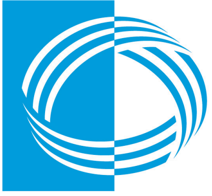

Georgia Department of Community Health

2008 Personal Care Home Survey

Part A : General Information

1. Identification

UID:

Facility Name:

County:

Street Address:

City:

Zip:

Mailing Address:

Mailing City:

Mailing Zip:

2. Report Period

Please report data for July 1, 2007 through June 30, 2008.
Do not use a different report period.

Check the box to the right if your facility **was** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name:

Contact Title:

Phone:

Fax:

E-mail:

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

2A. Operator Lessee? Check the box if the operator, if any, reported in Part C Question 1.c is a lessee ☐

2B. Operator SubLessee? Check the box if the operator, if any, reported in Part C Question 1.c is a sublessee ☐

3. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐

If you checked the box for yes, please provide a list of the parties involved and the date of change.

4. Owner Operation of Other Healthcare Facility

Check the box to the right if the Owner(s) reported in question C.1.a/b above also own or operate any other personal care home(s), nursing home(s) and/or any other health care facilities in Georgia as of the last day of the Report Period. ☐

If you checked the box for yes, please provide a list of the facilities, including the city and county of each location.

5. Organization Affiliations

Organizational Affiliations as of the last day of the Report Period. If item 5a,5b,5c or 5d is checked, provide the name of the organization.

5a.

Check the box to the right if your facility is organizationally related to a retirement complex. ☐

Retirement Complex Name:

5b.

Check the box to the right if your facility is organizationally related to a nursing home. ☐

Nursing Home Name:

5c.

Check the box to the right if your facility is organizationally related to a hospital. ☐

Hospital Name:

Location of your facility:

5d.

Check the box to the right if your facility is organizationally related to a hospice. ☐

Hospice Name:

6. Special Programs

Does your facility have special unit(s) to provide any of the following programs? (check the appropriate boxes.)

6a. Alzheimer's Disease? ☐

6b. Respite Care? ☐

6c. Mental Retardation/Mental Health Residential? ☐

6d. Adult Day Care? ☐

6e. Any Other? ☐

Specify:

Part D : Beds and Utilization

1. Total Beds
Please report the total beds set up and staffed (all beds both occupied and vacant) as of June 30, 2008.

2. Private Insurance
Please report the average percent of persons living at your facility who pay by private insurance (long term care insurance).

3. Average Daily Occupancy
Please report the average daily occupancy (number of beds rented) during the report period. For example, if your facility has 100 beds and there are usually 10 beds vacant, your average daily occupancy is 90.

4. Average Monthly Charge
Please report the average monthly charge for room and board (no extra services) for the report period.

5. Patients by Age Group and Gender

Please report the total residents on the last day of the Report Period (6/30/2008) provided by age and sex. Do not substitute admissions for residents. The Total All Ages column must equal the total by race/ethnicity in Question 6. In addition, these totals must match the calculated total resident occupancy from Part D Question 7 and the total in Part F.

Gender	Ages 0-14	Ages 15-64	Ages 65-74	Ages 75-85	Ages 85+
Male					
Female					

6. Patients by Race/Ethnicity

Please report the total number of patients as of 6/30/2008 using the following race and ethnicity categories.

Race/Ethnicity	Number of Patients
American Indian/Alaska Native	
Asian	
Black/African American	
Hispanic/Latino	
Pacific Islander/Hawaiian	
White	
Multi-Racial	

7. Admissions, Discharges and Discharged Days of Care for the Report Period:

Resident Occupancy as of 6/30/2007:
Total Admissons:
Total Live Discharges:
Total Discharges to Death:
Total Resident Occupancy as of 6/30/2008:

Part E : Financial Data and Indigent/Charity Care

1. Indigent Charity Care Policies: Check the Box to the right if the home had a formal writen policy or policies during the State Fiscal Year 2008 concerning the provision of care to residents who are indigent (income at or less than 125% of the federal poverty level) or who qualify for charity care (income above 125% of the federal poverty level as defined by the policy) ☐

2. Financial Data

Please provide the following financial data for State Fiscal Year 2008 (7/1/2007 to 6/30/2008). Responses should be limited to financial data from the personal care home program only. Gross Revenue should reflect total billings for all personal care home services during the year for all residents billed. Bad Debt should reflect any portion of the billings that residents legally owed but failed to pay. Indigent and Charity care reflects service costs that were written off or forgiven by the home because the resident qualified for indigent or charity care pursuant to state law or the home's charity policy. In case of indigent or charity care, the resident is authorized by the home to receive free services or services at a reduced cost. The number of residents is the total number that contributed to the revenue for the year.

Category	Dollar Amount	Number of Residents
Gross Revenue:		
Bad Debt		
Indigent/Charity Care:		

Part F : Patient Origin

County	Residents
Alabama	
Appling	
Atkinson	
Bacon	
Baker	
Baldwin	
Banks	
Barrow	
Bartow	
Ben Hill	
Berrien	
Bibb	
Bleckley	
Brantley	
Brooks	
Bryan	
Bulloch	
Burke	
Butts	
Calhoun	
Camden	
Candler	
Carroll	
Catoosa	
Charlton	
Chatham	
Chattahoochee	
Chattooga	
Cherokee	
Clarke	
Clay	
Clayton	
Clinch	
Cobb	
Coffee	
Colquitt	
Columbia	
Cook	
Coweta	
Crawford	
Crisp	
Dade	

Dawson	
Decatur	
DeKalb	
Dodge	
Dooly	
Dougherty	
Douglas	
Early	
Echols	
Effingham	
Elbert	
Emanuel	
Evans	
Fannin	
Fayette	
Florida	
Floyd	
Forsyth	
Franklin	
Fulton	
Gilmer	
Glascock	
Glynn	
Gordon	
Grady	
Greene	
Gwinnett	
Habersham	
Hall	
Hancock	
Haralson	
Harris	
Hart	
Heard	
Henry	
Houston	
Irwin	
Jackson	
Jasper	
Jeff Davis	
Jefferson	
Jenkins	
Johnson	
Jones	

Lamar	
Lanier	
Laurens	
Lee	
Liberty	
Lincoln	
Long	
Lowndes	
Lumpkin	
Macon	
Madison	
Marion	
McDuffie	
McIntosh	
Meriwether	
Miller	
Mitchell	
Monroe	
Montgomery	
Morgan	
Murray	
Muscogee	
Newton	
North Carolina	
Oconee	
Oglethorpe	
Other Out of State	
Paulding	
Peach	
Pickens	
Pierce	
Pike	
Polk	
Pulaski	
Putnam	
Quitman	
Rabun	
Randolph	
Richmond	
Rockdale	
Schley	
Screven	
Seminole	
South Carolina	

Spalding	
Stephens	
Stewart	
Sumter	
Talbot	
Taliaferro	
Tattnall	
Taylor	
Telfair	
Tennessee	
Terrell	
Thomas	
Tift	
Toombs	
Towns	
Treutlen	
Troup	
Turner	
Twiggs	
Union	
Upson	
Walker	
Walton	
Ware	
Warren	
Washington	
Wayne	
Webster	
Wheeler	
White	
Whitfield	
Wilcox	
Wilkes	
Wilkinson	
Worth	
Total	

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Signature of Chief Executive:

Date:

Title:

I hereby certify that I am the financial officer authorized to sign this form and that the information is true and accurate. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Comments: