COVER LETTER

ABC Home Healthcare, Inc.
999 Beach Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: JaneDoe@abchhealthcare.org

March 15, 2019

VIA PRIORITY MAIL:

California Department of Public Health
Licensing and Certification
P. O. Box 997377, MS 3207
Sacramento, CA 95899
Attn: Centralized Applications Branch

RE: **CHANGE OF SERVICE** Application for Star Home Healthcare Services, located at 1800 Beach Drive, Suite 777 Sacramento, CA 95814 License #222222222

To Whom It May Concern,

We are submitting a **Change of Service** application for Star Home Healthcare Services, located at 1800 Beach Drive, Suite 777, Sacramento, CA 95814.

Our facility would like to add physical therapy to Star Home Healthcare Services. Please see the report of change documents enclosed for this Change of Service application.

Should you have any questions, I will be the direct contact regarding this Change of Service application.

Emergency Contact Information (available 365/24/7)
Name: Jane Doe
Email:JaneDoe@abchhealthcare.org Alternate Email: JaneDoe@cmail.com
Phone: (999) 555-2626 Phone (Text Messages): (999) 555-5555
Fax: (999) 555-2600

Sincerely,

Jane Doe

Jane Doe, Owner
ABC Home Healthcare, Inc.

HS 200

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District:	*ELMS Facility Number:*
Proposed name of facility/agency/clinic:	

A. APPLICATION INFORMATION

1. Type of application (check one):
   - ○ **a.** Initial
   - ○ **b.** Change of Ownership (see #2 below)
   - ○ **c.** Management company (see Sections C1-5, F, and Attachment E-1)
   - ◉ **d.** Other change (see Section A4): Change of Service

2. **Change of Ownership Only - For Certification Purposes:**
   We wish to make certain that our records correctly show the effective date of the ownership change for certification. This date should reflect the actual date on which you took charge of the financial management of the facility rather than the date of sale or date of state license change. Effective date of change:

3. Amount of fee enclosed: $

4. Type of Change (check all that apply):
   - ☐ **a.** Not applicable
   - ☐ **b.** Change of capacity (see # 8 below)
   - ☐ **c.** Change of location
   - ☑ **d.** Change of services Physical Therapy
   - ☐ **e.** Change of facility type
   - ☐ **f.** Change of bed classification
   - ☐ **g.** Change of name
   - ☐ **h.** Construction of new or replacement facility
   - ☐ **i.** Stock transfer
   - ☐ **j.** Other (specify)

5. Type of facility, agency, or clinic (check one)
   - ○ **a.** Skilled Nursing Facility (SNF)
   - ○ **b.** Intermediate Care Facility (ICF)
   - ○ **c.** ICF/Developmentally Disabled (ICF/DD)
   - ○ **d.** ICF/DD-Habilitative (ICF/DD-H)
   - ○ **e.** ICF/DD-Nursing (ICF/DD-N)
   - ○ **f.** Primary care clinic – Free
   - ○ **g.** Primary care clinic – Community
   - ○ **h.** Surgical clinic
   - ○ **i.** Rural health clinic (for Certification "only")
   - ○ **j.** General acute care hospital
   - ○ **k.** Adult day health care center
   - ◉ **l.** Home Health Agency (HHA)
   - ○ **m.** Hospice
   - ○ **n.** Chronic dialysis clinic
   - ○ **o.** Other (specify)

6. **a.** Do you wish to apply for the Medicare program? ◉ Yes ○ No Medicare Provider #:
   b. Fiscal Intermediary choice: Fiscal Intermediary

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ◉ Yes ○ No

8. **a.** Current facility bed capacity: N/A
   b. Proposed facility bed capacity: N/A

9. Age range of clients: 0-100

10. Days and hours of operation: M-F 8am-5pm,

11. Is construction required? ○ Yes ◉ No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin:
    If "yes", date construction to be completed:

B. LICENSEE INFORMATION

1. Licensee name: ABC Home Healthcare, Inc.

2. Federal employer's tax ID number: 555555555

3. Owner type (check one): ***Submit*** organizational chart for b, c, d, and e.

- ○ **a.** Sole proprietorship (Individual)
- ◉ **b.** Profit corporation
- ○ **c.** Nonprofit corporation
- ○ **d.** Limited Liability Company (LLC)
- ○ **e.** Partnership – General
- ○ **f.** Partnership – Limited
- ○ **g.** City
- ○ **h.** County
- ○ **i.** State agency
- ○ **j.** Other agency (specify)
- ○ **k.** Public agency (specify)

