Commission on Accreditation for Home Care, Inc.
299 Market Street, Suite 235
Saddle Brook, NJ 07663
Tel: 201-880-9135 Fax: 201-880-9136

Provider Profile – Initial Application

Provider Name:

CAHC Contact:

Name: _____

Position: _____

Mailing Address: _____

Phone: _____

FAX: _____

Business Email: _____

Website: _____

Provider Classification (select one):

- ☐ Voluntary non-profit
- ☐ Proprietary, For Profit
- ☐ Other (Specify): _____

Sites Applying:

# of sites are applying for accreditation: ____

List the site locations: _____ City/town _____ City/town

_____ City/town _____ City/town

Prepared By: _____ Print Name _____ Position _____ Phone

General Information

If more than one site is seeking accreditation, please copy pages 13-16 for each site.

Check all services for which this site is applying for accreditation:
☐ *Personal Care Services (PCS)*
☐ *In-Home Skilled Nursing (IHSN)*
Complete all information and statistics based upon the service(s) for which you are applying.

Provider Name: _____

License DBA Name : _____

Site Information:
Address: _____

County: _____
Phone: _____
FAX: _____

Site Historical Data:
Date site opened: _____
PCS: Date services initiated, if applicable: _____
IHSN: Date services initiated, if applicable: _____

Supervisory Personnel at the Site:
PCS: Director of Nursing: ☐ Ms. ☐ Mr. Name: _____
IHSN: Director of Nursing: ☐ Ms. ☐ Mr. Name: _____

Miscellaneous:
Days and hours
Days and hours of office operation: _____
Days and hours of service: PCS: _____ IHSN: _____
On-Call days and hours: PCS: _____ IHSN: _____

List all services provided at this site:
☐ PCS
☐ IHSN
☐ Other (specify): _____ _____ _____

Statistics

Case Management

Report the following based upon statistics <u>for the past 4 months</u>:

PCS	IHSN	
_____	_____	Number of active cases
_____	_____	Number of discharged cases
_____	_____	Total number of cases serviced

Report the following based upon statistics for the past 12 months:

PCS	IHSN	
_____	_____	Number of cases
_____	_____	Service hours
		Enter the approximate percentages of patient population:
_____	_____	Pediatric
_____	_____	Geriatric
_____	_____	Other adults
		Enter the approximate percentage of payer source for patient population:
_____	_____	Private pay
_____	_____	Subcontracts
_____	_____	Medicaid
_____	_____	Insurance
_____	_____	Other (Specify: _____)

Personnel Management

Report the <u>current</u> statistics concerning directly-employed personnel at this site:

	PCS: Aides	IHSN: RNs	IHSN: LPNs
Available to work:	_____	_____	_____
Assigned to cases:	_____	_____	_____

Report the following based upon the <u>past 12 months</u>:

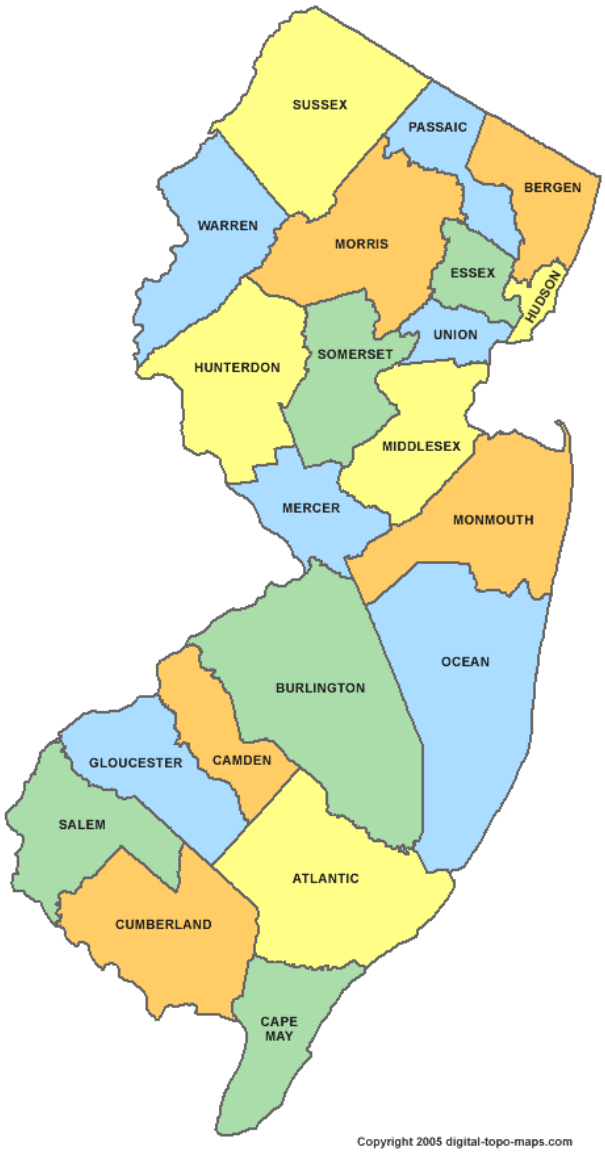
Does your agency directly employ all aides/field nurses?	☐ Yes	☐ No
Does your agency directly employ all supervisory personnel?	☐ Yes	☐ No
PCS: Are all aides certified?:	☐ Yes	☐ No
Does this site subcontract for aides/field nurses?:	☐ Yes	☐ No

Enter the following data regarding supervisory personnel who worked at this site:

full time: ____

part time: ____ (full time equivalent (FTE) for part time personnel: ___)

New Jersey Map



List all counties that your agency **is prepared to** service from this site: ---------- ---------- ---------- ---------- ---------- ---------- ---------- ---------- ----------	

Driving Directions and Parking Information

Instructions:

- *The directions will be used by the CAHC surveyors who are from all over New Jersey; therefore, the directions must be general, from all nearby major highways.*
- *Please include any information about parking that will be useful for the surveyor.*
- *Either type below or attach a sheet containing the typed direction and parking information.*
- *If a separate sheet is attached, include the agency name, the address and the phone number on the sheet.*

Provider Name: _____

License DBA Name: _____

Street Address: _____

Phone: _____

Parking:

Directions: