Home and Community Based Care: Telehealth Annual Survey

IMPORTANT: Please note. All required fields (red asterisk) must be entered before a form can be saved. Otherwise data may be lost.

IMPORTANT: Please note. All numeric and decimal fields must be entered without commas or special characters such as dollar sign

IMPORTANT: Please note. Although data may be entered by individuals who are designated in the Communications Directory as Data Reporter,HPN Coordinator,Director of Home Care Services or Administrator, the report can only be submitted by an Administrator

This insures that the operator, administrator or officer has reviewed the report and we have confirmation by electronic signature. It is not necessary to separately mail in the Certfication Statement.

New York State Department of Health

Division of Health Care Financing

Bureau off Long Term Care Reimbursement

Telehealth (Article 36 Section 14 Subsection 3C) Survey

Home Care Agencies that are receiving a Medicaid rate for telehealth technology must provide the following information:

1) Agency Information:

• Reporting Agency Name	
• Street	
• Street2	
• City	
• State	
• Zip Code	

2) Contact Information:

• Contact Person	
• Title	
• Telephone	

3) Type of Agency

• CH-LT	[CHHA] [LTHHCP]

Please provide the following information for the period January 1 through December 31

• 4) Number of Telehealth installations for year	
• 5) Number of Medicaid eligible patients screened	
• 6) Number of risk assessments completed for Medicaid eligible patients	
• 7) Number of unscheduled physician visits for Medicaid eligible patients	

8) Number of Medicaid eligible patients who received telehealth services who were discharged to:

• Hospital	
• Nursing Home	
• Adult Home	
• ALP	
• Enriched Housing	
• Hospice	
• Patients requesting discontinuance	

*Required Fields. **Repeatable Sections.