

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2025

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
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:

STREET ADDRESS

CITY

AL

ZIP

County of Location:

Facility Telephone:

(AREA CODE) & TELEPHONE NUMBER

Facility Fax:

(AREA CODE) & TELEPHONE NUMBER

This reporting period is for **October 1, 2024**, through **September 30, 2025** *; or for partial year of operation beginning _____ and ending _____ a period of _____ days.

MONTH DAY

MONTH DAY

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this provider.

PRINTED NAME OF PREPARER

SIGNATURE OF PREPARER

DATE

DIRECT TELEPHONE NUMBER

TITLE OF PREPARER

E-MAIL ADDRESS

A member of administration MUST 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 ADMINISTRATION OFFICIAL

SIGNATURE OF ADMINISTRATION OFFICIAL

DATE

DIRECT TELEPHONE NUMBER

TITLE OF ADMINISTRATION OFFICIAL

E-MAIL ADDRESS

FOR OFFICE USE ONLY

Facility Verified: _____

Initial Scan: _____

Completed: _____

Entered: _____

Final Scan: _____

Audited: _____

I **Agency Operations**

Days of week services are regularly available

☐ Monday – Friday

☐ Sunday-Saturday

☐ Other (specify)

Days on-call **only**

☐ Weekends

☐ Holidays

☐ Other (specify)

II **Ownership**

☐ Corporation

☐ Non-Profit Organization

☐ Partnership

☐ Individual

☐ Healthcare Authority

☐ LLC

☐ Joint Venture

☐ Government

☐ Other (specify)

III **Branch Offices**

Does the organization of your service include a staffed satellite or branch office?

YES		NO		
CITY OF LOCATION	OPENED IN LAST 12 MONTHS?		DAYS OF WEEK SERVICES AVAILABLE	
	YES	NO	REGULAR SCHEDULE	ON-CALL ONLY

IV **Drop Sites**

Has this agency received authorization to operate a drop site? NOTE: A drop site is considered to be a location from which supplies **only** are stored. A drop site may not be staffed, accept referrals, advertise, or operate in any manner as a branch office (CMS S&C-05-07). Drop sites can only be operated in CON approved/exempt counties.

YES		NO	
CITY OF LOCATION	OPENED IN LAST 12 MONTHS?		
	YES	NO	

*

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2025

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:

SOURCE	NUMBER OF ADMISSIONS
Physicians	_____
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 total number of services provided, broken down by services provided, for all visits made during this reporting period.

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.

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-A**