

Home Health
SUPPLEMENTAL APPLICATION



Instructions to the applicant:

1. Please answer all the questions. This information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation
2. If a question is not applicable, state N/A. If more space is required to answer a question, please attach exhibit with the question number.
3. Application must be signed and dated by authorized person.

APPLICANT: _____

A. Exposure Information

1. Please describe and give historical exposures (# of visits) by category of staff including contracted staff?

Type of Home Health Providers	Next 12 Months Projected	Current Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior	5 th Year Prior
Nurses(RN, LPN, LVN)							
Nurse Practitioner							
Physical/Speech/Occ Therapists							
Respiratory Therapist							
Social Worker							
Home Maker HHA							
Home Care (Companion)							
Pharmacy							
Other (Specify)							

2. Services Provided by Percentage of Gross Receipts (check all that apply)

Adult Day Care	%	Housekeeping	%	Maternal/Fetal Monitoring	%
Hospice	%	Wound Care	%	Infant Day Care	%
Cooking	%	Infusion Therapy	%	Dialysis	%
Dietician	%	Staffing	%	Drug Administration	%
Medical Lab	%	Nursing	%	Training	%
Hospital	%	Pers. Companion	%	Transportation	%
Pediatrics	%	Pediatric infusion	%	Cardiac Monitoring	%
Rehab Therapy	%	Ventilator Care	%	Durable Medical Equipment (if any complete Section C)	%

3. What states does the applicant perform services in and provide percentage by state if more than one?

4. Does the applicant own, control, or staff any of the following?

- | | |
|--|--|
| Medical Laboratory (in house) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nursing Home | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rehabilitation Facility | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hospital - General Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Substance Abuse Programs | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Adult Day Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Infusion/Respiratory/Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Rental and/or Leasing Services | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergency Rooms | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emergency Vehicles | <input type="checkbox"/> Yes <input type="checkbox"/> No |

B. Quality Assurance

Hiring/Screening/Employment Procedures:

1. Are employee/contractor references checked prior to hiring? Yes No
2. How are the references checked? Written Verbal Both
3. Are prospective employees screened for prior criminal records? Yes No
4. Are employees actively participating in CE programs? Yes No
5. Are job descriptions provided for each employee? Yes No
6. Are professional employees required to carry their own insurance? Yes No
If Yes, what minimum limit is required? \$ _____

Accreditation:

Is the applicant a member or accredited by any of the following (If yes please attach copy of the most recent survey):

- | | |
|-----------------------------------|--|
| National Homecare Council | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| JCAHO | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| National Association of Home Care | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CHAP | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other (please specify): _____ Yes No

Risk Management:

- 1. Does the applicant utilize a formal written QA/RM program? Yes No
If Yes, please provide a copy.
- 2. Does the applicant have a Peer Review Committee? Yes No
- 3. Does the applicant conduct patient/client surveys? Yes No
- 4. Does the applicant provide continuing education programs? Yes No
- 5. Are informed consent forms used? Yes No
If Yes, when? _____

6. Is there a written policy or procedure document describing:

- a. patient acceptance Yes No
- b. advance directives (Living Will) Yes No
- c. employee training Yes No
- d. safety for workers in offsite locations Yes No
- e. lifting requirements Yes No
- f. patient evaluations Yes No
- g. incident reporting Yes No
- h. drug administration procedures Yes No
- i. food preparation Yes No
- j. medical equipment training Yes No
- k. patient discharge procedures Yes No
- l. patients rights Yes No
- m. medical records Yes No
- n. termination of care Yes No
- o. MD signing of orders Yes No

C. Durable Medical Equipment (If Applicable)

Medical Equipment and Supplies (please attach product description for all products)

- 1. Does the applicant sell any medical equipment and/or supplies? Yes No
- 2. Does the applicant rent or lease any medical equipment and/or supplies? Yes No

3. If applicant answered Yes to either 1 or 2 above, then complete section below.

Category I. Expendable Items - intended for one time usage and disposal (i.e., adhesive tape, bandages, hypodermic needles, etc.)

Annual Sales: _____

Category II. Non-Expendable Items - Excluding diagnostic or treatment equipment or devices. This category includes but not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelers, etc., and prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment.

Annual Sales: _____ **Lease/Rental Receipts:** _____

Category III. Diagnostic or Treatment Devices - This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment not used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, portable EKG machines, or sending devices.

Annual Sales: _____ **Lease/Rental Receipts:** _____

Category IV. Life Sustaining or Critical Life Monitoring Equipment, or Devices - This category includes dialysis or heart/lung machines, IV pumps, ventilators, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/devices or improper function of which could result in death or serious deterioration in health condition. (Please attach list of category IV equipment or devices)

Annual Sales: _____ **Lease/Rental Receipts:** _____

4. Does the applicant perform any maintenance or repairs on equipment sold or leased? Yes No
If Yes, please indicate the category (as described above):

Category I Category II Category III Category IV

5. Are all devices/equipment checked and documented as to condition prior to release? Yes No

6. Does the applicant perform, or has the applicant performed, preventive maintenance on all equipment/devices according to a written schedule? Yes No

7. Is the applicant named as an additional insured or vendor on the manufacturers policy for any/all products? Yes No

8. Does the applicant obtain certificates of insurance from their product suppliers? Yes No

9. Does the applicant currently or has the applicant ever imported products from foreign manufacturers? Yes No

If Yes, does the manufacturer have a US location? Yes No

10. Does the applicant modify the product in any way from its original form/use? Yes No
If Yes, please attach explanation.

11. Does the applicant do any re-packaging or re-labeling of items obtained from suppliers? Yes No

12. Does the applicant have its own sales staff? Yes No

13. Does the applicant repair or sell used equipment of others? Yes No

14. Does the applicant reuse/resell any single use devices? Yes No
If Yes, please attach a list of those devices.

If additional space is needed, please provide details on a separate attachment.

I understand the information submitted herein becomes a part of my Professional Liability Insurance Application and is subject to the same warranty and conditions.

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 thereto, commits a fraudulent insurance act.

Signature of Owner, Officer or Partner

Print or Type Name and Title

Date (m-d-y)