAL	

**HOME HEALTH AGENCY PATIENTS
AND VISITS**

OSHDP Facility ID No. _____

Section 3 (Cont'd)

VISITS BY PRIMARY SOURCE OF PAYMENT

Line No.	Source of Payment	Visits (1)
91	Medicare	
92	Medi-Cal	
93	TRICARE (CHAMPUS)	
94	Other Third Party (Insurance, etc.)	
95	Private (Self Pay)	
96	HMO / PPO (Includes Medicare and Medi-Cal HMOs)	
97	No Reimbursement	
99	Other (Includes MSSP)	
100	TOTAL	

Section 4

OSHPD Facility ID No. _____

PATIENTS AND VISITS BY PRINCIPAL DIAGNOSIS FOR WHICH CARE WAS GIVEN'

Line No.	Principal Diagnosis	ICD-9-CM Code	Patients (1)	Visits (2)
1	Infectious and parasitic diseases (exclude HIV)	001.0-041.9, 045.0-139.8		
2	HIV infections (include AIDS, ARC, HIV)	042		
3	Malignant neoplasms: Lung	162.0-162.9, 197.0, 231.2		
4	Malignant neoplasms: Breast	174.1-174.9, 175.0-175.9, 198.2, 198.81, 233.0		
5	Malignant neoplasms: Intestines	152.0-154.8, 159.0, 197.4, 197.5, 197.8, 198.89, 230.3, 230.4, 230.7		
6	Malignant neoplasms: All other sites, excluding those in #3,4,5	140.0-208.91, 230.0-234.9		
7	Non-malignant neoplasms: All sites	210.0-229.9, 235.0-238.9, 239.0-239.9		
8	Diabetes mellitus	250.00-250.93		
9	Endocrine, metabolic, and nutritional diseases; Immunity disorders	240.0-246.9, 251.0-279.9		
10	Diseases of blood and blood forming organs	280.0-289.9		
11	Mental disorder	290.0-319		
12	Alzheimer's disease	331.0		
13	Diseases of nervous system and sense organs	320.0-330.9, 331.1-389.9		
14	Diseases of cardiovascular system	391.0-392.0, 393-402.91, 404.00-429.9		
15	Diseases of cerebrovascular system	430-438.9		
16	Diseases of all other circulatory system	390, 392.9, 403.00-403.91, 440.0-459.9		
17	Diseases of respiratory system	460-519.9		
18	Diseases of digestive system	520.0-579.9		
19	Diseases of genitourinary system	580.0-608.9, 614.0-629.9		
20	Diseases of breast	610.0-611.9		
21	Complications of pregnancy, childbirth, and the puerperium	630-677		
22	Diseases of skin and subcutaneous tissue	680.0-709.9		
23	Diseases of musculoskeletal system and connective tissue (include pathological fx, malunion fx, and nonunion fx)	710.00-739.9		
24	Congenital anomalies and perinatal conditions (include birth fractures)	740.0-779.9		
25	Symptoms, signs, and ill-defined conditions (exclude HIV positive test)	780.01-795.6, 795.77, 796.0-799.9		
26	Fractures (exclude birth fx, pathological fx, malunion fx, nonunion fx)	800.00-829.1		
27	All other injuries	830.0-959.9		
28	Poisonings and adverse effects of external causes	960.0-995.94		
29	Complications of surgical and medical care	996.00-999.9		
30	Health services related to reproduction and development	V20.0-V26.9, V28.0-V29.9		
31	Infants born outside hospital (infant care)	V30.1, V30.2, V31.1, V31.2, V32.1, V32.2, V33.1, V33.2, V34.1, V34.2, V35.1, V35.2, V36.1, V36.2, V37.1, V37.2, V39.1, V39.2		
32	Health hazards related to communicable diseases	V01.0-V19.8, V40.0-V49.9		
33	Other health services for specific procedures and aftercare	V50.0-V58.9		
34	Visits for Evaluation and Assessment	V60.0-V83.89		
45	TOTAL			

