



**HOME HEALTH CARE / HOSPICE / DME SUPPLEMENTAL APPLICATION**

This application must be completed in conjunction with the CNA Allied Health Care Facilities Common Application.

**Instructions:**

1. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

1. **Name of Applicant:** \_\_\_\_\_

2. **Type of Operations** (check all that apply):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Behavioral Health              | <input type="checkbox"/> Dialysis            | <input type="checkbox"/> Home Health Care           |
| <input type="checkbox"/> Hospice                        | <input type="checkbox"/> Infusion Therapy    | <input type="checkbox"/> Medical Equipment Supplier |
| <input type="checkbox"/> Nurse Registry/Staffing Agency | <input type="checkbox"/> Oxygen Supplier     | <input type="checkbox"/> Pharmacy Retail            |
| <input type="checkbox"/> Pharmacy Closed                | <input type="checkbox"/> Respiratory Therapy | <input type="checkbox"/> Telemonitoring (Describe)  |

Other (Describe): \_\_\_\_\_

3. **Where do you provide services?**

- |                     |                               |                       |
|---------------------|-------------------------------|-----------------------|
| Private Home _____% | Doctor's Office/Clinic _____% | Hospital _____%       |
| Hospice _____%      | Nursing Home _____%           | Child Day Care _____% |
| Surgicenter _____%  | Adult Day Care _____%         |                       |
| Other _____%        | Describe: _____               |                       |

4. **Current Number of Patients:** \_\_\_\_\_

- a. Typical % of pediatric patients \_\_\_\_\_%
- b. Typical % of adult patients \_\_\_\_\_%

5. **Indicate % of Gross Receipts by Type of Care and Visits.** "Visits" are defined as the number of patients entering the facility for health related services per year.

Services	% of Gross Receipts	Projected Annual Number of Visits
Activities of Daily Living	%	
Apnea Monitor	%	
Behavioral Health	%	
Dialysis	%	
Handy Man Services	%	
Home Dialysis	%	
Hospice Care – Homebound	%	
Hospice Care –Institutional	%	# of Beds
Infusion Therapy	%	