4. Licensee address (number & street): 999 Beach Side Court

Telephone number: (999) 555-2626

City, State, & Zip: Sacramento, CA 95814

E-Mail: JaneDoe@abcmedicalLLC.org

Fax number: (999) 555-2600

5. a. Identify other facilities, agencies, or clinics the licensee has been licensed for, operated, managed, held a **5%** or more interest in, or served as a director or officer. Include facilities both in and outside of California. ***Submit*** an attachment for additional facilities that includes all of the required information listed below.

(1) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(2) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(3) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(4) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

5. b. If any facility, agency, or clinic identified in 5.a. has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for agency or clinic resolved by settlement, receiver appointed, or had a final Medi-Cal decertification action taken, please ***submit*** additional information, including all ownership and facility information, date and any final action.

6. Is the licensee a **subsidiary** of another organization? ○ Yes ◉ No
If "yes", complete the information below and ***submit*** an organizational chart:

Parent organization name:

Parent federal tax ID Number:

P.O. Box or number & street:

City, State, & Zip:

C. FACILITY, AGENCY OR CLINIC INFORMATION

Management Agreement (this only applies to SNF's & ICF's):

1. **a.** Is the facility, agency, or clinic going to be operated under a management contract/agreement between the proposed owner and a management company? If "yes", proceed to **Section E** (below). ○ Yes ◉ No

b. Is there an "interim" management agreement, between the proposed owner and the current owner, to run the facility, agency, or clinic until the change of ownership is completed? If "yes", ***submit*** a copy of the "interim" management agreement. ○ Yes ◉ No

2. Name of **"proposed" facility**, agency, or clinic:
Current facility, agency, or clinic name (if change of ownership):
Star Home Healthcare Services Facility license number: 2222222

3. Address (number & street) of "proposed" facility, agency, or clinic: 1800 Beach Drive, Suite 777 Telephone number: (999) 555-0695
City, State, & Zip: Sacramento, CA 95814

4. Mailing address, if different from above:
Number & Street: Telephone number:
Fax number: E-mail address:
City, State, & Zip:

5. **Name of person to be in charge of facility, agency, or clinic:**
Title: Professional License number:

6. **a.** Name of administrator: Wain Jones Date of hire: 05/13/2015
Professional License number: Expiration date:
b. Name of director of nursing: Amber Dixie Date of hire: 05/31/2015
Professional License number: 777777 Expiration date: 11/30/2019

7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. Are any of these persons (listed below) related to one another as spouse, parent, child or sibling? ***Submit*** an attachment for additional names that includes all of the required information listed below.

	Name of individual	% Owned	EIN Number	Are they related to one another as a spouse, parent, child or sibling?		Relationship
(1)	Jane Doe	100	55-5555555	○ Yes	○ No	
(2)				○ Yes	○ No	
(3)				○ Yes	○ No	
(4)				○ Yes	○ No	
(5)				○ Yes	○ No	

8. **Financial resources -- Only applies to SNF and ICF:**
Submit evidence, i.e., bank statements, line of credit, certificate(s) of deposit, satisfactory to the department(s) that the licensee possesses financial resources sufficient to operate the facility for a period of at least 45 days. (The amount is determined by multiplying 45 days X number of beds X rate).

9. **Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:**
a. Are there any ICF/DD, ICF/DD-H, ICF/DD-N, RCF (residential care facility), or pediatric day health or respite care facilities within 300 feet of this facility? (H&S Code, Section 1267.9) ○ Yes ○ No ○ Don't know
b. Are there any congregate living health facilities within 1,000 feet of this facility? ○ Yes ○ No ○ Don't know

10. **Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N (H&S Code, Section 1275.3(b)(3))**
Has the program plan been approved by the Department of Developmental Services? ○ Yes ○ No
If "yes", ***Submit*** a copy of the approval letter. The "current licensee" can grant permission for their Program Plan to be used for 6 months if they ***submit*** a letter to CDPH. If "no", the application package will be delayed until a copy of the approved program letter is received.

D. PROPERTY INFORMATION

1. Property ownership: Check one and ***submit*** evidence of control of property: ○ Own ○ Rent ○ Lease ○ Sublease ○ Other (specify): Lease

2. **Owner of Record** name in the real estate: Sandy Beach Plaza, Inc.
   Address (number & street): 554 Crystal Beach Blvd., Suite 10
   City, State, & Zip: Sacramento, CA 95814

   Lessee name: ABC Home Healthcare, Inc.
   Address (number & street): 999 Beach Side Court
   City, State, & Zip:

   Sub-Lessee name:
   Address (number & street):
   City, State, & Zip:

E. MANAGEMENT COMPANY

If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, complete Attachment E-1 (next page). NOTE: if the facility is a SNF or ICF, the management company will have to SUBMIT a separate application to the Department, unless previously approved.

F. I (we) Accept responsibility to:

a. Comply with local ordinances concerning zoning, sanitation, building, and other appropriate ordinances.
b. Comply with the Labor Code on employment practices concerning nondiscrimination, liability insurance, wages, hour and working conditions.
c. Comply with Health and Safety Code and regulations concerning licensing and fire safety.

I (we) declare under penalty of perjury that the statements on this application and on the accompanying attachments are correct to my (our) knowledge.

Signature	Title	Date
Jane Doe	Owner	03/11/2018
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date

Release of Information Statement

This information shall be provided to the state department upon initial licensure. ***Any changes must be provided to the state department within 10 days of the change***. The information shall be made available to the public upon request and shall be included in the public file of the facility.

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicants or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with Health and Safety Code, Sections 1212, 1253, 1265, 1267.5, and 1728, and California Code of Regulations (CCR), Title 22, Sections 70107, 71107, 73205, 74105, 75022, 76205, and 78205.

Failure to provide the information as requested may result in nonissuance of a license or license revocation.

The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's or ICF's

1. ***Submit*** a copy of the Management Agreement with this application.

Name of management company: EIN:
Address (number & street):
City, State, & Zip:

Name of facility to be managed: EIN:
Address (number & street):
City, State, & Zip:

2. Provide the following information for ***each*** individual having a **5 percent** or more interest in the management company. ***Submit*** an attachment for additional names that includes all of the required information listed below.

(1) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(2) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(3) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(4) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

3. Provide a list of all facilities, agencies, or clinics with which you have entered into a management agreement. ***Submit*** an attachment for additional facility, agency, or clinic names that includes all of the required information listed below.

(1) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(2) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(3) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(4) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

INSTRUCTIONS

SNF or ICF Management Company Application: See Attachment E-1 below.

Type or print clearly. Return original and maintain a copy for your records. The Licensee's name must be consistent throughout all documents submitted. ***Submit*** all supplemental paperwork requested to complete your application. **Do not leave items blank. If not applicable, mark N/A.**

A. APPLICATION INFORMATION

1. Type of application: select items a, b, c, or d.
   If b is selected, provide effective date of change in number 2.
   If c is selected, complete Sections C1-5; F, and Attachment E-1.
   If d is selected you must select an option in number 4 -- "Type of Change."
2. Provide actual date applicant took charge of the financial management of facility.
   This date is used to show effective date of the ownership change for certification purposes only.
3. Amount of fee enclosed: enter the amount of money enclosed with this application.
   If no fee is required, enter "N/A". (Refer to fee schedule for appropriate fee requirements.)
4. Type of change: check all that apply.
5. Type of facility, agency, or clinic: select the appropriate category.
6. (a) Check "yes" if requesting certification for Medicare. ICF/DD, ICF/DD-N, ICF/DD-H facilities and primary care clinics that are not certified as rural health clinics are not eligible for Medicare.
   (b) If "yes" to item 6(a), provide name of fiscal intermediary under item 6(b).
7. Check "yes" if requesting participation in Medi-Cal (Medicaid).
8. (a) Current facility bed capacity: enter the total number of persons for whom care can currently be provided in any 24-hour period. This figure must agree with the "Certificate of Occupancy".
   (b) Proposed facility bed capacity: enter the proposed total number of persons for whom care will be provided in any 24-hour period.
9. Enter age range of persons to receive/receiving care.
10. Enter days and hours of facility operation.
11. Enter date construction is to begin, and date construction is to be completed (not applicable for ICF/DD, ICF/DD-N, ICF/DD-H facilities).

    ☐ ***Submit*** a copy of the form *"Construction Advisory Board "* (form OSH-FDD 377) if OSHPD has approved construction.

