



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:

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

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

Do caregivers assist in the following home care aide tasks? Yes No

- | | |
|--|---------------------------------------|
| - Bathing/Showering/Personal Hygiene | - Dressing/Undressing |
| - Medication monitoring | - Toileting/Peri Care |
| - Transfers (to/from bed, chair, etc.) | - Ambulation (assist w/walking, etc.) |

Does your agency offer:

- | | |
|--|--|
| <input type="checkbox"/> Registered Nursing Services | <input type="checkbox"/> Hospice Services |
| <input type="checkbox"/> Medical Social Services | <input type="checkbox"/> Licensed Practical Nursing Services |
| <input type="checkbox"/> Nutritional Services by a Dietitian | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Respiratory Therapy | <input type="checkbox"/> Provide Medical Supplies/Equipment |

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 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:
Details: _____
- Other fees Explain: _____

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 caregiver employees?
- ___ ___ Does the Member perform random drug testing for cause for caregiver 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: _____

Additional Information: _____

