FORM DM-1 Revised 09/2025 THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2025

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
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TELEPHONE: (334) 242-4103
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MONTGOMERY AL 36104
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bradford.williams@shpda.alabama.gov

2025 ANNUAL REPORT FOR HOME HEALTH AGENCIES

SHPDA ID NUMBER FACILITY NAME

Mailing Address:	STREET ADDRESS	CITY	STATE	ZIP		
Physical Address:			AL			
•	STREET ADDRESS	CITY		ZIP		
County of Location:						
Facility Telephone:		Facility Fax:				
_	(AREA CODE) & TELEPHONE NUM	IBER	(AREA CODE) & TELEPH	ONE NUMBER		
This reporting period is for C	October 1, 2024, through Se	ptember 30, 2025 *; or for partia	al year of operation be	eginning		
	and ending	a period of		days.		
should be reported. If there we the current owner. We hereby affirm and atte	as a change in ownership du st that the reported inform the following pages of this	pecified, may be provided, but no more tring the reporting period, data for mation has been verified, and to be report is a true and accurate	the full year should b	e reported by		
PRINTED NAME OF PREPAR	RER SIGN	NATURE OF PREPARER	DATE			
DIRECT TELEPHONE NUMB	ER T	ITLE OF PREPARER	E-MAIL ADDRES	SS		
A member of administration <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and must be separate from the preparer.						
PRINTED NAME OF ADMINISTRATIO	N OFFICIAL SIGNATURE	OF ADMINISTRATION OFFICIAL	DATE			
DIRECT TELEPHONE NUMB	ER TITLE OF	ADMINISTRATION OFFICIAL	E-MAIL ADDRES	SS		
	FOR	OFFICE USE ONLY				
Facility Verified:	Initial Sca		Completed:			
Entered:	Final Sca	in:	Audited:			

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i Agency Ope	rations		
Days of week services a regularly available	are 🔲 Monday – Frid	day □ Sunday-Saturo	day □ Other (specify)
Days on-call only	☐ Weekends	☐ Holidays	☐ Other (specify)
II Ownership Corporation Individual Joint Venture	Non-Profit Healthcare Governme		Partnership LLC Other (specify)
III Branch Offic	es		
Does the organization of	your service include a sta	affed satellite or brand	ch office?
YES CITY OF LOCATION	OPENED IN LAST 12 MONTHS? YES NO	NO DAYS OF WEEK S REGULAR SCHEDULE	ON-CALL ONLY
			_
		-	
IV Drop Sites			
to be a location from whereferrals, advertise, or op-	d authorization to operate nich supplies only are stoperate in any manner as CON approved/exempt c	ored. A drop site ma a branch office (CMS	y not be staffed, accept
YES		_	NO
CITY OF	LOCATION	OPENEI YES	O IN LAST 12 MONTHS? NO
	_		
		<u></u>	

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V Authorized Service Area

List <u>all</u> counties for which your agency and branch offices are approved to provide services, number of visits, and number of persons (unduplicated) served during this reporting period. If no visits were made in an approved county, list "0" for the number of visits and persons served. A contiguous county is not considered to be "authorized" until the home health provider has accepted the first referral and has sent the required notification to SHPDA. A person receiving services during this reporting period should be counted only once, regardless of whether the person was admitted more than once and/or received more than one service. Attach additional sheets as necessary.

COUNTY	VISITS	PERSONS SERVED
TOTALS	*	
	*THIS TOTAL MUST	

Page 3

EQUAL THE TOTAL VISITS IN SECTION VIII.

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VI. ADMISSIONS BY SOURCE OF PAYMENT. List below the total number of admissions, broken down by county of residence, for each payment source category during this annual reporting period. Since a patient may be discharged and readmitted several times during an annual reporting period, and payment source may vary for subsequent readmission(s), most agencies will show more admissions than patients served. Attach additional sheets if necessary.

County of Residence	Self- Pay	Workman Comp	Medicare	Medicaid	Tricare	Blue Cross	All Kids	Other Ins.	Charity	НМО	Other**
Category Totals											
TOTAL ADMISSIO	NS						*THIS TOTA ADMISSIONS	AL MUST EQUAL S IN SECTIONS V IX-B.	THE TOTAL (II, IX-A, AND	k	
**Please specify "other"	navment soi	irce category:									

Physicians

SOURCE

VII. ADMISSIONS BY REFERRAL SOURCE. While it is acknowledged that all patient services are rendered in accordance with a physician's treatment plan, the entity which initiates the patient's entry into the Home Health Care System should be indicated below:

NUMBER OF ADMISSIONS

Hospital	
Nursing Home	
Family or Self	
Department of Human Resources	
Public Health or Agency Nurse	
Other (including Social Service Agencies)	
Specify Other	
TOTAL ADMISSIONS	*
	*THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, IX-A, AND IX-B.
VIII. SERVICES OFFERED. List below the tota services provided, for all visits made during this	
SERVICE	VISITS BY SERVICE
Skilled Nursing Services (RN/LPN)	
Home Health Aide	
Homemaker	
Orderly	
Medical Social Service	
Physical Therapy	
Speech Therapy	
Occupational Therapy	
Medical Equipment	
Other (please specify other service offered):	
TOTAL VISITS BY SERVICE	*
	*TOTAL MUST EQUAL THE TOTAL VISITS ON PAGE 3. SECTION V.

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IX. PATIENT ADMISSION DEMOGRAPHICS

A. ADMISSIONS BY AGE AND GENDER (entire reporting period)

	MALE	FEMALE	TOTAL
18 & under			
19 – 34 years of age			
35 – 54 years of age			
55 – 64 years of age			
65 – 74 years of age			
75 – 84 years of age			
85 years and older			
TOTALS			*
			*THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS

IN SECTIONS VI, VII, AND IX-B

B. ADMISSIONS BY RACE (entire reporting period)

	TOTAL
White/Caucasian	
Black/African American/Negro	
Hispanic/Spanish/Latino	
Asian	
American Indian/Alaskan Native	
Pacific Islander	
India	
Middle Eastern	
Other (Please specify other race category):	
TOTALS	*
	*THIS TOTAL MUST EQUAL
	THE TOTAL ADMISSIONS IN SECTIONS VI, VII, AND
	IX-Δ