    ☐ ***Submit*** a copy of the above form to the local district office *prior* to the survey if OSHPD has not yet approved construction.

B. LICENSEE INFORMATION

1. Licensee name: enter the full legal organization name (LLC, partnership, and corporation) or individual(s) responsible for the facility/agency. If "Inc." is included in your legal name, it must appear in the name. Individuals enter first, middle, and last name. Husband and wife, if joint applicants, must both be listed.

   NOTE: All individuals including owners, partners, principal officers of corporations/LLCs, members, managers, and administrators (clinics only) must complete "Applicant Individual Information" (HS 215A).

2. Enter the federal employer's tax ID number.
3. Owner Type: select one of the options and then:

   ☐ ***Submit*** an organizational chart, for items b, c, d, or e showing entity, persons, facilities, and tax EIN numbers.

   ☐ ***Submit*** a copy of the Internal Revenue Service and Franchise Tax Board letters of determination of nonprofit status, if item c, "nonprofit corporation" is selected, and the facility is a primary care Clinic.

4. Licensee address: enter address of legal organization (LLC, corporation, partnership) or individual(s) responsible for the facility, agency, or clinic. Provide phone number with area code, fax number, and e-mail address.

5. Other Facilities:
   (a) Identify all other facilities, agencies, or clinics the licensee (LLC, corporation, partnership, individual) has been involved in, both in and outside of California.
   ☐ ***Submit*** an attachment, if needed, for additional entities, which includes the facility, agency or clinic type (including "affiliate" clinics), name, address, nature of involvement, and dates of involvement. This attachment must include all of the required information listed.
   ☐ ***Submit*** an attachment, if needed, for any entity identified in number 5a, which has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for SNFs and ICFs, resolved by settlement, receiver appointed, or has a final Medi-Cal decertification action taken. Include all ownership and facility information, dates, and any final action.

6. Subsidiary: check "yes" if the licensee is a subsidiary of another organization and complete the information requested.
   ☐ ***Submit*** a detailed organizational chart, including parent and all subsidiary information, and federal tax ID numbers.

C. FACILITY, AGENCY, OR CLINIC INFORMATION

1. Management Agreement:
   (a) Check "yes" if the facility, agency, or clinic is going to be operated under a management contract/agreement, between the proposed owner and a management company. Proceed to Section "E" (below).
   (b) Check "yes" if there is an "interim" management agreement, between the proposed owner and the current owner, to run the facility until the change of ownership is completed.
   ☐ ***Submit*** a copy of the "interim" management agreement, if applicable.

2. Facility, agency, or clinic name: Enter the name used to designate the single facility, agency or clinic under the license being requested. Also, provide the current facility, agency, or clinic name, and current license number (if different). Change of ownership usually results in a name change.

3. Provide facility, agency, or clinic address, including phone number with area code, fax number, and e-mail.

4. Provide facility, agency, or clinic mailing address, if different from number 3 (above).

5. Provide the name and title of the individual to be in charge of the facility, agency, or clinic as well as any professional license number (if applicable).

6. Administrator:
   (a) Provide the name of the facility administrator, date of hire, license number, and license expiration date.
   (b) Provide the name of the director of nursing services (if applicable), date of hire, license number, and license expiration date.

7. Provide name(s) of all individuals having a **5 percent** or more interest in the ownership of this facility, if applying for SNF or ICF licensure. For all other facility, agency, or clinic types, provide the name(s) of those having **10 percent** or more interest in the ownership. Specify how these persons are related to one another as spouse, parent, child or sibling.
   ☐ ***Submit*** an attachment for all additional names. This attachment must include all of the required information.

8. Financial Resources: Only applies to SNF, ICF, and ICF/DD:
   ☐ ***Submit*** evidence, satisfactory to the Department, that the licensee has sufficient financial resources to operate the facility for at least 45 days (bank statement, certificate of deposit etc.). The amount is determined by multiplying 45 days X number of beds X rate.

9. Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
   (a) Are there other ICF/DD, ICF/DD-H, ICF/DD-N residential care, pediatric day health, or respite care facilities within 300 feet of this facility? Check "yes", "don't know" or "no".
   (b) Are there any congregate living health facilities within 1,000 feet of this facility? Check "yes", "don't know" or "no".

10. Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
Indicate if the program plan has been approved by the Department of Developmental Services. The "current licensee" can grant permission for their Program Plan to be used for 6 months if a letter is submitted to CDPH. If "no" is checked, the application package will be held until a copy of the approved program plan letter is received.

☐ ***Submit*** a letter to CDPH from the "current" licensee that the "proposed" licensee has their permission to use the "current" licensee's Program Plan for up to 6 months, if applicable.

☐ ***Submit*** a copy of the Program Plan approval letter, if "yes".

D. PROPERTY INFORMATION

1. Licensee must show evidence of control of property.

☐ ***Submit*** **a** copy of the deed and/or bill of sale, if property is owned.

☐ ***Submit*** a copy of the rental agreement, if property is rented.

☐ ***Submit*** a copy of the lease agreement, if property is leased.

☐ ***Submit*** a copy of the original lease plus a copy of the sublease, if property is subleased.

☐ ***Submit*** appropriate evidence if "other" is checked.

2. Provide name and address of the Owner of Record, Lessee and Sub-lessee as applicable.

E. MANAGEMENT COMPANY INFORMATION
(Complete Sections A1, C1-5, F & ATTACHMENT E-1)

F. STATEMENT OF RESPONSIBILITIES
Application must be signed by licensee or authorized representative.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's OR ICF's

1. If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, provide the name, address, and federal tax ID number of Management Company and name of facility to be managed.

☐ ***Submit*** a copy of the Management Agreement.

2. Provide the name, address, and percent of ownership for each person having a **5 percent** or more interest in the Management Company.

☐ ***Submit*** an attachment for additional names. This attachment must include all of the required information.

3. Provide a list of all facilities, agencies, or clinics that you have contracted to manage.

☐ ***Submit*** an attachment for additional facilities, agencies, or clinics. This attachment must include all of the required information.

CMS 1572

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB N0. 0938-0355

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

1. Name of Facility: Star Home Healthcare Services

11. Provider No.:

2. Street Address: 1800 Beach Drive, Suite 777

12. Type of Survey:
[1] Initial (G2) [ ] Resurvey (G3)
1 = Standard
2 = Partial Extended
3 = Extended
4 = 1 and 2
5 = 1 and 3
6 = 1, 2 and 3

3. City and/or County: Sacramento

4. State: CA

5. Zip Code: 95814-7402

6. Telephone No. (G4): (999)555-0695

7. State/County Code: (G5)

8. State/Region Code: (G6)

13. Eligibility: (G7)
[3]
1 = Medicare
2 = Medicaid
3 = Both

9. Name of Administrator: Wain Jones

10. Discipline of Administrator: (G8)
[1]
1 = RN/LPN
2 = Physician
3 = PT/OT
4 = Speech Path/Audiologist
5 = Medical/License Social Worker
6 = Pub Adm/MBA/ACCT
7 = Lawyer
8 = Proprietor
9 = Other

14. Has there been a change of ownership since last survey? (G9)
[ ] Yes [X] No

15. A. Is this home health agency also a Medicare certified hospice? (G10)
[ ] Yes [X] No

If yes, give the hospice Medicare provider number: (G11)

B. Does this home health agency operate sub-units? (G12)
[ ] Yes [X] No

If yes, how many: (G13)

C. Is this home health agency a sub-unit? (G14)
[ ] Yes [X] No

If yes, parent agency provider number: (G15)

D. Does this home health agency or sub-unit operate branch(es)? (G16)
[ ] Yes [X] No

If yes, how many: (G17)

If yes, give official name and mailing address of each branch (include street, state and zip code):

[ ] If more space is needed, check here, use a separate page and attach.

16. Type of Agency: (G18)
[0][7]
01 = VNA
02 = Combination Government Voluntary
03 = Official Health Agency
04 = Rehab based program*
05 = Hospital based program*
06 = Skilled Nursing Facility/Nursing Facility based program*
07 = Other

*If Medicare/Medicaid certified give the provider number: (G19)

17. Type of Control: (G20)
[0][4]
Voluntary Non-Profit
01 = Religious Affiliation
02 = Private
03 = Other
For Profit
04 = Proprietary
Government
05 = State/County
06 = Combination Govt. and Voluntary
07 = Local Government

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

(continued)

