HOME HEALTH CARE CAHPS SURVEY DISCREPANCY REPORT

To submit this form online, please go to https://homehealthcahps.org/.

Date Submitted:

I. GENERAL INFORMATION

The following general information should be filled out about the survey vendor organization.

1. Survey Vendor Organization Information

Organization Name:

Mailing Address 1:

Mailing Address 2:

City:

State:

ZIP Code:

(Area Code) Telephone number:

(Area Code) Fax number:

Website address:

2. Survey Vendor Contact Person

First Name, Middle Initial, Last Name:

Title:

Degree/License (e.g., BA, PhD, MBA. PMA):

Mailing Address 1:

Mailing Address 2:

City:

State:

ZIP Code:

(Area Code) Telephone number:

(Area Code) Fax number:

E-mail address:

II. DISCREPANCY INFORMATION

Please complete the items below in detail.

1. Description of discrepancy, how it was discovered, and the affected timeframe

2. Number of eligible patients affected by the discrepancy

3. Description of corrective action to be taken to address discrepancy, along with proposed timeline

4. Additional information not provided above which will help the Coordination Team understand the discrepancy

III. LIST OF HOME HEALTH AGENCIES IMPACTED BY THIS DISCREPANCY REPORT

Vendor should submit a New Discrepancy Report if additional agencies are added after this form is submitted.

1. Home Health Agency Name:
   CMS Certification Number:

2. Home Health Agency Name:
   CMS Certification Number:

3. Home Health Agency Name:
   CMS Certification Number:

4. Home Health Agency Name:
   CMS Certification Number:

5. Home Health Agency Name:
   CMS Certification Number: