

# Home care & hospice application

## APPLICANT INFORMATION

Please include the following with your completed application:

- Loss runs for current year and 4 years prior, currently dated
- Descriptive brochures, publications, and/or newsletters
- Copies of current policy declaration pages
- Current financial statements and pro forma budget
- Resumes of director and all management team members

Applicant /entity name

Physical address

Phone

Fax

Email

Website URL

Name and phone number of person to contact for an inspection

Requested effective date:

FEIN Number (Federal Employer ID)

Applicant type:    Individual    Corporation    Partnership    Non-Profit    For Profit

Date business started:

How long under current management?

States in which you operate:

Are you a franchisee?

### Officers of operating company or general partners

Name	Title	Years of Health Experience	Active	Inactive
			YES	NO

Does common ownership (over 50%) exist with any other operation or entity?

Total Annual Gross Revenues

Total Receipts from Medicare

Total Receipts from Medicaid

Total Receipts from Private Pay

Total Annual Payroll

## PRESENT CARRIER INFORMATION

	Carrier Name	Limits	Expiration Date	Years Insured	Annual Premium
Property/Crime/Inland Marine					
General Liability					
Professional Liability					
Automobile					
Auto/Hired & Non-Owned					
Workers Compensation					
Umbrella					
Employment Practices Liability					
Other					

Item	Five Year History	YES	NO
1	Have you ever been under investigation or convicted by any state or local authorities, the FBI or Department of Justice? If YES, please explain on the last page.		
2	Have any claims/suits been made against you within the last five years? If YES, please attach copy of insurance company loss reports for each claim or suit. Specify date, description, amount paid and amount outstanding for each claim.		
3	Are you aware of any circumstances which may result in any claim or suit made (including request for medical records)? If YES, please explain on the last page.		
4	Has any company declined, cancelled, or refused to renew any of your Insurance? If Yes, please explain on the last page.		

Is the present General Liability Policy Claims-Made? Retro Date:

Does the present liability policy have a deductible? If Yes, please state amount:

Have you (including owners, managers, partners, or administrators) ever been involved in a personal or business bankruptcy? If Yes, attach a complete explanation.

YES      NO

Are you required to carry a Healthcare Agency license in each state in which you operate?

Licensed by:

Has your license ever been suspended, revoked, voluntarily surrendered or undergone enforcement action? If YES, attach a copy of Authority's report, provide specifics, and corrective action taken.

Have there been any claims that allege negligence or failure to comply with any regulatory/licensing guidelines? If YES, provide details and explanation on last page.

Are you Medicare licensed and certified?

Are you Medicaid licensed and certified?

**LOCATIONS WHERE SERVICES ARE PROVIDED, AND PERCENTAGE OF BUSINESS (MUST TOTAL 100%):**

Location	Check if "yes"	%	Location	Check if "yes"	%
Adult Day Care Facilities			Assisted Living Facilities		
Clinics			Doctor's Offices		
Hospices			Hospitals		
Laboratories			Nursing Home/ Assisted or Independent Living Facilities		
Outpatient Facilities			Owned Facility		
Prison Facilities			Private Homes		
Schools			Other		

If "Other," please describe and include percentage:

Current Accreditations and Memberships	YES	Membership Number
Accreditation Commission for Health Care (ACHD)		
Community Health Accreditation Program (CHAP)		
The Joint Commission (JCAHO)		
CARF		
COA		
Other		

National/State Professional Associations:

	YES	NO
Do you provide Skilled Care?		
Do you provide Hospice Care?		

## NON-SKILLED CARE

Service	Check if "yes"	%	Service	Check if "yes"	%
Bathing/Dressing/Eating Assistance			Repositioning		
Errand Running			Restroom Aid		
Housework/Laundry			Supplemental Staffing		
Meal Preparation			Telehealth		
Medical Staffing (not a PEO)			Transport to/from Appointments		
Medication Reminders			Other		
Oxygen Equipment Provider			<b>TOTAL NON-SKILLED CARE</b>		
<b>Age Group</b>	<b># of Patients</b>	<b>%</b>	<b>Age Group</b>	<b># of Patients</b>	<b>%</b>
0 - 8 years			9 - 18 years		
19 - 55 years			56 + years		

Please describe the types of clients you serve:

Are any of your patients deemed medically fragile (i.e. feeding tubes, breathing ventilators)?      YES      NO

Staff composition: F/T = Full time (20+ hours/week), P/T = Part time (less than 20 hours/week)

Type	F/T	P/T	Estimated Annual Payroll	Type	F/T	P/T	Estimated Annual Payroll
Administrative/Clerical				Child Care Workers			
Clergy				Counselors			
Dentists				Home Health Aides			
Housekeepers				Interns			
LPN/LVN				Medical Directors (Admin)			
Management/Supervisors				Nurse Practitioners			
Nursing Aides				Nutritionists			
Occupational Therapists				Opticians			
Paramedic EMTs				Pediatricians			
Pharmacists				Physical Therapists			
Physicians Assistants				Physicians Hospice			
Physicians				Psychiatrists			
Psychologists				Registered Nurses			

Staff composition: F/T = Full time (20+ hours/week), P/T = Part time (less than 20 hours/week)

Type	F/T	P/T	Estimated Annual Payroll	Type	F/T	P/T	Estimated Annual Payroll
Resident Managers				Sitters/Companions			
Social Worker (BSW)				Social Worker (MSW)			
Sociologists				Speech/Hearing Therapist			
Teacher/Tutor/Aid				Other			

## STAFF TOTALS

Total Number of Employees: \_\_\_\_\_ Employee Annual Turnover Rate % \_\_\_\_\_

Total Number of Full Time Employees \_\_\_\_\_ Total Number of Part Time Employees \_\_\_\_\_

Number of Union Employees \_\_\_\_\_ Number of Non-Union Employees \_\_\_\_\_

Total Number of Volunteers \_\_\_\_\_ Total Number of Annual Volunteer Hours \_\_\_\_\_

Are medical/health insurance benefits offered to full-time employees? YES NO

Do you anticipate any workforce reduction in the next six months? YES NO If YES, please detail on last page.

## RISK MANAGEMENT

YES NO

Do you have a formal, written Quality Assurance Risk Management Program?  
If "NO," please explain:

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Do you have a plan in place for a medical emergency?

Are files maintained to protect the confidentiality of clients?

Is there formal staff training?

Do you screen potential client locations for a safe work environment prior to assignment of staff?

Are formal written procedures in place for staff hiring?

Do you have a formal, written safety program?

IF YES, CHECK ALL THAT APPLY:	YES	NO		YES	NO
Formal Accident/Injury Investigation			Labor/Management Safety Committee		
Formal Written Accident Report			Proper Lifting Techniques Instruction		
Safe Handling/Disposal of Needles/Sharps			Blood Borne Pathogens/ Infection Training		
Drug Free Workplace Program			Home Site Safety Surveys Conducted		
Loss Control Procedures in Place			Training & Incentive Program		
Patient Handling/Transfer Training			Post Accident Drug Testing		
Workplace Violence Training			Return to Work/Modified Duty Plan		
Accident/Injury Investigation Procedures			Daily Work Reports Required		

**CHECK ALL METHODS USED IN THE HIRING/SCREEN PROCESS**

METHOD	YES
Drug & Alcohol Testing	
Criminal Background Checks - Federal (10 years data)	
Criminal Background Checks - State (10 years data)	
Reference Checks	
Personal Interview	
Sexual Abuse Registry	
Validate Work History	
Validate Education	
Verify Current Certifications/Professional Licenses	
Validate Driver's License	
Validate personal auto insurance and limits (if operating owned vehicle during company hours)	

## CHECK ALL METHODS USED IN THE HIRING/SCREEN PROCESS

Pre-Employment Physical

Require Insurance Certificates for Independent Contractors

Documentation of Pre-Existing Injuries

Employee Orientation Program

Specific Job Training Provided

Reference Checks/Verifications are done:            Before Hiring            After Hiring            Random

If not done prior to hiring, please explain:

What actions do you take if any of these reports are unfavorable?

How are references checked?            Written            Verbal            Both. If verbal only, please explain:

Do you employ relatives of the patient as their care provider?

YES            NO

Do you require job applicants to complete an employment application? If yes, please attach a copy.

Do you conduct a personal interview for each prospective staff member?

Do you have 24-hour employee exposure such as live-in care for clients?

Do you verify if potential employees and/or independent contractors have ever had their license revoked or suspended, or disciplinary action taken against them?

Do you have written procedures on how to prevent theft from the client's home?

Are written job descriptions provided for all professional and non-professional employees?

YES NO

Do you have an employee handbook or statement of work rules, and is it given to all employees? If YES, please check the items that are included.

- Anti-Sexual Harassment Policy
  - Anti-Discrimination Policy
  - Written Grievance/Complaint Procedures
  -
- Drug & Alcohol Policy
  - “Open Door” Policy
  - ADA Policy
  - Employment-at-Will Statement

Do you obtain signed employee acknowledgement?

Do employees actively participate in continuing education programs?

If contracted professionals are used, do you require them to sign a hold harmless or indemnification agreement?

If YES, attach a copy of the standard agreement.

Do you have a formal incident report procedure in place?

Is the staff required to report to the administrator all incidents that may result in a claim?

Are written records of all incidents kept by the administrator?

Are all incidents reviewed?

YES NO

Do you have formal, documented training in place for the following?

- Crisis Management
- Disposal of Medical Waste
- First Aid
- AED Training
- Infusion Therapy
- Safe Lifting
- Transferring & Client Handling
- Blood Borne Pathogens
- Safe use of equipment

Are companion care providers certified through the National Association for Home Care and Hospice (NAHC)

Do you have current contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and assisted living homes

Is the staff informed of AIDS/HIV patients

Do you prominently display all posters required by state and federal law such as but not limited to anti-discrimination, wage and hours, etc

Do patient records include the following?

- A complete treatment plan prescribed by a physician, including follow-up plans
- An “informed consent” document obtained and placed in the patient’s medical record
- Patient care home visits meticulously documented
- Complete medical records maintained on all patients
- Patient records kept on file (hardcopy or electronic) for a minimum of six years
- All changes in condition and incidents documented to the physician and family
- Medications and dosage, including documentation of administering medications
- A copy of literature given to clients explaining services and fees
- Termination of services and discharge criteria
- Are standard client contracts used? If YES please attach a copy.
- Do you conduct patient/client surveys
- Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional

YES NO

Are medications kept in a locked area to prevent tampering? If YES, answer the following:

- Where are the medications stored?
- Who has the authority to dispense medications?
- Can over-the-counter medicines be dispensed without written permission from a doctor?

## ABUSE & MOLESTATION

YES NO

Does your current insurance program include Abuse & Molestation coverage? If yes:

Claims Made      Retro Date      Effective Date      Limit of Liability

Carrier:

Does your organization have a written “zero tolerance” sexual abuse molestation policy?  
If YES, check which items are included:

Definition of Sexual Abuses/Molestation      Incident Reporting Procedures  
Investigative Procedures      Disciplinary Procedures      Retaliation Warning

Do you have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if you have an incident of abuse?

Are there written complaint procedures and are they displayed prominently?  
If NO please explain below.

Are there written procedures that monitor staff in day-to-day relationships with clients, on and off premises?

Is there documented, formal staff training on sexual abuse, including how to recognize the signs and how to report a known or suspected incident?

Is there more than one person responsible for the welfare of any single patient?

Are you aware of ANY claims, allegations, and/or incidences (including abuse & molestation) made against your organization, or against anyone working on your behalf that may give rise to a claim against you in the last five years or is currently an open/closed claim? If YES, check the appropriate boxes and provide requested information.

Case was settled      Case went to trial      Amount paid for damages to the victim

Please provide details including dates, current status, amount paid/incurred, and resulting organizational/policy changes implemented as a result (attach additional page). Please attach a copy of your current abuse and molestation prevention policy.

## EMPLOYMENT PRACTICES LIABILITY

YES      NO

Have you had any cases of inappropriate employment acts, discrimination, wrongful termination or sexual harassment in the last five years? If YES, please complete the following:

Do you currently carry Employment Practices Liability Insurance?

If YES, Limit of Insurance \$

Deductible \$

	Year	Type Claim/Suit	\$ Legal Expense	\$ Claim Payment	Claim Now Closed
1					
2					

## AUTOMOBILE

YES      NO

Do you have a Commercial Business Auto Policy for owned autos?

If YES, in what names are the vehicles titled?

If NO, do you wish to apply for Hired and Non-Owned Auto Liability?      YES      NO

Vehicle Year, Make, Model, VIN:

Driver Name, DOB, Drivers License#, State

Driver Name, DOB, Drivers License#, State

Do you have a written driver safety program and/or driver training?    YES            NO

What are the limits of liability required to be carried by your employees?

Do you allow employees to drive the client's vehicle?

If YES, how do you verify patient and/or client owned automobile liability insurance coverage is in force?

YES            NO

Do you have a program to monitor an employee's personal auto liability insurance program?

If YES, is the employee's insurance monitored            At time of hire            Annually

Do you run MVRs on all employees?

If YES, are MVRs run:            At time of hire            Annually            Randomly

Do you obtain a copy of drivers licenses for all employees and volunteers?

Are there criteria/consequences for "bad" drivers?

If YES, please explain:

YES            NO

Do employees use personal vehicles for company business?

Do your employees or volunteers transport clients in their own automobiles (appointments or errands)?

If YES, please indicate:            Car            Truck            Van            Bus

How many clients?            For What Purpose?

Radius of Operations (in miles):            Less than 10            11 - 50            51 - 100            101 - 300            301 - 500

Do you transport non-ambulatory clients?

Do you contract with an ambulance or livery service to transport clients?

What is the maximum and minimum age of drivers allowed to drive vehicles?    Maximum            Minimum

Do you allow personal use of a company-owned vehicle?

Do you make sure travel logs are kept for all drivers?

Do you transport clients/consumers for private or government agencies? If YES, please explain on last page.

If YES, is this transportation for a fee?

REMARKS:

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## Workers compensation section

### CORPORATE OFFICERS

Name	Title	% Ownership	Duties	Included or Excluded
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### ESTIMATED ANNUAL PAYROLL BY CLASSIFICATION:

Clerical/Admin	\$		
Direct Care Staff	\$		
Other	\$		Please detail

Current Experience Modification Factor

Any Workers Compensation Claims in the past 5 years?  
If YES, include 5-year claim history provided by prior carrier(s).    YES            NO

The applicant warrants that information in this application is true to the best of its knowledge and includes all material information.

Applicant also warrants that if information material to the nature of this insurance changes, applicant will immediately notify InPro Insurance Group.

I authorize inpro insurance group to obtain our experience modification factor data for the purpose of quoting workers compensation insurance.

## APPLICANT SIGNATURE

Electronic Signature—type your full legal name to sign electronically:

Date:

It is understood and agreed that the completion of this supplemental application does not bind the company to issue, nor the Applicant to purchase, the insurance.

If you have answered YES to any questions requiring explanation, please use the space below or attach additional sheets.

Submit >