WALTERS & ASSOCIATES
CPAs
CERTIFIED PUBLIC ACCOUNTANTS

HOME HEALTH AGENCY START UP QUESTIONNAIRE

Today's Date: _____

1. Please provide the following agency information:

Agency Name	
Contact Name	
Agency Address	
Agency City, State and Zip	
Agency Phone	
County	
Agency Fax	
Email Address	
Date Agency was founded	
Type of Agency	___ Skilled - If Skilled, a Director of Nursing (DON) is required. ___ Non-skilled

2. Provide the employee names, position, salary, and number of hours worked at each position

Position	Name	Number of Hours per Week	Hourly Salary
Administrator			
Director of Nursing			
Alternate Administrator			
Financial Officer			
Other -			
Other -			
Other -			
Other -			

3. List the agency rent amount and lease terms.

4. Itemize start-up cost and identify if these amounts will reduce your current cash available

Expense Item	Amount	Has Item already been paid? Y or N
Advertising		
Equipment Purchases		
Legal Cost/ Consulting		
Beginning Inventory		
Insurance		
License Fee		
Accreditation Survey and/or Medicare & Medicaid Certification		
Building Deposits		
Utility Deposits		
Other Deposits		
Staffing Recruitment		
Staff Training		
Other -		
Other -		
Total		

5. Which services will be provided by Salary/Contractors? Please indicate with an "X" in each column.

Discipline	N/A	Salary	Contract
Skilled Nursing			
Physical Therapy			
Occupational Therapy			
Speech Therapy			
Medical Social Services			
Home Health Aide			
Homemaker/Companion			
IV			
RT			
Nutritional Guidance			

6. Please list your estimated billing rates per discipline.

Discipline	Billing Rates
Skilled Nursing	$
Physical Therapy	$
Occupational Therapy	$
Speech Therapy	$
Medical Social Services	$
Home Health Aide	$
Homemaker/Companion	$
IV	$
RT	$
Nutritional Guidance	$

7. If your State requires you to provide one service by direct employees only, Skilled Nursing will be used for this requirement. In other words, you would have to pay the nurses through payroll (W-2). If you would like a different service to be used instead, please indicate that service_____.

8. Identify the amount of cash on hand. Is it currently in the bank and available?

9. Identify the owners and percentage owned.

10. Are any of the owners skilled (for example Therapists or Nurses)? If so, please list.

11. Have you developed a business plan? Is so, please attach for review. If not, one will be provided.

12. Which types of payers will you accept?

Payer	Indicate "Y" or "N"
Private Pay	
Medicare	
Medicaid	
Insurance	
HMO/PPO	

13. Explanation of how you expect to recruit patients and estimate of patient volume once licensed.

14. Please indicate the Accreditation body you will use, if applicable.

    ☐ Accredidation Commission for Homecare (ACHC)

    ☐ Community Health Accredidation Program (CHAP)

    ☐ The Joint Commission

15. Will you be part of a Franchise? If so, please list the franchise cost and monthly fee.

16. Please identify the person completing this form and list contact information.

17. Please list the email address where you would like the completed project to be scanned and emailed.

18. Is it ok to include your agency on my website listing past and present clients/references?

19. Please explain how you learned about Walters & Associates, CPAs:

    ___ Our Web Site/Internet

    ___ Consulting Company (name) _____

    ___ Other Referral Source _____

☐ Please check box for **RUSH SERVICE**.

Please note this process takes 10 business days to complete. If you would like a RUSH placed on this service (to be done within **3 business days**), there will be a **$350 additional charge.**

Once complete, please email this form to nancy@waltersaccounting.com or fax it to 727-279-2851. Feel free to call Doug at 941-756-0700 with any questions. Thank you.