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**Home Care Assistance & Hospice - Supplemental Application**

Applicant Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Address (City/State/Zip): \_\_\_\_\_  
 Website: \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Agent Information			
Agency Name: _____		City/State: _____	
Contact Person: _____	Tel #: _____	Email: _____	

For Profit  || Non-Profit

Indicate all Programs administered by the Insured (check all that apply):

Non-Skilled Services – CNA, HHA			
Companion/ Sitter/ Personal Care	_____ %	Mid-Wife	_____ %
Dietician / Nutritionist	_____ %	Palliative Care	_____ %
Gastronomy (GT) Care	_____ %	Respite Care	_____ %
Hospice	_____ %	Other (Specify)	_____ %
Wound Care (Minor)	_____ %	<b>Total Non-Skilled Services</b>	_____ %

Skilled Care Services – LPN, RN			
Cardiac Care	_____ %	Pain Management Care	_____ %
Case Management	_____ %	Post Surgical Care	_____ %
Chemotherapy	_____ %	Hospice Services	_____ %
Clinical Trails	_____ %	Palliative Care	_____ %
Dialysis	_____ %	Respite Care	_____ %
Infusion Therapy	_____ %	Special Care (Alzheimer's /Dementia)	_____ %
Obstetrical/Doula	_____ %	Rehabilitation: Physical, Occupational	_____ %
Radiation Therapy	_____ %	Speech Therapy	_____ %
Gastronomy (GT) Care	_____ %	Dietician / Nutritionist	_____ %
Trach / Ventilator	_____ %	Other (Specify):	_____ %
Wound Care (Complex)	_____ %		_____ %
Catheter Care	_____ %	<b>Total Skilled Care Services</b>	_____ %

Miscellaneous Services			
Child daycare	_____ %	Social services	_____ %
Clergy	_____ %	Supplemental staffing	_____ %
Handyman	_____ %	Training/Certification	_____ %
Meals on Wheels	_____ %	Telehealth	_____ %
Medical equipment supplier	_____ %	Thrift Shops	_____ %
Pet therapy	_____ %	Wet Nurse	_____ %
Pharmacy	_____ %	Other (Specify)	_____ %
		<b>Total Misc Services</b>	_____ %

## General Information

FEIN # \_\_\_\_\_ # of Years in Business: \_\_\_\_\_ # of Years Experience: \_\_\_\_\_

Description of Operations: \_\_\_\_\_

1. Total Number of Employees \_\_\_\_\_ Total Number of Volunteers \_\_\_\_\_
2. Do you have all required licenses? Yes  No  Are they current? Yes  No
3. Total Annual Gross Revenues: \$ \_\_\_\_\_ Total Payroll: \$ \_\_\_\_\_
4. Average annual number of non-ambulatory clients? \_\_\_\_\_
5. Is the Applicant licensed in all states in which it is operating? Yes  No
6. Are you Medicare and Medicaid licensed and or certified? Yes  No
7. Are you a member of any state associations? Yes  No   
If yes, which ones? \_\_\_\_\_
8. Do you contract with a hospital or skilled nursing facility for inpatient beds? Yes  No   
If yes, which ones? \_\_\_\_\_
9. Has Applicant's license ever been suspended, revoked, voluntarily surrendered or undergone enforcement action? Yes  No   
If "yes", provide specifics and corrective action taken: \_\_\_\_\_

10. Please provide locations of services provided and % at each location:
 

Private Home	Yes <input type="checkbox"/> No <input type="checkbox"/> _____%	Hospitals	Yes <input type="checkbox"/> No <input type="checkbox"/> _____%
Doctor's Office	Yes <input type="checkbox"/> No <input type="checkbox"/> _____%	Clinics	Yes <input type="checkbox"/> No <input type="checkbox"/> _____%
Nursing Home	Yes <input type="checkbox"/> No <input type="checkbox"/> _____%	Residential Facility	Yes <input type="checkbox"/> No <input type="checkbox"/> _____%

11. Do you accept clients with any of the following disorders/issues? N/A

Prader-Willi Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/> % Clients	Schizophrenia	Yes <input type="checkbox"/> No <input type="checkbox"/> % Clients
Velocardial Facial Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/> % Clients	Adjudicated Sex or Violent Offenders	Yes <input type="checkbox"/> No <input type="checkbox"/> % Clients
Lesche-Nyhan Syndrome	Yes <input type="checkbox"/> No <input type="checkbox"/> % Clients	'Profound' mental retardation.	Yes <input type="checkbox"/> No <input type="checkbox"/> % Clients

## Hiring and Screening

1. Does the applicant verify if potential employees and/or independent contractors have ever had their license revoked or suspended, or disciplinary action taken against them? Yes  No
2. What is the average staff turnover rate: \_\_\_\_\_%
3. Are all employees screened to rule out drug, alcohol and sexual abuse? Yes  No
4. Check all methods used in hiring employees and independent contractors:
 

Drug Testing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Validate Work History	Yes <input type="checkbox"/> No <input type="checkbox"/>
Criminal Background check (Federal/State)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Validate Education	Yes <input type="checkbox"/> No <input type="checkbox"/>
Reference Checks	Yes <input type="checkbox"/> No <input type="checkbox"/>	Verify certificate/professional license	Yes <input type="checkbox"/> No <input type="checkbox"/>
Personal Interview	Yes <input type="checkbox"/> No <input type="checkbox"/>	Validate Drivers License	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexual Abuse Registry	Yes <input type="checkbox"/> No <input type="checkbox"/>	Validate Personal Auto Insurance & Limits	Yes <input type="checkbox"/> No <input type="checkbox"/>

## **Risk Management**

1. Does the Applicant utilize a formal written Quality Assurance Risk Management Program? Yes  No   
If "no", please explain. \_\_\_\_\_
2. Has the Applicant developed written protocols that govern the admission and medical treatment of patients for the following policies and procedures?
  - a. Complete treatment plan prescribed by the physician, including follow up plans? Yes  No
  - b. Assessments of clients prior to and after accepting the clients? Yes  No
  - c. Client's care and home visits documented? Yes  No
  - d. Documentation of all homecare training? Yes  No
  - e. All changes in the condition of the client or incidents involving the client documented in the records and reported to the family and physician? Yes  No
3. How is staff monitored? \_\_\_\_\_
4. Do you have written procedures in place to help prevent theft from client's homes? Yes  No
5. In the event that an assigned aide is unable to arrive on time, or unable to work that day, what is the procedure to ensure that a client is not left unattended? \_\_\_\_\_  
\_\_\_\_\_
6. Do you have formal HIPPA compliance procedures in place? Yes  No
7. Is the over responsibility for Risk Management assigned to one individual? Yes  No   
If yes, whom? (Name and Title) \_\_\_\_\_  
If no, how are these functions monitored? \_\_\_\_\_
8. Do the accepted patients have primary care physicians? Yes  No   
If no, who oversees the plan of care? \_\_\_\_\_
9. Does the Applicant have a formal accident report procedure in place? Yes  No
10. Describe the organization's policy for disposal of controlled substances: \_\_\_\_\_  
\_\_\_\_\_
11. Is there formal documented training in place for the following:
 

Crisis Management	Yes <input type="checkbox"/> No <input type="checkbox"/>	Safe lifting, transferring & client handling	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disposal of medical waste	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood borne pathogens	Yes <input type="checkbox"/> No <input type="checkbox"/>
First Aid	Yes <input type="checkbox"/> No <input type="checkbox"/>	Safe use of equipment	Yes <input type="checkbox"/> No <input type="checkbox"/>
AED training	Yes <input type="checkbox"/> No <input type="checkbox"/>	HIV/AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/>
Infusion Therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>		
12. Does the Applicant have current contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and/or assisted living homes in place? Yes  No   
If "yes" is there a review process requiring the following elements:
  - a. Hold harmless and indemnification clauses favorable to the applicant? Yes  No
  - b. Insurance requirements? Yes  No
  - c. Confidentiality clause? Yes  No
  - d. Terms and renewal conditions clearly outlines? Yes  No
  - e. Defined roles and responsibilities? Yes  No

## Professional Liability

1. Have you/the agency entered into any agreements relating to professional liability (such as a Professional service contract with any employee/contractor or intern) which contains either a hold harmless agreement, indemnification agreement, or any other professional agreement? Yes  No

2. Do you/the agency currently have a professional liability policy in place? Yes  No

If yes, please complete the following:

**Name of Carrier:** \_\_\_\_\_

**Expiration Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Premium:** \$ \_\_\_\_\_ **Limit:** \_\_\_\_\_

**Type of Coverage:**  Occurrence  Claims Made (Retro Date \_\_\_\_\_)

3. Annual Staffing – Employees & Independent Contractors

Total number of: \_\_\_\_\_ Full time employees: \_\_\_\_\_ Part Time Employees: \_\_\_\_\_ Volunteers: \_\_\_\_\_

### Employee Breakdown (MUST BE COMPLETED)

Type of Professional	# of Employees		# Volunteers	# Contractors	# Interns	Annual Payroll
	F/T	P/T				
Counselor/Social Worker - Unlicensed						
Dietician/Nutritionist						
Home Health Aide						
Medical Director						
Nurse LPN						
Nurse Practitioner						
Nurse RN						
Pharmacists						
Psychiatrist/Optometrst/Dentist						
Psychology/Clergy						
Physicians/Physicians Assistant/ Paramedic/EMT						
Residential Manager or Care Provider						
Counselor/Social Worker - Licensed						
Teacher/Tutor/Child Care						
Therapist - Occupational						
Therapist – Physical, Speech. Hearing						
Other (describe)						
<b>TOTALS</b>						

\*F/T = Full Time – over 20 hours per week/ \*\* P/T = Part Time – up to 20 hours per week

## Abuse & Molestation

1. Do all employees meet the minimum mandated education or professional experience level for the position assigned? Yes  No
2. Have any employees been the subject of a child abuse/neglect investigation? Yes  No   
If yes, what were the results of the investigation? \_\_\_\_\_
3. Have there ever been any alleged or actual incidents regarding any abuse or molestation? Yes  No   
If yes, please provide details: \_\_\_\_\_
4. What procedures have been instituted to prevent reoccurrences of previous events?  
\_\_\_\_\_
5. Is any counseling conducted off premises? Yes  No   
If yes, by whom and what type of clients? \_\_\_\_\_
6. What is your procedure on how allegations of abuse are handled?  
\_\_\_\_\_
7. Do volunteers work directly with clients? Yes  No   
If yes, please describe the degree of their job function and responsibilities: \_\_\_\_\_
8. What is the ratio of staff to clients: \_\_\_\_\_
9. Is there more than one person responsible for the welfare of any single client? Yes  No
10. Are there written complaint procedures? Yes  No

## Alzheimer's Stages

Do you provide services to Alzheimer patients? (if yes, complete table below) Yes  No

Stage	Description	Percentage
1	<u>No impairment</u> – The person doesn't experience any memory problems. No evidence of symptoms of dementia.	
2	<u>Very mild cognitive decline</u> – The person may feel as if they are having memory lapses, such as forgetting familiar words or locations of everyday objects. No symptoms of dementia.	
3	<u>Mild cognitive decline</u> – Friends, family and co-workers begin to notice difficulties. Doctors may be able to detect problems in memory or concentration.	
4	<u>Moderate cognitive decline</u> – Clear symptoms in several areas, such as forgetfulness of recent events, difficulty performing complex tasks such as planning dinner or paying bills, forgetfulness of one's own personal history and becoming moody or withdrawn.	
5	<u>Moderately severe cognitive decline</u> – Gaps in memory and thinking are noticeable, and they begin to need help with day-to-day activities such as unable to recall their address/phone number, confused on what day it is, trouble with mental arithmetic, and needs help choosing clothing that is appropriate season.	
6	<u>Severe cognitive decline</u> – Memory worse, personality changes, need extensive help with daily activities. Client may lose awareness of recent events as well as their surroundings, difficulty remembering their personal history, trouble remembering faces/names of loved ones, need help dressing, major changes in sleep patterns, need help with going to the restroom, compulsive behaviors and a tendency to become lost or wander.	
7	<u>Very severe cognitive decline</u> – Final stage, loss of ability to respond to their environment, to carry on conversations and eventually lose control of movement, such as the ability to smile, hold head up, reflexes, swallowing, and muscles grow rigid. Need extensive daily assistance.	

**TOTALS MUST EQUAL 100%**

## Products/Medical Supplies

1. Do you manufacture any products? Yes  No
2. Do you provide any durable medical equipment to clients? Yes  No
3. Do you sell any medical equipment? Yes  No   
Annual Sales? \_\_\_\_\_
4. Do you rent or lease any medical equipment? Yes  No   
Annual Sales? \_\_\_\_\_
5. Do you repair or perform maintenance on any medical supplies or equipment? Yes  No

## Auto & Hired/Non-Owned

1. Do you obtain MVRs on all drivers? Yes  No
2. Does the insured maintain driver's record files? Yes  No   
Does it include:
- |                         |  |                                  |  |
|-------------------------|--|----------------------------------|--|
| Date of Hire            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Reference Checks                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Dates of Training       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Accident information             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Drug Test Results/Dates | Yes <input type="checkbox"/> No <input type="checkbox"/> | Copy of insurance policy/ID card | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| MVRs                    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Travel logs on each employee     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
3. Are there any drivers under the age of 21 years of age? Yes  No
4. Do you furnish anyone with an auto? Yes  No   
If yes, are relatives ever allowed to operate an organization's auto? Yes  No
5. How many of your employees use their own vehicle in your business? \_\_\_\_\_  
a. What percentage of your employees/ volunteers using their own vehicle to transport clients around on errands or to and from doctor appointments? \_\_\_\_\_ %  
b. On average, how many days a week will they transport these clients? \_\_\_\_\_
6. Do you require that employees/volunteers using their own autos carry a liability of at least \$100,000? Yes  No   
If yes, do you verify (with a photocopy of the policy or other)? Yes  No
7. Do you have an accident investigation program? Yes  No
8. Do you obtain written authorization to release driver information from all your staff? Yes  No
9. What are your procedures for dealing with driver accidents or violations?  
\_\_\_\_\_
10. How often are non-owned autos used in your business? Daily  Weekly  Monthly
11. Do employees transport non-ambulatory clients? Yes  No   
Are any of the vehicles equipped with wheelchair lifts? Yes  No   
Is training provided for:
- |                                       |  |
|---------------------------------------|--|
| Operation of the lift or ramp system. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Securing the wheelchair and patient.  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Unloading the wheelchair and patient. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
12. Does anyone other than employees and volunteers drive your vehicles? Yes  No
13. Do you hire a transportation company to transport clients? Yes  No
14. Are you listed as additional insured on their policy? Yes  No

## Hospice

Are informed consent papers obtained from all patients prior to acceptance into care?

