



Provider Profile

Provider Name: _____

License DBA Name : _____

CAHC Contact:

Name: _____

Position: _____

Full Mailing Address: _____

Phone: _____

FAX: _____ Preferred Correspondence Email: _____

Business Email: _____

Website: _____

Provider Classification (select one):

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

Sites seeking accreditation renewal:

of sites for accreditation: _____

List other site locations:

| | |
|-----------|-----------|
| _____ | _____ |
| City/town | City/town |
| _____ | _____ |
| City/town | City/town |
| _____ | _____ |
| City/town | City/town |

Profile Prepared By: _____
Print Name Position Phone

Signature Date

General Information

Check services for which this site is applicable:

- Personal Care Services (PCS)
- In-Home Skilled Nursing (IHSN)

Provider Name: _____

License DBA Name : _____

Site Information:

Address: _____
Town/City: _____
County: _____
Phone: _____
On-Call# (off hours): _____
FAX: _____

Site Historical Data:

Date site opened: _____
PCS: Date of initial accreditation: _____
IHSN: Date of initial accreditation: _____

Supervisory Personnel at the Site:

PCS: Director of Nursing: Ms. Mr. Name: _____
IHSN: Director of Nursing: Ms. Mr. Name: _____
Corporate Compliance Officer: Ms. Mr. Name: _____

Miscellaneous:

Days and hours:
Days and hours office is open: _____
Days and hours of service: PCS: _____ IHSN: _____
On-Call days and hours: PCS: _____ IHSN: _____
IHSN: Is a Nursing Supervisor available 24 hours a day, seven days a week for assistance, if needed?
 Yes No

Earliest time key personnel will be present for survey: _____AM

List all services provided at this site:

- PCS
- IHSN
- Other (specify): _____

Statistics

Case Management

The Surveyor will select clinical records of any clients who received service during the period of accountability.

1) Please report the following based upon statistics during the period of accountability (up to the present day):

| | | |
|-------|-------|---|
| PCS | IHSN | |
| _____ | _____ | Number of active cases |
| _____ | _____ | Number of discharged cases |
| _____ | _____ | Number of cases "on hold" |
| _____ | _____ | Total number of cases serviced during period of accountability |

2) Report the following numbers of patients based upon payer source for the period of accountability:

| | | |
|-------|-------|---|
| PCS | IHSN | |
| _____ | _____ | Enter the number of patients currently receiving care: |
| _____ | _____ | Pediatric (up to age 21) |
| _____ | _____ | Adult |
| _____ | _____ | Geriatric |
| _____ | _____ | Enter the number of patients per payer source : |
| _____ | _____ | Private pay |
| _____ | _____ | Subcontracts |
| _____ | _____ | Medicaid (CRPD, Title XIX (9) Model Waivers, HMO's) |
| _____ | _____ | State funded (JACC, Respite Care, etc.) |
| _____ | _____ | Long Term Care Insurance |
| _____ | _____ | Other (Specify: _____) |
| _____ | _____ | Total |

| | | |
|---|------------|-------------|
| 3) For the past 12 months: | PCS | IHSN |
| Total number of cases serviced: (total # current active cases + discharges) | _____ | _____ |
| Total number of <u>service hours</u> provided | _____ | _____ |

IHSN: Breakdown # of active cases:

| | |
|------------------------|--------------------------|
| Medicaid Managed Care: | Private Insurance: _____ |
| ESPD _____ | |
| ACCAP _____ | Other: _____ |
| CRPD _____ | |
| Total: _____ | |

| |
|---------------------------|
| Medicaid Fee for Service: |
| ACCAP _____ |
| CRPD _____ |
| Total: _____ |

The state of NJ reserves the right to cross reference your case counts with Medicaid claims paid data.

Personnel Management

The Surveyor will select personnel records of any staff member worked during the period of accountability.

Report the **current** statistics concerning directly-employed personnel at this site:

| | CHHAs | RNs | LPNs |
|--------------------|--------------|------------|-------------|
| Available to work: | _____ | _____ | _____ |
| Assigned to cases: | _____ | _____ | _____ |

Enter the following data regarding **nursing supervisory personnel** who worked at this site during the period of accountability:

full time: _____
part time: _____ (full time equivalent (FTE) for part time personnel: _____)
per diem _____

Please list all **nursing supervisory personnel** who have worked since the last survey. Include all new hires and nurses that worked during the period of accountability, including any now terminated.

| <i>Name:</i> | <i>Title:</i> | <i>First day worked / last day worked</i> |
|--------------|---------------|---|
| _____ | _____ | _____/_____ |
| _____ | _____ | _____/_____ |
| _____ | _____ | _____/_____ |
| _____ | _____ | _____/_____ |

****If the Director of Nursing or Nursing Supervisor has changed in past year, please be sure that CAHC has a copy of the resume or employment application for that employee.**

Report the following based upon the **past 12 months**:

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

Is malpractice insurance required of your nursing staff? Yes No

Are periodic physical exams required for staff? Yes No
If yes, how often? _____.

