



Arizona In-Home Care Association Agency 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:
Amount: \$_____ 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: