Tennessee's Health

Guidelines For Growth

Criteria and Standards for Certificate of Need 2000 Edition

Prepared by the Health Planning Commission

HOSPICE SERVICES

Need

1. Hospices shall have the capacity to admit new patients in a quantity equal to the sum of:
   a. 55% of the mean annual number of cancer deaths in the hospice service area during the preceding two years; and
   b. 12% of the mean annual number of deaths from all other non-traumatic causes in the hospice service area during the preceding three years.

2. New hospices shall be approved for Certificate of Need only if the projected need, as determined by this formula, exceeds existing service levels by 150 or more patients per year.

CON Review Criteria

1. The application shall document the existence of at least one of the following three conditions to demonstrate a need for additional hospice services in an area:
   a. absence of services by a hospice certified for Medicaid and Medicare, and evidence that the applicant will provide Medicaid- and Medicare-certified hospice in the area; or
   b. absence of services by a hospice that serves patients regardless of the patient's ability to pay, and evidence that the applicant will provide services for patients regardless of ability to pay; or
   c. evidence that existing programs fail to meet the demand for hospice services for persons who have terminal cancer or other qualifying terminal illness.

2. The applicant shall set forth its plan for care of patients without private insurance coverage and its plan for care of medically underserved populations. The applicant shall include demographic identification or underserved populations in the applicant's proposed service area and shall not deny services solely based on the patient's ability to pay.

Exception to the Hospice Formula

The applicant must demonstrate that circumstances exist to justify the approval of a new hospice. Evidence submitted by the applicant must document one or more of the following:

1. That a specific terminally ill population is not being served;
2. That a county or counties within the service area of a licensed hospice program are not being served; and
3. That there are persons referred to hospice programs who are not being admitted within 48 hours (excluding cases where a later admission date has been requested). The applicant shall indicate the number of persons.

If the need for the exception to the hospice formula is justified, then the review criteria above shall also apply.

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
Site: 1205 Umstead Drive
Raleigh, North Carolina 27603
Mailing: 2712 Mail Service Center
Raleigh, North Carolina 27699-2712
Telephone: (919) 855-4620 Fax: (919) 715-8476

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License # _____
Computer:
PC _____ Date _____

Total License Fee: _____

2009
LICENSE APPLICATION FOR HOME CARE, NURSING POOL, AND HOSPICE

A separate application is to be completed for each site from which home care (including home health), nursing pool, or hospice services are offered. Separate legal entities operated out of the same office must submit separate applications.

Legal Identity of Applicant: Owner/Corporate Identity:

_____

(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Agency Name/Doing Business As:
(D/B/A) - Name(s) under which the facility or services are advertised or presented to the public:

PRIMARY:

_____

Agency Mailing Address: (If materials are to be mailed to another address list here)
Street/P.O. Box: _____
City: _____, State: _____ Zip: _____

Agency Site Address: Street: _____
City: _____, State: _____ Zip: _____

County:
Telephone: (___) _____ Fax: (___) _____
E-Mail:(if applicable) _____
Web Site :(if applicable) _____

Administrator/Director: _____

Title: _____

Name of the person to contact for any questions regarding this form:

Name: _____ **Telephone:** _____

E-Mail: _____

Licensure Categories Licensed For: *(Check All That Apply)*

1. ___ Home Care Agency (G.S. 131E-138)
2. ___ Nursing Pool (G.S. 131E-154.3)
3. ___ Hospice Services (G.S. 131E-200)

Scope of Services:
DHSR licenses Home Care agencies for a Scope of Services: Nursing Care, Infusion Nursing Services, In-Home Aide, Medical Social Services, Physical Therapy, Occupational Therapy, Speech Therapy, and Clinical Respiratory Services (including Pulmonary or Ventilation if provided separately from routine nursing practice). Any agency adding a new service category as outlined in G.S. 131E-136(3)(a)-(f) shall notify the Department in writing at least 30 days prior to the provision of that service to any clients. **YOU MAY NOT ADD SERVICES ON THIS APPLICATION.** Below are the services you are currently licensed to provide:

1) Under this home care license number, are you directly providing HME/DME? _____ Yes _____ No

2) Do you also have a medical equipment permit issued by the NC Board of Pharmacy? _____ Yes _____ No

If "yes," please provide the permit number: _____

Hours:

Indicate the hours that the agency is regularly open for business each day:
[Example: 9 am – 5 pm. Use "O" if not open]

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Nursing:

Full-time Equivalents (FTE)

	R.N.	L.P.N.	Aides
Number:			

Accreditation Information:
If home care licensure is being requested on the basis of deemed status as an accredited agency, **attach a complete copy of accrediting organization's inspection report (or findings) together with its decision, if surveyed within the last 12 months.** Licensure based upon deemed status cannot be completed without full disclosure.

