

# Home Health Care Agencies

Effective Date Requested: \_\_\_\_\_

Limits \_\_\_\_\_

Check coverage desired:  Professional Liability  General Liability  Non-owned Automobile

**Submit the following for each location:**

1. Agency or Service Brochures
2. Certificates of Accreditation (If Applicable)
3. Employment Application

**General Information**

1. Applicant Name: \_\_\_\_\_

2. Address: \_\_\_\_\_

3. County: \_\_\_\_\_ 4. Website Address: \_\_\_\_\_

5. Addresses of additional office locations: \_\_\_\_\_

6. Business Form  Corporation  Partnership  Individual

7. Executive Director: \_\_\_\_\_ Years in Business \_\_\_\_\_

8. Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

9. Agency is licensed as:  Non-profit corporation  For profit corporation

10. Describe all services that your agency provides.  
\_\_\_\_\_

**11. Prior Carrier Information (Professional and General Liability)**

Year	Carrier	Premium	Limits	CM or Occurrence	# of Claims

If Claims Made, what is retroactive date? \_\_\_\_\_

During the retroactive period, did the applicant ever go without insurance?  Yes  No

During the retroactive period, was Claims Made coverage provided continually with the same retro date?  Yes  No

12. Have there been any known claims, lawsuits or reported incidents in the past 5 years  Yes  No  
If yes, provide company loss runs or details on attached sheet.

13. Year agency founded: \_\_\_\_\_ Please check box next to current accreditations and association memberships.

NAHC  CHAP  NHPCO  JCAHO  Other (specify) \_\_\_\_\_

14. Please Provide five years of past revenue in the space provided below

Year	Annual Operating Budget

15. Receipts from Sale or rental of Durable Medical Equipment \$ \_\_\_\_\_ List percentage breakdown of types of DME. \_\_\_\_\_

16. Please provide the percentage breakdown of funding sources (Medicare, Medicaid, Private Pay)

17. Does the agency have subsidiaries?  Yes  No

If yes, describe operations: \_\_\_\_\_

18. Is the operation licensed by the state?  Yes  No Date: \_\_\_\_\_

19. Are any professional services provided on your premises?  Yes  No

If yes, please explain: \_\_\_\_\_

20. Are any bed or board or overnight services provided?  Yes  No

If yes, please explain: \_\_\_\_\_

21. Location where Services are Provided % (Total must equal 100%):

- |   |  |
|---|--|
| <input type="checkbox"/> Private Home _____ % | <input type="checkbox"/> Nursing Home _____ %    |
| <input type="checkbox"/> Hospital _____ %     | <input type="checkbox"/> Assisted Living _____ % |
| <input type="checkbox"/> Clinic _____ %       | <input type="checkbox"/> Other (specify) _____ % |

22. Types of Services Provided % (Total must equal 100%):

- |  |  |
|--|--|
| <input type="checkbox"/> Personal Care Chore or Companion _____ %                        | <input type="checkbox"/> Skilled Nursing Care _____ %  |
| <input type="checkbox"/> Infusion Therapy _____ %  | <input type="checkbox"/> Hospice _____ %               |
| <input type="checkbox"/> Infant Care _____ %   | <input type="checkbox"/> Pediatric Care _____ %        |
| <input type="checkbox"/> Supplemental Staffing, (if yes, complete below section) _____ % | <input type="checkbox"/> Obstetrical Services _____ %  |
| <input type="checkbox"/> Adult Day Care* _____ %   | <input type="checkbox"/> Child Day Care _____ %        |
| <input type="checkbox"/> Closed Pharmacy _____ %   | <input type="checkbox"/> Retail Pharmacy _____ %       |
| <input type="checkbox"/> Other Services, please describe: _____                          | <input type="checkbox"/> Clinics Owned/Operat. _____ % |

\*Supplemental application is required

23. Supplemental Staffing % (Total must equal 100%)  
(Supplying health care providers to other facilities for a fee)

If no supplemental staffing provided, please check here

- |   |  |
|---|--|
| <input type="checkbox"/> Nursing Home _____ % | <input type="checkbox"/> Assisted Living _____ % |
| <input type="checkbox"/> Hospital _____ %     | <input type="checkbox"/> Doctor's Office _____ % |
| <input type="checkbox"/> Clinic _____ %       | <input type="checkbox"/> Other (specify) _____ % |

24. If providing Supplemental Staffing in a hospital, please complete department staffed % (Total must equal 100%):

- |   |   |
|---|---|
| <input type="checkbox"/> Emergency Room _____ % | <input type="checkbox"/> Labor and Delivery _____ % |
| <input type="checkbox"/> Intensive Care _____ % | <input type="checkbox"/> Other (specify) _____ %    |

### Staffing Information

Please list the number of individuals in each category:

