Add your Logo

Company: ____________________

Phone: ____________________

Fax: ____________________

Home Health Agency Screening Questionnaire

Name of Agency: ______________________________ Date of Screening: ____________________

Point of Contact for Escalated Clinical Questions: ____

Any Additional Point of Contacts for Reference: ____

Do You Have Bilingual Nursing Staff Available? ☐ YES ☐ NO

Do You Have Language Line ASL Availability? ☐ YES ☐ NO

Spanish Speaking? ☐ YES ☐ NO Other: ________________________________

Zip Codes/Counties You Service: ____

List of Payers/Insurance Accepted: ____

Medicare Certified? ☐ YES ☐ NO Pediatric Patients Accepted? ☐ YES ☐ NO

Types of Home Health Services Provided? ☐ SN ☐ PT ☐ OT ☐ MSW ☐ HHA

Chemotherapy Certified Nurses: ____

Do Your Agency Accept Specialty Patients? ☐ YES ☐ NO

What Are the Specialty Services You Offer? ☐ IVIG ☐ MABs

What is Your Intake Process? *(Phone, Fax, Forms, Documentation and Order Requirements, etc.)*

____

What Are Your Hours of Operations? ______________ Do You Have After Hour Abilities? ______________

Does Your Agency Place Peripheral Lines in the Home? ☐ YES ☐ NO

Does Your Agency Give First Dose in the Home? ☐ YES ☐ NO

Does Your Agency Infuse Cathflo®/Alteplase? ☐ YES ☐ NO

Does Your Agency Offer Any Type of Patient Supply Cost/Coverage Assistance? ☐ YES ☐ NO

Additional Comments: ____