Accredited	Accrediting Organization	Expiration Date	*Deemed Status
	JCAHO (Joint Commission on Accreditation for Healthcare Organizations)		
	CHAP (Community Home Association Program)		
	ACHC (Accreditation Commission for Home Care, Inc.)		
	Other:		

*Please provide a copy of your letter if you are deemed

Home Care Agency Applicants:

1. If Medicare Certified Home Health, what is your provider number? _____
2. This agency is a Home Health Agency. ____ Yes ____ No.
   If 'Yes', please check one: Parent __ Branch __ Sub-unit __
3. Is this agency owned or operated by a Continuing Care Retirement Center (CCRC)? _____Yes _____ No

Hospice Applicants:

1. If Medicare certified, what is your hospice provider number? _____
2 For Medicare certified hospices do you operate more than one office under this provider number? If yes please list each license operating under this Medicare number.
   _____.
3 Has this site been issued a Certificate of Need to provide hospice services? _____Yes _____ No.
4. Do you have an agreement to operate Hospice licensed inpatient beds or hospice residential beds in another facility? If so, list facility.
   _____

Nursing Pool Applicants:

All nursing pool applicants must attach a copy of the agency's current general and professional liability insurance policy (binder acceptable). The document must show that the applicant is insured against loss, damage, and expense related to a death or injury claim resulting from negligence or malpractice in the provision of health care by the nursing pool and its employees.

Ownership Disclosure: (Please fill in any blanks and make changes where necessary).

1: What is the name of the legal entity with ownership responsibility and liability? If this is a Corporation, complete the exact wording of the corporate name as on file with the NC Secretary of State (Corporate Office). If this is a Unit of Government, the name of the governmental unit that has the ownership responsibility and liability for services offered.

Owner: _____
Federal Tax ID No.: _____
Street/Box: _____
City: _____ State: ____ Zip: _____
Telephone: (____) _____ Fax: (____) _____
Senior Officer: _____

a. Legal entity is: _X_ For Profit ____ Not For Profit
b. Legal entity is ____ Corporation ____ Limited Liability Company ____ Partnership
____ Proprietorship ____ Limited Liability Partnership ____ Government Unit

Corporation:

a. What is the exact wording of the corporate name on file with the NC Secretary of State?

_____

b. In what state was the corporation originally established? _____

c. Address and Telephone number of the corporation:

_____

_____

d. List names and addresses of ALL officers and any other persons with a controlling interest of 5% or more.

Name	Title	Percent of Stock

(Attach additional sheets as needed)

Government Unit:

a. Name of the governmental unit that has the **ownership responsibility and liability** for the services offered:

_____

b. Title of the official in charge of the governmental unit: _____

c. Check which best describes the type of governmental unit:

City ___ County ___ State ___ Authority ____ Health Dept _____ DSS _____

Other (Please specify): _____

Multiple Facilities:

a. Is this facility part of a multiple facility/agency system in North Carolina? ____ Yes ____ No
(A multiple facility system is defined as two or more facilities under the same management or ownership).

b. If 'Yes' above, are medical records in a centralized location? _____ Yes _____ No

c. If 'Yes', please specify location.

Name	Location	License #

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
Site: 1205 Umstead Drive
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Raleigh, North Carolina 27699-2712
Telephone: (919) 855-4620 Fax: (919) 715-8476

For Official Use Only
License
Medicare #:
Computer:
PC _____ Date _____

HOSPICE AGENCY

2009 Annual Data Supplement to Licensure Application

(Reporting 2008 Fiscal Year Data)

SECTION A: Identification and Contact Information

License No: _____

Legal Identity of Applicant: _____

Agency d/b/a: _____

Agency Site Address: Street: _____

City: _____, State: _____ Zip: _____

County: _____

Agency E-Mail:
(If Applicable) _____

Agency Web Site:
(If Applicable) _____

Agency Phone #: (___) _____

Agency Fax: (___) _____

Reporting Period* _____

***Data is requested for the twelve-month period beginning on October 1, 2007 and ending on September 30, 2008.** If your agency has a fiscal year end of June, July, August, September or October, you may use your data from your actual fiscal year end, as long as you do not report more than 12 months worth of data. If your agency or facility was not open for this entire twelve-month period, please specify the time period covered in this report, in the space provided above.

AUTHENTICATING SIGNATURE: I certify the information submitted in this Data Supplement is accurate.

Title: _____

Typed Name: _____ **Date:** _____

Signature: _____

Name of the person to contact for any questions regarding this form:

Telephone: _____

Name: _____

E-Mail: _____

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

SECTION B: Program Demographics

1. **AGENCY TYPE** Check all that apply.
   - ☐ Free Standing
   - ☐ Hospital Based
   - ☐ Home Health Based
   - ☐ Nursing Home Based

2. **MEMBERSHIPS** Are you a member of:
   A State Hospice Association? ☐ Yes ☐ No
   If yes, which state(s)? _____
   NHPCO? ☐ Yes ☐ No
   Member # _____
   NAHC? ☐ Yes ☐ No

3. **CENSUS AS OF 9/30/2008**
   _____1-15
   _____16-30
   _____31-49
   _____50-99
   _____100+
   (If zero please give explanation)
   _____

4. **MULTIPLE LOCATIONS**
   ☐ Yes ☐ No
   If so, how many are reported together in this survey? _____

5. **FISCAL YEAR**
   Last month of your fiscal year? _____

6. **MEDICARE CERTIFICATION**
   Are you Medicare Certified?
   ☐ Yes ☐ No
   Medicare Provider No. _____

7. **ACCREDITATION STATUS**
   Accredited by:
   - ☐ ACHC
   - ☐ CHAP
   - ☐ JCAHO
   - ☐ Other
   - ☐ Not accredited

8. **BUDGET SIZE**
   _____<$500,000
   _____$500,001 - $999,999
   _____$1,000,000 - $1,999,999
   _____$2,000,000 - $3,999,999
   _____$4,000,000 - $5,999,999
   _____>$6,000,000

9. **OWNERSHIP**
   - ☐ Voluntary (not for profit)
   - ☐ Proprietary
   - ☐ Government

10. **INPATIENT FACILITIES & RESIDENTIAL FACILITIES**

a. Does your hospice operate one or more dedicated hospice facilities or units? A dedicated facility or unit consists of one or more beds that are owned or leased by the hospice, staffed by hospice staff, and have major policies/procedures set by the hospice.
   - ☐ No–*Please **SKIP** Section K on pages 12-13.*
   - ☐ Yes–*Please **COMPLETE** Section K on pages 12-13*

b. No. Licensed Inpatient Beds _____ No. Licensed Residential Beds _____

REPORT FACILITY DATA FOR SECTIONS "C" THROUGH "J" ON YOUR MAIN LICENSE. IF YOU HAVE A SEPARATE LICENSE FOR YOUR FACILITY, COMPLETE SECTION "K" ONLY ON THE FACILITY LICENSE.

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

SECTION C. Patient Volume:

1. **AVERAGE DAILY CENSUS AND LENGTH OF STAY:** Please review the definitions and calculation examples carefully before completing the following data for the period 10/01/07 – 09/30/08.

a. Average Length of Stay (ALOS) _____

Divide the total days of care provided to died/discharged patients from 10/01/07 to 09/30/08 by the total number of patients that died/discharged in 2007/2008. *EXAMPLE:* 100 patients died or were discharged from 10/01/07 to 09/30/08. Their total patient days from admission to died/discharge were 4200. ALOS = 4200/100 = 42 days.

b. Median Length of Stay (MLOS) _____

The midpoint for all died/discharged patients from 10/01/07 to 09/30/08 (same populations as for ALOS, above). Half of the patients have a LOS longer than the median and half of the patients have a LOS shorter than the median. Calculate the MLOS by arranging the LOS scores for all patients from lowest to highest (1, 2, 3, …). Find the score that falls in the exact middle of the list. This is the median length of stay.

EXAMPLE 1 – Even number of patients. You have six patients that stayed the following number of days: 11, 2, 9, 5, 8, 4. Arrange the LOS scores from lowest to highest: 2, 4, 5, 8, 9, 11. The median will fall between the third & fourth number; in this case, the median falls between 5 and 8. Add 5 + 8, and divide by 2. (5+8)/2 = 6.5. Therefore, 6.5 is your median.

EXAMPLE 2- Odd number of patients. You have five patients with the following number of days: 8, 22, 3, 10, 7. Arrange the LOS scores from lowest to highest (3, 7, 8, 10, 22). The median length of stay is in the middle – 8 days.

c. Average Daily Census (ADC) _____

ADC is computed as follows: Take all patient days for a given period and divide by the number of days in that period.

EXAMPLE: You provided a total of 12,775 patient days for all levels of care from 10/01/07 to 09/30/08. 12,775 divided by 366 days equals an ADC of 35 patients per day.

d. Total Number of Deaths (must agree with the total number of deaths in sections D, E, and I)_____

Number of Patients Who Died in ≤ 7 days (stays of 7 days or fewer) _____

{Include the number of deaths for patients who died from 10/01/07 to 09/30/08 with stays of 7 days or fewer.}

Number of Patients Who Died in > 180 days (stays of 180 days or more)____

{Include the number of deaths for all patients who died from 10/01/07 to 09/30/08 with stays of 180 or more **consecutive** days.}

2. **LEVEL OF CARE AND PAY SOURCE:** Please provide patient days for all patients served, including those in nursing facilities, from 10/01/07 to 09/30/08. Patients who change primary pay source during this time should be reported for each pay source with the number of days of care recorded for each pay source (count each day only once even if there is more than one pay source on any given day). The # of patients served may be higher than the actual number of patients served due to a change in pay source. **Days of care should agree to days of care in Section I.**

Hospice Payment Source	# of Patients Served	Days of Routine Home Care	Days of Inpatient Care	Days of Respite Care	Days of Continuous Care	Total Patient Care Days
Hospice Medicare						
Hospice Medicaid						
Private Insurance						
Self Pay*						
Other**						
Totals:						

* *Self Pay included charity/indigent care and foundation help; does NOT include any commercial or government 3rd party payor.*

** *Other Payment Sources (to be used rarely) may include but are not limited to VA, Workers Comp, Home Health Benefit (only for non-Medicare Certified agencies).*

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

SECTION C. Patient Volume- *continued*

3. REFERRALS

Total number of referrals received in from 10/01/07 – 09/30/08 _____

Do not include requests for general information as referrals. One or more of the following defines a referral:

- Contact from a physician, case manager, discharge planner, health care organization, or equivalent that requests assessment of a patient for admission;
- Contact from a patient or their family or friend, that identifies a specific patient who may need hospice care.

SECTION D. Number Of Admissions And Deaths By Location:

Please report the number of admissions and deaths in each location during the period 10/01/2007 - 09/30/2008. Admission location is the actual site where the patient is on the first day of care. Patient can start in one location and finish at another location. **Number of admissions should agree to the # of admissions in Sections E, G and I. Number of deaths should agree to the # of deaths in Sections C. and I.**

Location	# of Admissions	# of Deaths
Home - Private residence of either the patient or the caregiver		
Nursing Facility - A licensed long term care facility providing nursing and supportive services		
Hospice Unit - An inpatient unit (one or more beds) operated by a hospice, and located in a facility operated by another entity (includes hospital, nursing home, and other).		
Hospital - An acute care facility not operated by the hospice (may be a floating or scattered bed contract).		
Free Standing Hospice Inpatient Facility or Residence - An inpatient facility and/or residence operated entirely by a hospice.		
Residential Care Setting - A residential care facility that is not run by the hospice (assisted living, boarding home, rest home, shelter, etc.)		
Totals:		

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

SECTION E. Number Of Admissions, Deaths and Live Discharges, By Diagnosis:

Please provide the number of hospice patients' admissions and deaths during the period 10/01/2007 - 09/30/2008 regardless of pay source. Count the patient only under the primary diagnosis at admission, for which care is provided. Report each patient only once. Number of admissions must equal Sections D, G and I. Number of deaths must equal Sections C, D, and I.

Primary Diagnosis	# of Admissions	# of Deaths	# of Live Discharges	*Patient Days for Patients Who Died or Were Discharged
Cancer Include all cancers				
Heart All patients with heart disease including CHF & primary sclerotic heart disease				
Dementia Include Alzheimers, vascular dementia, etc.				
Lung COPD (emphysema) and other non-cancer lung diseases				
Kidney End stage renal disease				
Liver Cirrhosis, advanced hepatitis, and other non-cancer liver disease				
HIV All AIDS and HIV related conditions				
Stroke/Coma				
ALS				
Other Motorneuron Include Parkinsons, Huntingtons, MS				
Debility Unspecified Include terminal debility, failure to thrive				
All Others Please specify				
Totals				

*** Please report total days for live discharges _____.**

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

SECTION F. Productivity and Cost of Care. Complete Sections F1 and F2 using the following definitions.

Direct Care: Includes all activities involved in care delivery, including visits, telephone calls, charting, team meetings, travel for patient care, and arrangement or coordination of care. When a supervisor provides direct care, estimate the time involved in direct care as distinct from supervision of other staff or program activities.

PRN Employees: also called "per diem" employees, are called upon to work when necessary without a commitment to work a specific number of hours for your agency. They may be available all of the time or they may be only available for certain days or times. However, they are not the same as part-time employees, even though they may routinely work on the same day or number of hours each week. A part-time employee is expected to work a certain number of hours each week, but there is no expectation for number of hours for a PRN employee. PRN employees are included in the fourth column of question 1a of this section only.

Separation: a voluntary or involuntary termination of employment.

FTE: One full time equivalent (FTE) is 2080 hours per year (40 hours per week times 52 weeks). Provide actual FTEs utilized, not the budgeted number of FTEs.

Calculations: Total FTEs: Divide paid hours by 2080. Include vacation, sick leave, education leave, and all other time normally compensated by the agency. Categorize your FTEs as you do for the Medicare Hospice Cost Report. Include hourly, salaried and contract staff.

1a. STAFFING BY DISCIPLINE on last day of fiscal year

Staffing by Discipline	Total Home Hospice FTE's	Total Employees (on last day of FY, no PRN)	Total PRN Employees	Total Separations (all causes)
Nursing Include RNs, and LPNs. Include on-call and after hours care. Do not include supervisors or other clinical administrators *unless a portion of their time is spent in direct care**.				
Social Services Include medical social services staff as defined by CMS for the cost report. Do not include chaplains or bereavement staff.				
Home Health Aides & Homemakers Include Home Health Aides and Homemakers as defined by CMS for the cost report.				
Physicians – Paid Include medical directors and other physicians providing direct care to patients and participating in clinical support. Exclude volunteer physicians.				
Physicians - Volunteer				
Other Clinical Include any paid staff in addition to those captured above who provide direct care to patients or families. Include chaplains, therapists, and dietitians. Do not include volunteers.				
Bereavement Include all paid staff providing bereavement services, including pre-death grief support. Do not include volunteers.				

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

1b. GENERAL STAFF Please review the definitions and calculations carefully before completing the following questions for the time period 10/01/2007 – 09/30/2008.

General Staff	Total Home Hospice FTEs	Total Employees (on last day of FY no PRN)	Total PRN Employees	Total Separations (all causes)
Clinical Includes all direct care* time. This is the total of Nursing, Paid and Volunteer Physicians, Social Services, Home Health Aides, and Other Clinical FTEs, above. Do not include bereavement services.				
Non Clinical Include all administrative and general staff or contracts.				
Total Include all staff time. This is the total of Clinical plus Non-Clinical plus Bereavement FTEs, above.				

*Direct care includes all activities involved in care delivery, including visits, telephone calls, charting, team meetings, travel necessary for patient care, and arrangement or coordination of care. When a supervisor provides direct care, estimate the time involved in direct care, as distinct from supervision of other staff or program direction activities.