18. Services Offered: (G21)

1 = Provided by Agency Staff
2 = Under Arrangement
3 = Combination

1	01 = Nursing Care
2	02 = Physical Therapy
	03 = Occupational Therapy
2	04 = Speech Therapy
	05 = Medical Social Worker
	06 = Home Health Aide
	07 = Intern/Resident
	08 = Nutritional Guidance
	09 = Pharmaceutical Services
	10 = Appliance and Equipment Service
	11 = Vocational Guidance
	12 = Laboratory Services
	13 = Other

19. Staffing (List full-time equivalent):

Registered Nurse (G22)				1	.	0	0
Licensed Practical Nurse (G23)				1	.	0	0
Physical Therapist (G24)				1	.	0	0
Occupational Therapist (G25)					.		
Speech Pathologist/Audiologist (G26)				1	.	0	0
Social Worker (G27)					.		
Home Health Aide (G28)					.		
Pharmacist (G29)					.		
Dietitian (G30)					.		
All Others (G31)					.		

20. Home Health Agency provides directly: (G32)

	1 = Home Health aide training program
	2 = Home Health aide competency evaluation program
✓	3 = Both
	4 = Neither

21. Number records reviewed with home visits (G33)

Number records reviewed, no home visits (G34)

Number of home visits with no records review (G35)

Total records reviewed (G36)

Total home visits (G37)

22. Patient census since last standard survey:

Admissions:

(G38) _____ Unduplicated admissions

(G39) _____ Readmissions

Discharges

(G40) _____ Hospital discharges

(G41) _____ Nursing home discharges

(G42) _____ Goals met discharges

(G43) _____ Death discharges

(G44) _____ Total discharges

23. Surveyor summary: Based on the reviews of the patients from this home health agency including all information surveyed in the standard survey and using the Functional Assessment Instrument (FAI), this home health agency: (G45)

	1. Provides care that promotes a high potential for reaching the highest attainable levels of functioning for its patients. There is no evidence of need for a partial extended or extended survey.
	2. Provides care that promotes a moderate potential for reaching the highest level of functioning for some but not all of its patients. There are standard level deficiencies and need for a partial extended survey. If no conditions are out of compliance, a Plan of Correction will be requested for the standard level deficiencies.
	3. Provides substandard care. There are condition level deficiencies in one or more Conditions of Participation. There is an immediate need for an extended survey.

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

1. NAME OF FACILITY:	4. DATE:

2. DEFICIENCIES		3. Standard _____ Extended _____ Partial Extended _____
Data Tag No.	COP/Stnd No.	COMMENTS

2. DEFICIENCIES		3. Standard _____ Extended _____ Partial Extended _____
Data Tag No.	COP/Stnd No.	COMMENTS

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

Record deficiencies identified on a Standard Survey, Partial Extended Survey, and/or Extended Survey on different pages, check the type of survey under item 3 and enter the date of the survey in item 4.

A. In the first column, identify the data tag number.

B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter "CoP" below the regulatory citation.

C. In column three, describe the findings and evidence under "Comments."

D. Draw horizontal lines to separate identified tag numbers.

E. If more space is needed, photocopy the “Deficiencies & Comments” page and continue the recording (front and back).

F. Each surveyor must sign the certifying statement on the last page for each type survey(s) conducted (i.e., Standard Survey, Partial Extended Survey, and/or Extended Survey). If more space is needed to list deficiencies identified during a Partial Extended Survey, photocopy page.

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

A. STANDARD SURVEY

I certify that I have reviewed each HHA Condition of Participation and related Standard(s) included in the Standard survey and except as indicated on this form, the facility was found to be in compliance with the standards and/or the Conditions of Participation.

Signature: _____ Title: Owner Date: 03/11/2019

Signature: _____ Title: _____ Date: _____

Signature: _____ Title: _____ Date: _____

B. PARTIAL EXTENDED SURVEY

I certify that I have reviewed each HHA Condition of Participation and related Standard(s) listed below, and except as indicated on this form, the facility was found to be in compliance with the standards and/or the Conditions of Participation.

Signature: _____ Title: _____ Date: _____

Signature: _____ Title: _____ Date: _____

Signature: _____ Title: _____ Date: _____

C. EXTENDED SURVEY

I certify that I have reviewed all of the HHA Conditions of Participation and related Standard(s) not reviewed during the Standard Survey and/or Partial Extended Survey and except as indicated on this form, the facility was found in compliance with the standards and/or Conditions of Participation.

Signature: _____ Title: _____ Date: _____

Signature: _____ Title: _____ Date: _____

Signature: _____ Title: _____ Date: _____