	Employees			Non-Employees		Does Professional Person Carry Own Liability?	
	Full Time	Part-Time	Annual Hours	Contractor	Annual Hours	Yes	No
Administrators						<input type="checkbox"/>	<input type="checkbox"/>
Physicians						<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrists						<input type="checkbox"/>	<input type="checkbox"/>
Psychologists-Doctorate						<input type="checkbox"/>	<input type="checkbox"/>
Psychologists-Bachelors/Masters						<input type="checkbox"/>	<input type="checkbox"/>
Counselors-Marriage and Family						<input type="checkbox"/>	<input type="checkbox"/>
Counselors-Other						<input type="checkbox"/>	<input type="checkbox"/>
Social and Case Workers						<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapist						<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Therapist						<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapist						<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapist						<input type="checkbox"/>	<input type="checkbox"/>
Therapist Aides						<input type="checkbox"/>	<input type="checkbox"/>
Nurses-RN						<input type="checkbox"/>	<input type="checkbox"/>
Nurses LPN						<input type="checkbox"/>	<input type="checkbox"/>
Nurse Practitioner						<input type="checkbox"/>	<input type="checkbox"/>
Nurse Mid-wife						<input type="checkbox"/>	<input type="checkbox"/>
Nurse Aide						<input type="checkbox"/>	<input type="checkbox"/>
Home Health Aid						<input type="checkbox"/>	<input type="checkbox"/>
Dental Hygienist or Assistant						<input type="checkbox"/>	<input type="checkbox"/>
Pharmacists						<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy Assistant						<input type="checkbox"/>	<input type="checkbox"/>
Physician Assistant						<input type="checkbox"/>	<input type="checkbox"/>
General Clerical or maintenance						<input type="checkbox"/>	<input type="checkbox"/>
Medical Technician						<input type="checkbox"/>	<input type="checkbox"/>
Other(Specify):						<input type="checkbox"/>	<input type="checkbox"/>

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or have any of the above employees or contractors:

1. Ever had their license suspended or revoked?  Yes  No
2. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No
3. Ever been treated for alcoholism or drug addiction?  Yes  No
4. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?  Yes  No

**Hiring Practices**

1. Do you require signed applications for all prospective:  Employees?  Non-employees?  
 Yes  No
2. Do you conduct personal interviews with every prospective employee or non-employee?  
If yes, are these:  In person  By Telephone  Yes  No
3. Do you require professional and personal reference of each employee?  Yes  No # \_\_\_\_\_
4. Do you require professional and personal references of each non-employee?  Yes  No # \_\_\_\_\_
5. Do you verify all professional qualifications, licenses, and certifications?  
Describe your background verification checks on new employees:
  - a. Work History: \_\_\_\_\_
  - b. Education: \_\_\_\_\_
  - c. Criminal Record: \_\_\_\_\_
  - d. Driving Record: \_\_\_\_\_
  - e. Drug Testing: \_\_\_\_\_
  - f. Is written documentation maintained in the employee's file?  Yes  No
6. Are Home Healthcare Aides required to participate in a program to become:  
Certified Nurses Aide?  Yes  No  
Certified in CPR?  Yes  No  
Certified in First Aid?  Yes  No
7. Do your contracts with medical professionals, consultants, or self-employed professionals contains a hold harmless agreement in your favor?  Yes  No  
Do the contracts require you to be named as an additional insured?  Yes  No
8. List all entities to be named as Additional Insured with names and insurable interests, (Attach a separate list if necessary). Other than a lease, attach a copy of the contract.  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Interest: \_\_\_\_\_
9. Have you entered into any contractual agreements in which you have agreed to indemnify (hold harmless) others for liability?  Yes  No

10. Describe your policies and procedures for reviewing your staff's day-to day interaction with their clients. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Do you practice Universal Precautions?  Yes  No

12. Does your agency have policies and procedures in place regarding medications?  Yes  No  
If yes, please describe: \_\_\_\_\_

13. In case of emergency, is management available seven days a week, 24 hours a day?  Yes  No

**Training**

Briefly describe any training or orientation program that you have for new employees.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physical Abuse or Sexual Misconduct Liability Information**

1. Do you have written policies regarding physical or sexual abuse?  Yes  No

2. Are these policies reviewed at least annually with all employees or volunteers?  Yes  No

3. As part of the new employee/contractor orientation, do you discuss physical abuse/ sexual misconduct, how to recognize telltale signs, and what to do if a child/client reports such activity?  Yes  No

4. Are your clients instructed to report possible instances of physical or sexual misconduct?  Yes  No

5. Do you have a management plan for dealing with staff, personnel, victim, parents, authorities, and media if you have an incident of physical abuse or sexual misconduct?  Yes  No

• Please describe your procedure for handling allegations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Are known or suspected incidents of physical abuse or sexual misconduct reported to the proper police authorities?  Yes  No

• Are employees and volunteers advised of this procedure?  Yes  No

7. Have you ever had an incident which resulted in an allegation of physical abuse or sexual misconduct?  Yes  No

• If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Was the case settled?  Yes  No      Taken to trial?  Yes  No

• How much was paid to the victim damages? \_\_\_\_\_

**Non-Owned Automobile Liability**

1. What liability limits do you require your employees/contractors to carry? \_\_\_\_\_
2. Describe the procedures you practice in order to confirm safe driving habits of your employees/contractors.

\_\_\_\_\_

\_\_\_\_\_

**INCOMPLETE AND UNSIGNED APPLICATIONS WILL BE RETURNED FOR COMPLETION**

I/We hereby declare that the above statements and particulars are true to the best of my/our knowledge and that I/we have not suppressed or misstated any material facts and I/we agree that this application shall be the basis of the contract with the Company. If a policy is issued, this application will be attached and become part of the policy.

**APPLICABLE STATES - INSURANCE FRAUD PREVENTION ACT NOTICE**

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any false information, or conceals for the purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime.

Date: \_\_\_\_\_

Applicant's Signature \_\_\_\_\_