2. VISITS BY DISCIPLINE Please provide the following information for the time period 10/01/2007 – 9/20/2008. Count ALL visits, regardless of setting (hospital, nursing home, residential facility, etc.). If you own/operate a hospice, inpatient or residential facility-**do not include visits to your facility here.**

Discipline	Total Visits
Nursing Include visits made by RNs and LPs. Include on-call and after hours care visits.	
Social Services Include visits made by medical social services staff as defined by CMS for the cost report. *Do not include chaplains or bereavement staff.*	
Home Health Aide	
Physicians – Paid Include visits made by medical directors and other physicians providing direct care to patient. *Exclude volunteer physicians.*	
Physicians - Volunteer	
Other Clinical Include any paid staff in addition to those captured above who make visits as part of direct care to patients or families. Include chaplains, therapists, and dieticians. *Do not include volunteers or bereavement staff.*	
Bereavement	

3. CASELOADS: Please provide average caseloads (**NOT RANGE**) for the following positions.

	Caseload*
Primary Nurse, Nurse Case Manager *RN with primary responsibility for the patient's care*	
Social Worker *SW with medical social services duties, as defined by CMS*	
Home Health Aide, Nurses Aide, Certified Nursing Assistant	
Chaplain	

** Caseload is the number of patients for which a staff member has responsibility or to which she/he is assigned at a time*

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

4. ADMISSION MODEL: Does your agency utilize dedicated admission nurses for a majority of the initial admission visits? ☐ Yes ☐ No

SECTION G. Patient Demographics

For the period 10/01/07 - 09/30/08, report the number of patients admitted that falls into each category below:

1. GENDER

a. Female _____
b. Male _____
Total _____

2. AGE

Use patient's age on the first day of Admission in FY2008.

a. 0-17 _____
b. 18-34 _____
c. 35-64 _____
d. 65-74 _____
e. 75-84 _____
f. 85+ _____
Total _____

CDC pediatric categories complete, If possible:

g. <1 _____
h. 1-4 _____
i. 5-14 _____
j. 15-24 _____
k. 25-34 _____
Total 0-34 _____

3. ETHNICITY all patients should be categorized as Hispanic or non-Hispanic, and further categorized by Race below.

a. Hispanic (as defined by U.S. Census Bureau) _____
b. Non-Hispanic _____
Total (should equal Race total) _____

4. RACE

a. American Indian or Alaskan Native _____
b. Black or African American _____
c. Asian, Hawaiian or Other Pacific Islander _____
d. White
e. Some other race or races _____
Total (should equal Ethnicity total) _____

Number of admissions should agree to the number of admissions in Sections D, E and I.

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

SECTION H. Processes Of Care

1. DIRECT PATIENT CARE VOLUNTEERS: Provide the following information during the period 10/01/2007 – 09/30/2008.

Volunteers	Number	Hours	Visits
Direct Patient Care Volunteers - Report the number and the hours for volunteers who visit patients. Also note the number of patient visits done by these volunteers (do not include phone calls as a visit).			
Clinical Support Volunteers - Report the number/hours for volunteers who provide patient care support. These volunteers are combined with Direct Patient Care Volunteers, to meet the Medicare Condition of Participation regarding 5% volunteer hours. ***Medicare interpretive guidelines define administrative volunteers in this context as supporting patient care activities (e.g., clerical duties), rather than general support (e.g., fundraising).***			N/A
General Support Volunteers - Report the number and the hours for volunteers who provide general support, such as those who help with fundraising and members of the board of directors. These volunteers ***do not contribute to the 5%*** Medicare Requirement.			N/A
All Hospice Volunteers - Sum of above three categories.			

Prorate number of volunteers (relative to the number of hours) if a volunteer serves in more than one category.

2. BEREAVEMENT SERVICES Provide the following information for 10/01/2007 - 09/30/2008.

	Hospice Family Members	Community Members	Total
Total Number of Contacts by Visit Include any face-to-face one-to-one contact with individuals, regardless of setting. Do not include support group or camp services.			
Total Number of Contacts by Phone Call			
Total Number of Mailings to the Bereaved			
Total Number of Individuals Who Received Bereavement Services Include all individuals enrolled for bereavement, including those served through support groups and camps.			

2009 Hospice Data Supplement Reporting for: License No:

Facility Name: Facility ID:

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

SECTION I. Patient Volume

PATIENTS SERVED BY STATE, BY COUNTY & PATIENT DAYS OF CARE: Please complete the following information (for the period 10/01/2007 to 09/30/2008) for each state and county you served. Make additional copies if needed.

- The number of patients served (Column E) includes carry over patients from the prior year and new admissions.
- Data should reflect all patients served during the reporting period including those in nursing facilities.
- Patients should be listed by county of residence.
- Column J should be the sum of columns F-I. The totals in columns F through J should agree to the totals in **Section C, Item 2.**
- The total of column B (# of admissions) should equal the total admissions in **Sections D, E** and **G.**

STATE #1 _____

A	B	C	D	E	F	G	H	I	J
County	**# of Admissions**	**# of Deaths**	**# of Non-death Discharges**	**# of Patients Served**	**Routine Home Care Days**	**Continuous Care Days**	**Inpatient Care Days**	**Respite Care Days**	**Total Days of Care**
Totals State #1									
State #2 _____									
Totals State #2									

*** Please complete the following totals carefully. This is the primary source of volume data for analysis. ***									
Total – Agency Wide									

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

SECTION J. Nursing Facility Patients Served

NURSING FACILITY PATIENTS SERVED BY PAY SOURCE: Please complete the following information for 10/01/2007 - 09/30/2008 for each county you served, based on who paid for the hospice care. Make additional copies, if necessary.

- These patients are a **subset** of patients reported in Section I.
- Data should reflect all patients served in nursing facility beds during the reporting period.
- Pay source is the source of payment for the hospice services. The source of payment for the nursing facility room and board is irrelevant for this analysis.
- Patients who change pay source during the reporting period should be reported for each pay source with the number of days of care recorded for each pay source.
- Self pay includes all patients with no payor source even if application of a sliding fee scale puts the charge for their care at zero.

County	Patients Served							Patient Care Days						
	Medicare	Medicaid	Private Insurance	Self Pay	VA/ Tri Care	Other	Totals	Medicare	Medicaid	Private Insurance	Self Pay	VA/ Tri Care	Other	Totals
Totals:														

*For questions, contact **The Carolinas Center for Hospice and End of Life Care** at (919) 677-4113, or the Association for Home & Hospice Care at (919) 848-3450.*

SECTION K. Inpatient & Residential Facilities: Please provide the following information for the period 10/01/2007 to 09/30/2008.

1a. Inpatient or Combination Facility Name:

_____

2a. Location:

County:_____

State: _____

3a. Where is the inpatient facility sited?

- ❑ On campus of Free Standing Hospice
- ❑ in Hospital
- ❑ in Nursing Home
- ❑ other (please specify): _____

4. What level of care does the inpatient facility predominantly provide?

- ❑ Acute/General Inpatient – short-term, intensive hospice services provided to meet the hospice patient's need for skilled nursing, symptom management, or complex care.
- ❑ Residential Care – hospice home care provided in a facility rather than in the patient's personal residence.
- ❑ Mixed Use – both acute and residential levels.

5a. If the facility opened during the period 10/01/07 – 09/30/08, please note first month of operation:

_____

1b. Residential Only Facility Name:

_____

2b. Location:

County:_____

State: _____

3b. Where is the residential facility sited?

- ❑ On campus of Free Standing Hospice
- ❑ other (please specify): _____

5b. If the facility opened during the period 10/01/07 – 09/30/08, please note first month of operation:

_____

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SECTION K. INPATIENT & RESIDENTIAL FACILITIES – *continued*

Hospice Inpatient Facility Patients *-and/or-* Hospice Residence Patients

Only freestanding hospice inpatient facilities operated by a licensed hospice or hospice inpatient units with a Certificate of Need for hospice beds ***and/or*** freestanding hospice residences operated by a licensed hospice should complete this table.

Instructions:

- **List each county served and report all inpatient clients admitted or residential patients admitted, by county of residence.** Count each *inpatient* client only once. Count each residential patient only once.
- **The purpose of this table is to collect bed utilization data. Include all patients admitted in the facility even if the care was provided under contract to another hospice.**
- **TOTAL DAYS OF CARE DURING THE TIME PERIOD 10/01/2007 - 09/30/2008 ONLY.** IF A PATIENT WAS ADMITTED BEFORE 10/01/2007, INCLUDE ONLY THE DAYS OF CARE THAT OCCURRED DURING THE TIME PERIOD 10/01/2007 - 09/30/2008 .

Hospice Inpatient Facility Patients					Hospice Residence Patients		
County of Residence	Direct Admits	Transfer from Hospice Home Care	Total Days Of Care	Total # of Deaths	Total Number Of Patients Admitted	Total Days Of Care	Total # of Deaths
Out of State							
Total							