FORM HPCE-2
IN-HOME HOSPICES
8/2008

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2008
2007 REPORT

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
paul.may@shpda.alabama.gov

2007 ANNUAL REPORT FOR IN-HOME HOSPICES

TYPE FACILITY ID # HERE

TYPE FACILITY NAME HERE

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, 2006, through September 30, 2007*; or for partial year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*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 <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.

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:	

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I. PROGRAM DEMOGRAPHICS

A. Agency Type

- ◯ Free Standing
- ◯ Home Health Based
- ◯ Government/Healthcare Authority Based
- ◯ Hospital Based
- ◯ Nursing Home Based

B. Ownership

- ◯ Corporation
- ◯ Individual
- ◯ Joint Venture
- ◯ Non-Profit Organization
- ◯ Healthcare Authority
- ◯ Government
- ◯ Partnership
- ◯ LLC
- ◯ Other (specify) _____

C. Reporting Entity

1. Does this agency have the capability to provide patient information, specific only to this licensed location? ◯ YES ◯ NO

2. If no, provide the name of the licensed hospice agency that will be reporting patient information for this entity:

SHPDA ID #: _____

NAME OF REPORTING HOSPICE: _____

NAME OF CONTACT: _____

TELEPHONE NUMBER: _____

3. Will the information contained in this report include patient information from other licensed hospice agencies, for services offered and performed in the State of Alabama? ◯ YES ◯ NO

4. If yes, provide the SHPDA ID # and the name of the licensed hospice agency(ies) for which information is included in this report:

SHPDA ID #:	**NAME OF HOSPICE AGENCY**

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II. ADMISSIONS

A. ADMISSIONS BY COUNTY OF RESIDENCE

(This data should reflect all patients served during the reporting period, including those in nursing facilities. Information should be provided by county of residence. Attach additional sheets as necessary.)

COUNTY	NUMBER OF ADMISSIONS	NUMBER OF DEATHS	NUMBER OF NON-DEATH DISCHARGES	NUMBER OF PATIENTS SERVED (include carryover from the prior year)	ROUTINE HOME CARE DAYS	CONTINUOUS CARE DAYS	INPATIENT CARE DAYS	RESPITE CARE DAYS	TOTAL CARE DAYS (sum of routine home, continuous, inpatient & respite care days
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
TOTALS	** 0	0	0	0	0	0	0	0	0

****TOTAL NUMBER OF ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-C, AND II-D.**

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B. PATIENT DAYS BY PAYMENT SOURCE

Provide the number of patient days for all patients including those in hospitals, specialty care assisted living, and nursing facilities, for the reporting period.

HOSPICE PAYMENT SOURCE	NUMBER 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						0
Hospice Medicaid						0
Private Insurance/ Managed Care (non-Medicare)						0
Charity/ Indigent						0
Private Pay						0
Other (VA, Worker's Comp, etc)						0
TOTALS	0	0	0	0	0	0

C. ADMISSIONS BY DEMOGRAPHICS

Use the patient's age on the first day of admission.

AGE GROUPS	MALE	FEMALE	TOTAL
18 and under			0
19 – 34			0
35 – 54			0
55 – 64			0
65 – 74			0
75 – 84			0
85 years and older			0
TOTAL ADMISSIONS	0	0	** 0

****TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A AND II-D.**

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D. TOTAL ADMISSIONS BY RACE

RACE	ADMISSIONS
a. White/Caucasian	
b. Black/African American/Negro	
c. Hispanic/Spanish/Latino	
d. Asian	
e. American Indian/Alaskan Native	
f. Pacific Islander	
g. India	
h. Middle Eastern	
i. Other	
TOTAL ADMISSIONS	** 0

****TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A, AND II-C.**

III. REVENUES AND EXPENSES (***AMOUNTS DO NOT HAVE TO BE AUDITED)***

EXPENSES		REVENUES	
Payroll	$ .00	Medicare	$ .00
Non-Payroll	$ .00	Medicaid	$ .00
Transportation	$ .00	Commercial Insurance	$ .00
Bad Debt	$ .00	Private Pay	$ .00
Charity	$ .00	Other	$ .00
TOTAL EXPENSES	$ 0.00	**TOTAL REVENUES**	$ 0.00