



Arizona In-Home Care Association Business Member Profile

Member Information

Business Name: _____

Registered Name (if different from above): _____

Address: _____
Street City State Zip

Telephone: _____ Fax: _____

Email: _____ Website: _____

Counties Served: _____

Weekly Operational Schedule:

7 days/week Monday thru Friday only Hours of Operation: _____

Available after hours? Yes No After Hours Phone: _____

Other business locations: .

Services Offered:

Light Housekeeping:

Sweep/Vacuum/Mop Yes No
 Clean bathroom(s) Yes No
 Make bed Yes No

Kitchen:

Meal Preparation Yes No
 Wash Dishes Yes No
 Menu Planning Yes No

Laundry:

Change bedding: Yes No
 Laundry: Yes No

General Household:

Assist w/organization Yes No
 Assist w/reading/writing Yes No

Transportation/Shopping:

Accompany client to medical, or other, appointments Yes No
 Caregiver drives **clients** vehicle for such trips Yes No
 Caregiver drives **personal** vehicle for such trips Yes No
 Are caregivers who drive on behalf of your clients
 required to have clean driving records? Yes No
 Are those caregivers driving records verified via DMV? Yes No

How do caregivers assist in the following home care aide tasks?

- Complete Hands-on Assistance Limited Hands-on Assistance No Hands-on Assistance
- | | |
|---|---|
| <ul style="list-style-type: none"> - Bathing/Showering/Personal Hygiene - Medication monitoring - Transfers (to/from bed, chair, etc.) | <ul style="list-style-type: none"> - Dressing/Undressing - Toileting/Peri Care - Ambulation (assist w/walking, etc.) |
|---|---|

Other Services (check all that apply):

- Registered Nursing Services
- Medical Social Services
- Nutritional Services by a Dietitian
- Speech Therapy
- Respiratory Therapy
- Hospice Services
- Licensed Practical Nursing Services
- Occupational Therapy
- Physical Therapy
- Provide Medical Supplies/Equipment

Are any of your employees Registered or Licensed for the above services? Yes No

Does your company have a home health license? Yes No

Does your company accept AHCCCS / ALTCS Payments: Yes No

Client/Consumer Information and Practices

YES NO

We perform an evaluation or assessment prior to providing care for clients.

We charge a fee for any type of evaluation or assessment prior to providing care for a client. If Yes, please indicate the amount charged for this service: \$_____

We require a deposit from customers in order to perform services. If yes, please explain:

We charge one or more of the following fees.

Set-up or Start-up fees Amount: \$_____

Administrative fees Amount : \$_____

Cancellation fees Amount: \$_____ (see below)

Other fees Explain: _____

We have a minimum amount of hours, whether per day, per week or per month, or minimum charge that is required of its clients. If Yes, please explain: _____

We have a business policy regarding cancellation of services. If Yes, please explain:
Amount: \$_____ Details: _____

Member's Employment Information and Practices

YES NO

Does the business have and perform criminal background checks for all individuals who have direct contact with clients in their homes or in the community?

Does the Member perform criminal background checks for all managers, supervisors, office personnel and volunteers?

Does the business obtain at least two positive references from two previous employers in the past five years for each caregiver applicant?

Does the Member validate home-making and home care skills of caregivers through demonstration and written questionnaires?

Does the Member require all caregivers to read, write and communicate in English?

Does the Member require its Caregivers to maintain current First Aide certification and have policies in place to ensure these are updated on a routine basis?

YES **NO**

___ ___ Does the Member require its Caregivers to maintain current CPR certification and have policies in place to ensure these are updated on a routine basis?

___ ___ Does an employee of the Member conduct an interview with caregiver applicants that cover employment history experience, training, skills and employment preferences?

___ ___ Does the Member perform drug testing for all new employees?

___ ___ Does the Member perform random drug testing for all employees?

___ ___ Does the Member require all caregiver employees to be tested for TB annually?

___ ___ Are Member's Caregivers W-2 Employees. If no, please explain below.

Comments: _____

Business Information:

Name(s) of Owner(s), Officer(s), Director(s), followed by Title:

Operating as a Business since: _____ AZNHA Member Since: _____

Comments: _____

