Provider Profile

Provider Name: _____

License DBA Name : _____

Provider Contact:

Name: _____

Position: _____

Full Mailing Address: _____

_____

Phone: _____

FAX: _____

Business Email: _____ Preferred Correspondence Email:

Website: _____ _____

NOTE: *Please make sure to "whitelist" cahcnj.org in your email systems*

Provider Classification (select one):

- ☐ Voluntary non-profit
- ☐ Proprietary, For Profit
- ☐ Other (Specify): _____

Sites seeking accreditation renewal:

# of sites for accreditation: _____

List other site locations:

_____ City/town _____ City/town

_____ City/town _____ City/town

_____ City/town _____ City/town

Profile Prepared By: _____ Print Name _____ Position _____ Phone

_____ Signature _____ Date

General Information

Provider Name: _____

License DBA Name : _____

Site Information:

Address: _____

Town/City: _____

County: _____

Phone: _____

On-Call# (off hours): _____

FAX: _____

Supervisory Personnel at the Site:

CPCS: Director of Nursing: ☐ Ms. ☐ Mr. Name: _____

CBSN: Director of Nursing: ☐ Ms. ☐ Mr. Name: _____

Corporate Compliance Officer: ☐ Ms. ☐ Mr. Name: _____

Miscellaneous:

Days and hours:

Days and hours office is open: _____

Days and hours of service: CPCS: _____ CBSN: _____

On-Call days and hours: CPCS: _____ CBSN: _____

CBSN: Is a Nursing Supervisor available 24 hours a day, seven days a week for assistance, if needed?

☐ Yes ☐ No

List all services provided at this site:

☐ CPCS

☐ CBSN

☐ Other (specify): _____

Statistics

Case Management

The Surveyor will select clinical records of any clients who received service during the period of accountability.

1) **Please report the following based upon statistics during the period of accountability (up to the present day)*:***

CPCS	**CBSN**	
_____	_____	Number of active cases
_____	_____	Number of discharged cases
_____	_____	Number of cases "on hold"
_____	_____	**Total** number of cases serviced during period of accountability

2) **Report the following numbers of clients for the period of accountability**:

CPCS	**CBSN**	Enter the number of clients **currently** receiving care:
_____	_____	Pediatric (up to age 21)
_____	_____	Adult
_____	_____	Geriatric

3) **For the past 12 months:**

	CPCS	**CBSN**
Total number of cases serviced: (total # current active cases + discharges)	_____	_____
Total number of <u>service hours</u> provided	_____	_____

Personnel Management

The Surveyor will select personnel records of any staff member worked during the period of accountability.

*Report the **current** statistics concerning directly-employed personnel at this site:*

	CHHAs	RNs	LPNs
Available to work:	_____	_____	_____
Assigned to cases:	_____	_____	_____

Enter the following data regarding **nursing supervisory personnel** who worked at this site during the period of accountability:

full time: _____
part time: _____ (Full Time Equivalent (FTE) for part time personnel: _____) # per diem _____

Please list all **nursing supervisory personnel** who have worked since the last survey. Include all new hires and nurses that worked during the period of accountability, including any now terminated.

Name:	*Title:*	*First day worked / last day worked*
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____
_____	_____	_____/_____

If the **Director of Nursing or Nursing Supervisor has changed in past year, please be sure that CAHC has a copy of the resume or employment application for that employee.

Report the following based upon the past 12 months:

Does your agency directly employ all aides/field nurses? ☐Yes ☐No
Does your agency directly employ all supervisory personnel? ☐Yes ☐No
CPCS: Are all aides certified? ☐Yes ☐No
Does this site subcontract for aides/field nurses? ☐Yes ☐No

Is malpractice insurance required of your nursing staff? ☐Yes ☐No

Are periodic physical exams required for staff? ☐Yes ☐No
If yes, how often? _____

Time frame for **Post Orientation Evaluations**: _____

Do you have additional specific requirements for your field staff ? ☐Yes ☐No

If yes, what are those requirements? _____
_____
_____

Please attach an updated and complete **Organizational Chart.**

1) Who will be assigned to assist the surveyor with **Personnel Records** at the time of the survey?

Name:	Title:	Department:
_____	_____	_____

2) Who will be assigned to assist the surveyor with **Clinical Records** at the time of the survey?

Name:	Title:	Department:
_____	_____	_____

3) Who will be assigned to assist the surveyor with **Administrative** matters at the survey?

Name:	Title:	Department:
_____	_____	_____

*****All staff assigned to assist during the survey must have a thorough understanding and ability to access relevant files. All records must be easily accessible during the survey. Any delay in receiving files may result in the need for a follow up visit (with additional cost to the provider.)***

For CBSN Services:

What is the frequency of **renewal of orders** from physicians? _____

What is the frequency of **updates** to the medication profile? _____

PLEASE LIST ALL CAHC REQUIRED **FORMS, POLICIES, OR JOB DESCRIPTIONS** ***REVISED OR ADDED*** SINCE THE LAST SURVEY.

POLICY/JOB DESCRIPTION/FORM NAME:	REVISION/IMPLEMENTATION DATE
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/ _____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

If additional space is needed, please include separately.

****PLEASE INCLUDE A COPY OF EACH DOCUMENT WITH THIS PROFILE****

Parking Information/Questionnaire:

- Please include any information about parking that will be useful for the surveyor
- Attach a sheet containing additional parking information if available
- If separate sheet is attached, include the agency name, address and phone number

1. Do you have your own parking lot?

☐ No (Describe parking situation): Ex: Street parking, Meter parking, Garage parking

_____

_____

_____

_____

_____

☐ Yes (Describe location): _____

_____

_____

_____

_____

_____

2. Do you have assigned visitor parking?

☐ No

☐ Yes

3. If offsite parking, what is the distance from your location:

_____

_____

_____

Provider Questionnaire

1. Is there another address that needs to be entered into GPS?

   ☐ No

   ☐ Yes (list address): _____

   _____

   _____

2. What floor is the agency located on: _____

3. Is there access to an elevator?

   ☐ No

   ☐ Yes

4. Is there a restroom available on the same floor?

   ☐ No (list floor): _____

   ☐ Yes

5. Do you have a room/desk/chair for the surveyor?

   ☐ No

   ☐ Yes: _____

6. Is there heating/air conditioning depending on the weather?

   ☐ No

   ☐ Yes

7. Do you have an additional number for on-call?

   ☐ No

   ☐ Yes (Provide Number): _____

8. Do you have an additional email address?

   ☐ No

   ☐ Yes (Provide Email): _____