Time frame for **Post Orientation Evaluations**: _____

Do you have additional specific requirements for your field staff? Yes No
If yes, what are those requirements? _____

Please attach an updated and complete **Organizational Chart**.

1) Who will be assigned to assist the surveyor with **Personnel Records** at the time of the survey?

Name: _____ Title: _____ Department: _____

2) Who will be assigned to assist the surveyor with **Clinical Records** at the time of the survey?

Name: _____ Title: _____ Department: _____

3) Who will be assigned to assist the surveyor with **Administrative** matters at the survey?

Name: _____ Title: _____ Department: _____

*****All staff assigned to assist during the survey must have a thorough understanding and ability to access relevant files. All records must be easily accessible during the survey. Any delay in receiving files may result in the need for a follow up visit (with additional cost to the provider.)***

For IHSN Services:

What is the frequency of **renewal of orders** from physicians? _____

What is the frequency of **updates** to the medication profile? _____

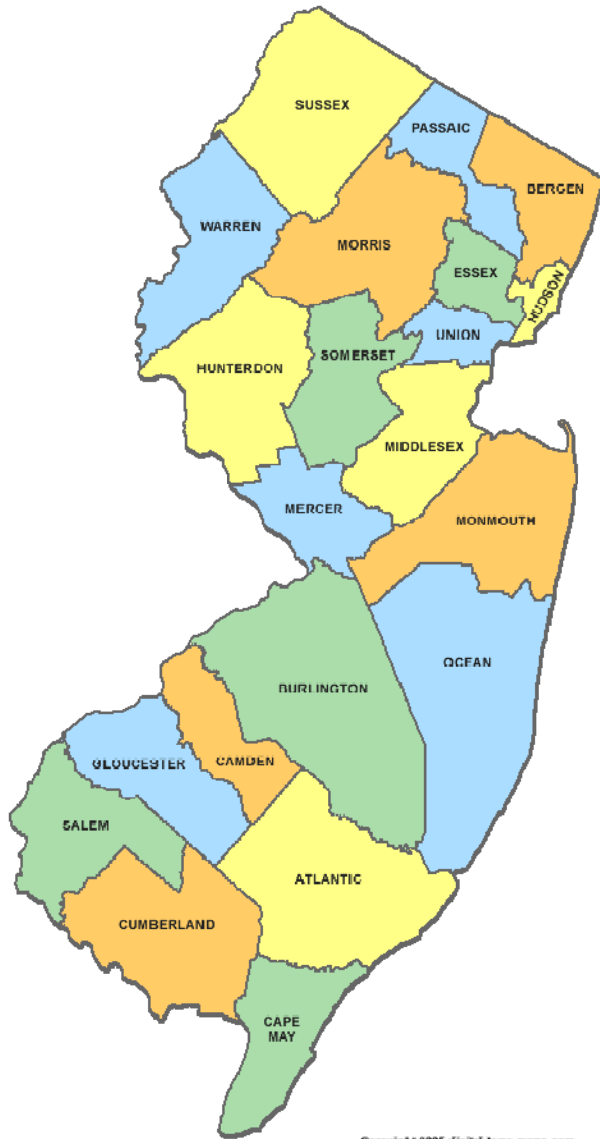
PLEASE LIST ALL CAHC REQUIRED FORMS, POLICIES OR JOB DESCRIPTIONS REVISED OR ADDED SINCE THE LAST SURVEY.

| POLICY/JOB DESCRIPTION/FORM NAME: | REVISION/IMPLEMENTAION DATE |
|-----------------------------------|-----------------------------|
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |
| _____ | _____/_____/_____ |

If additional space is needed, please include separately.

****PLEASE INCLUDE A COPY OF EACH DOCUMENT WITH THIS PROFILE****

New Jersey Map



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

With a marker, outline the geographic area that your agency **is prepared to** service from this site, indicating partial counties accurately.

Put an “+” on the map, indicating the site location.

If the site is a satellite office, put an “●” on the map, indicating the branch location.

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.*

Street Address:

Phone:

Parking information/availability:

Directions/ landmarks to watch for:

