Member Information

Business Name: _____

Registered Name (if different from above): _____

Address: _____
    Street   City   State Zip

Telephone: _____ Fax: _____

Email: _____ Website: _____

Please list zip codes and/or cities you serve. And if you are a franchise agency please provide the zip codes you serve. _____

_____

_____

Weekly Operational Schedule:

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

Available after hours? ___ Yes ___ No After Hours Phone: _____

Other business locations: (address, phone and contact name/email)

_____

_____

_____

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

Does your agency provide the following services? ___ Yes ___ No

<u>Light Housekeeping</u>:   <u>Kitchen</u>:
 Sweep/Vacuum/Mop   Meal Preparation
 Clean bathroom(s)   Wash Dishes
 Make bed   Menu Planning

<u>Laundry</u>:   <u>General Household</u>:
 Change bedding: Assist w/organization
 Laundry: Assist w/reading/writing

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.)

Transportation/Shopping: __Yes   __ No

    Accompany client to medical, or other, appointments

    Caregiver drives *clients'* vehicle for such trips

    Caregiver drives *personal* vehicle for such trips

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

Does your agency offer:

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

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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:
_____
_____
_____

____ ____ 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?

YES   **NO**

___ ___ 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?

___ ___ 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: _____