INFORMATION TO ASSIST HOME HEALTH AGENCIES IN PREPARATION FOR SURVEY

Dear Applicant:

The following information must be available in your agency's office for review by the Indiana State Department of Health surveyor to conduct an initial licensure/certification or re-licensure/re-certification survey:

Applicable Corporations

- Articles of Incorporation
- Corporate Bylaws
- Names of the members of the your Board of Directors
- Minutes of meeting of your Board of Directors

Applicable to All

- Organizational Chart
- Written designation of the Agency's Administrator
- Written designation of the agency's Supervising Physician or Registered Nurse
- Written designation of the agency's Alternate Administrator
- Written designation of the agency's Alternate Supervising Physician or Registered Nurse
- Personnel records for all employees and contract employees providing in-home care, including documentation that employees meet job qualifications
- Copy of certification of license as applicable, if survey is for re-licensure or re-application
- A physician-signed health statement and results of a Mantoux skin test or chest x-ray
- Contracts for therapy services (i.e. physical therapy, occupational therapy, etc.), for individuals or companies, which meet the statutory and/or

regulatory requirements (410 IAC 17-4-1-(k) for state licensure; CFR 484.14 for Medicare/Medicaid certification)

- Copy of the agency's annual budget, name(s) of individuals(s) who developed the budget, and the budget approval process
- Agency policies and procedures for patient care and personnel practices

The following is what the surveyor will provide you during the entrance conference:

FACILITY COPY

Please provide the following to the surveyor <u>within 1 hour</u> of conclusion of the entrance conference: Time entrance conference concluded: _____

☐	Facility Census Form
☐	List of ALL active patients to include: Patient name; certification dates (SOC/ROC); admitting diagnosis; services provided by discipline, case manager
☐	Provide listing of ALL patients receiving the following clinically complex specialized services and Treatments: * Infusion Therapy * Pediatric Care *Anticoagulant Therapy Management *Mechanical Ventilator * Tracheostomy Care * Wound Care * Pressure Ulcer Care * Foley Catheter *Enteral Feeding *Receiving Dialysis
☐	Admission Packet---- Review for: ☐ Written notice of patient rights ☐ OASIS Privacy Notice ☐ Advance Directives ☐ Written notice of transfer/discharge policy ☐ HHA administrator contact information
☐	Organizational Chart Parent, and branches if applicable
☐	Complete list of discharged patients for the last 6 months, including: patient name, SOC/DC date, diagnosis, services patient disposition at time of discharge.
☐	List of ALL patients scheduled for home visits during the survey; incl. branches, including: date/time of visit, staff name with discipline assigned, location of patient (city) *This is for ALL patients, including contracted services, regardless of payer source.*
☐	Current list of ALL employees, to incl. contracted personnel, with the following: name of employee/contracted staff, job title, date of hire, first patient contact date, phone number.
☐	**MEDICARE ONLY PROVIDERS:** Emergency Preparedness Plan
	Provide by end of first survey day:
☐	Completed CMS-1572
	Provide within 24 hours of entrance conference:
☐	Complaint log
☐	Abuse tracking log, if applicable
☐	Completed Home Health State Form "STATE FORM" Landscape orientation-contains hours of operation, email, etc.
☐	Verification of compliance of Indiana Drug Screen Requirements
☐	Geographic location form
	I have received a copy of the entrance checklist and the surveyor has reviewed the document with me and understand I am to provide these documents in accordance with timeframes specified. **SIGNATURE:** _____