Yes  No

### Type of Services Offered

Services Provided	Percentage	Services Provided	Percentage
Clergy		Pharmacy	
Companion/Sitter		Physical Therapy	
Clinical Care		Radiation Therapy	
Dialysis		Speech Therapy	
Dietician/Nutritionist		Ventilator	
General Nursing (LPN/LVN)		Nurse Practitioner	
Infusion Therapy/Pain Management		Other (describe)	

**TOTALS MUST EQUAL 100%**

### Hospice Model

Freestanding	A hospice inpatient facility that is administratively and physically freestanding. This type of hospice operates a home care program for the inpatient.	<input type="checkbox"/>
Hospital Based	A hospice administratively or physically linked to a hospital. This type of hospice operates a home care program and may also operate an inpatient unit.	<input type="checkbox"/>
Nursing-Home Based	A hospice administratively or physically linked to a nursing home or long-term care facility. This type of hospice operates a home care program and an inpatient unit.	<input type="checkbox"/>
Community Based	A hospice home care program that operates under an autonomous administration. This type of hospice may be affiliated with an inpatient unit.	<input type="checkbox"/>
Home Health Agency Based	A hospice administratively or physically linked to a Hospital Based or Home Health Agency. This type of hospice may contract for inpatient services.	<input type="checkbox"/>

### Hospice Type

Routine Home Care	As long as the patient's symptoms are under control, the hospice team supports the caregivers in providing this level of care in the home setting, whether that is a private residence, assisted living or nursing home. # of patients for type of service (12 months time) _____ # of visits for type of service (12 months time) _____	<input type="checkbox"/>
Crisis Care	In the event of a medical or psychosocial crisis, 24 hour care can be provided in the home for brief periods. # of patients for type of service (12 months time) _____ # of visits for type of service (12 months time) _____	<input type="checkbox"/>
Inpatient Respite Care	Caregivers occasionally need to take short breaks to maintain their own health. In this instance, the patient can be transferred to a short-term care unit while the caregiver takes a break. Respite care is provided in a nursing home setting. # of patients for type of service (12 months time) _____ # of visits for type of service (12 months time) _____	<input type="checkbox"/>
General Inpatient Care	When symptoms can't be controlled in a home setting, this level of care may be provided in many hospitals or the patient can be moved to an inpatient center for a short-term stay until symptoms are under control. This level of care is also offered in select nursing homes. Patients residing in such nursing homes may be moved to an inpatient bed within the same facility. In all the nursing homes, patients may be moved to an inpatient center or to a nearby hospital. # of patients for type of service (12 months time) _____ # of visits for type of service (12 months time) _____	<input type="checkbox"/>

## Pharmacy

1. If Applicant owns or operates a pharmacy what are the total receipts from:

- a. Retail pharmacy                 \$ \_\_\_\_\_
- b. Closed pharmacy                 \$ \_\_\_\_\_
- c. Mail Orders                         \$ \_\_\_\_\_
- d. Does the pharmacy compound medications?                 Yes  No
- e. Does the pharmacy dispense controlled narcotics?                 Yes  No
- f. Does the pharmacy dispense medications to patients?                 Yes  No
- g. Does the pharmacy provide medication to other organizations?                 Yes  No

If "yes", please describe:

\_\_\_\_\_

## Home Healthcare/In-Home Support Services

Type	Percentage	Type	Percentage
Developmental Disabled/Autism/MRDD		Medical Recovery Assistance	
Dementia Care		Alzheimer's Care	
New Parent Assistance		Other (describe)	

**TOTALS MUST EQUAL 100%**

## Type of Services Offered

Services Provided	Percentage	Services Provided	Percentage
Bathing/Dressing/Feeding/Bathroom Assistance		Companionship/Sitter	
Laundry/Cleaning/Light Housekeeping		Running Errands/Driving Clients to Appts	
Meal Preparation		Medication Reminders	
Social Work		Speech/Physical/Hearing Therapy	
Unskilled Nursing (Non-medical HHA or CNA)		Skilled Nursing (medical RN, LPN)	
Respite Care		Other (describe)	
Assistive Technology (Personal Emergency Response Systems, Medication Dispensing Systems, etc.)		Home Modification & Installations (Installation of ramps, special walkways, railings, support bars, etc)	

**TOTALS MUST EQUAL 100%**

### NOTICE TO APPLICANTS:

**In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information or who, for the purpose of misleading, conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime.**

\_\_\_\_\_  
(Applicant Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Agent's Signature)

\_\_\_\_\_  
(Date)