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: .

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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

Laundry:
- Change bedding: __ Yes __ No
- Laundry: __ Yes __ No

Kitchen:
- Meal Preparation __ Yes __ No
- Wash Dishes __ Yes __ No
- Menu Planning __ 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

Revised May 8, 2018

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

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

Does your agency offer:

___ 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

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: ____

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Business Information:

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

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Operating as a Business since: _________________ AZNHA Member Since: _______________

Additional Information: ____

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Revised May 8, 2018