Provider Profile

Provider Name: _____

License DBA Name : _____

CAHC Contact:

Name: _____

Position: _____

Full Mailing Address: _____

_____

_____

Phone: _____

FAX: _____

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"
0	0	**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.)
_____	_____	Private Insurance
_____	_____	Other (Specify: _____)
0	0	**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:
- ESPD _____
- ACCAP _____
- CRPD _____
- **Total:** 0

Private Insurance: _____

Other: _____

Medicaid Fee for Service:
- ACCAP _____
- CRPD _____
- **Total:** 0

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.

Name:	*Title:*	*First day worked / last day worked*
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____

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? _____

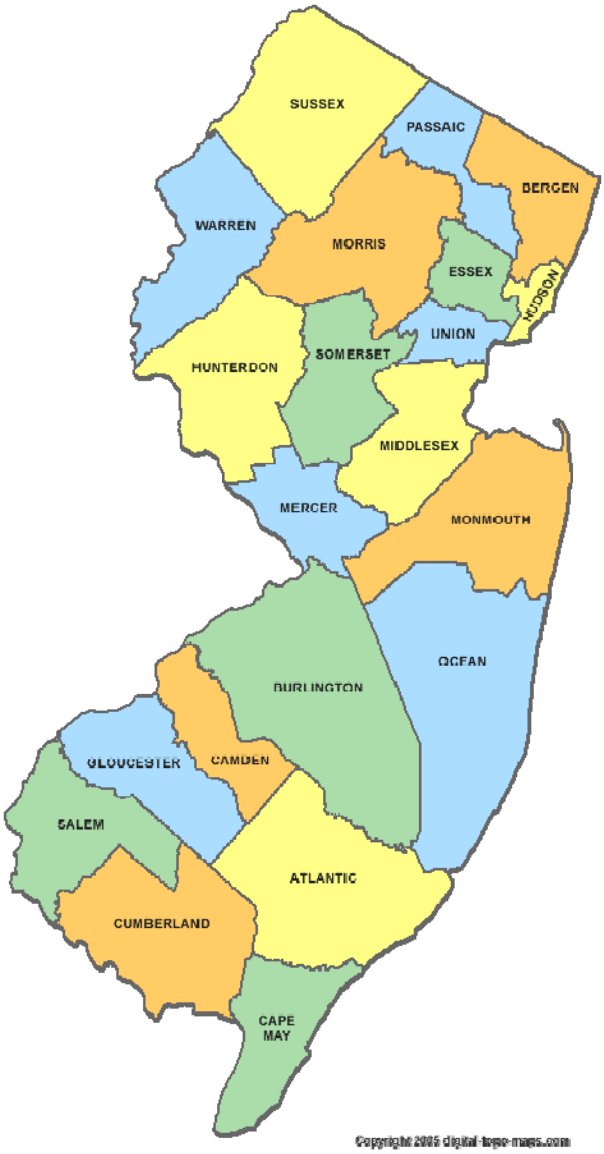
PLEASE LIST ALL CAHC REQUIRED **FORMS, POLICIES OR JOB DESCRIPTIONS REVISED OR ADDED** SINCE THE LAST SURVEY.

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 geograpic 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:

_____
_____
_____
_____
_____
_____