*The list of ICD-9-CM codes excluded: 795.71, V08, V27.0-V27.9

Section 4 (Cont'd)

OSHPD Facility ID No. _____

How many of the patients you reported in Section 3 "Patients and Visits by Age" Table had a **primary** or **secondary** diagnosis of HIV or Alzheimer's Disease and how many health care visits were made to them? The primary condition for which an HIV or Alzheimer's patient was visited may have been a fracture, a skin infection, cancer, or any number of primary conditions. What we are asking relates to the number of HIV or Alzheimer's patients among your total patient load, regardless of the nature of the treatment received or the primary condition of the patient.

Line No.		ICD-9-CM Code	Patients (1)	Visits (2)
51	HIV	042		
52	Alzheimer's Disease	331.0		

HOSPICE DESCRIPTION

ANNUAL UTILIZATION REPORT OF HOSPICES - 2003

Section 5

OSHPD Facility ID No. _____

DO NOT COMPLETE SECTIONS 5 THROUGH 10 UNLESS YOU HAVE A HOSPICE.

LICENSEE TYPE OF CONTROL

Line No.		(1)
1	From the list below, select the ONE category that best describes the licensee type of control of your hospice and enter the number which appears next to that category.	

LICENSEE TYPE OF CONTROL CODES

1	City and/or County	6	Investor - Individual
2	District	7	Investor - Partnership
3	Non-profit Corporation (incl. Church-related)	8	Investor - Limited Liability Company
4	University of California	9	Investor - Corporation
5	State		

MEDICARE/MEDI-CAL CERTIFICATION

Line No.	
5	Select certification: (1) Medicare <input type="checkbox"/> (2) Medi-Cal <input type="checkbox"/>

AGENCY ACCREDITATION STATUS (Check all applicable ones.)

Line No.	
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11	Accredited by CHAP (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/>
12	Accredited by JCAHO (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/>
13	Accredited by other: (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/>

AGENCY TYPE AS REPORTED ON MEDICARE COST REPORT

Line No.		(1)
20	From the list below, select ONE category and enter the number which appears next to that category	

AGENCY TYPE CATEGORIES

Line No.		Line No.	
1	Free Standing	4	Long-Term Care Facility-based
2	Hospital-based	5	Veteran Administration-based
3	Home Health-based	6	Other

LOCATION OF SERVICE DELIVERY (Check one)

Line No.	
25	Primary Urban <input type="checkbox"/> Primary Rural <input type="checkbox"/> Mixed Urban and Rural <input type="checkbox"/>

HOSPICE SERVICES

ANNUAL UTILIZATION REPORT OF HOSPICES - 2003

Section 6

OSHPD Facility ID No. _____

BEREAVEMENT SERVICES

Line No.	Bereavement Services	People Served (1)
1	Survivors of hospice patients	
2	Survivors of persons not receiving hospice care	

VOLUNTEER SERVICES

Line No.	Volunteer Services	No. of Volunteers (1)	Volunteer Hours (2)
3	Patient / Family Services		
4	Bereavement		
5	Administrative		
	Medicare Reportable Hours (sum lines 3-5)		
6	Fundraising		
9	Other		
10	TOTAL		

ADDITIONAL AND SPECIALIZED SERVICES

Check all services directly provided by OR contracted for by the hospice.

Line No.	Additional and Specialized Hospice Services	Services (1)
11	Hospice Designated Inpatient Facility / Unit	
12	Specialized Pediatric Program	
13	Bereavement services to survivors of persons not receiving hospice care	
14	Adult Day Care	
15	Specialized Palliative Care Program	
16	Other	

VISITS BY TYPE OF STAFF (Include After-Hours and Bereavement Visits)

Line No.	Type of Staff	Visits (1)
21	Nursing - RN	
22	Nursing - LVN	
23	Social Services	
24	Hospice Physician Services	
25	Homemaker and Home Health Aide	
26	Chaplain	
29	Other Clinical Services	
30	TOTAL	