

HOME HEALTH CARE QUESTIONNAIRE

Please answer all questions. Submit this questionnaire with a completed ACORD application and prior carrier loss runs.

Named Insured: _____

Website: _____

PROHIBITED CIRCUMSTANCES

If any of the questions in this section are answered "YES," you are not eligible for coverage.

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| 1. Has applicant been in business for less than 1 year? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Has applicant been under present management for less than 1 year? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Does the applicant contract to provide employees to any of the following:
Convalescent/Nursing/ACLF Homes, Jails/Prisons/Detention Centers, Laboratories,
Infusion Therapy Centers, Hospitals or Physician's Offices? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Does the applicant provide any of the following services:
Infant/Pediatric Care, Blood Transfusion, Dialysis, Foster Care Placement, Birthing
Services or Doula? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Does the applicant employ any Lab Technicians, Physicians or Psychologists? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Has applicants license ever been revoked, suspended, voluntarily surrendered or had
disciplinary action taken against them? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Does the applicant own/operate a pharmacy or provide pharmaceuticals? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Does the applicant modify/repackage/re-label any non-disposable products? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Does the applicant sell or lease any medical equipment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Is the sole job duty of any employee to just drive patients around? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If any of the questions below are answered "NO," you are not eligible for coverage.

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| 11. Are all independent contractors required to provide a certificate of insurance for
professional liability? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Does the applicant provide written instructions to employees regarding specific services
the employees should not do? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Is all equipment checked and conditions documented prior to release? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Is all staff informed of all patients with AIDS/HIV? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

GENERAL INFORMATION

1. What states is the applicant licensed to do business in:

Submit to your UW if services are provided in any of the following counties or cities:

FL: Lee, Hendry, Palm Beach, Collier, Broward, Monroe and Miami-Dade Counties; **IL:** Cook County; **IN:** Marion County; **KY:** Pike County; **MD:** Baltimore; **MI:** Detroit; **MS:** Jefferson County; **MO:** St. Louis; **NV:** Clark County; **NJ:** Atlantic, Burlington, Camden, Gloucester, Salem, Cumberland and Cape May Counties; **NY:** 5 Boroughs; **PA:** Philadelphia; **TX:** South of Hwy 10 incl. Houston

2. Are employees authorized to use personal vehicles to transport patients? Yes No

3. Employee and independent contractors are placed (by percentage) at the following locations:

Assisted Living Facilities	%	Infusion Therapy Centers	%
Clinics	%	Schools	%
Private Homes	%	Other (describe):	%

4. Percentage of operations (if not listed submit to UW):

Non-Professional Service - # of Employees	Full-time	Part-time
Homemaker Health Aide	_____	_____
Nanny Services	_____	_____
Patient Care Assistant	_____	_____
Personal / Home Care Aide	_____	_____
Personal Trainer	_____	_____
Professional Services - # of Employees	Full-time	Part-time
Certified Nursing Assistant (CNA)	_____	_____
Dietician/Nutritionist	_____	_____
Licensed Counselor	_____	_____
Medical Director	_____	_____
Nurse – Practitioner	_____	_____
Nurse – Registered (RN)	_____	_____
Nurse – General (LPN, LVN)	_____	_____
Nurse – Student	_____	_____
Occupational Therapist	_____	_____
Physical Therapist	_____	_____
Radiologist	_____	_____
Rehabilitation Therapist	_____	_____
Respiratory Therapist	_____	_____
Social Worker	_____	_____
Speech Therapist	_____	_____
X-Ray Technician	_____	_____
Other (Describe below)	_____	_____

EMPLOYEE SCREENING INFORMATION

1. What is the turnover ratio for: Professional Staff ____% and Non-Professional Staff ____%?
2. As part of the hiring/screening of new employees or independent contractors, the applicant performs the following:
 - a. Verify certifications and/or professional licenses and confirm status?
 - b. Contact applicants' references before they are hired/placed?
 - c. Require that they sign a formal confidentiality statement?
 - d. Obtain criminal background checks and review sexual abuse registry?
 - e. Conduct a personal interview?
 - f. Validate education, work history and driver's license?
 - g. Have a formalized disease, drug or alcohol screening process?
 - h. Ask applicant if any previous involvement as a defendant in professional malpractice litigation?
 - i. Ask applicant if they ever had their license revoked or suspended, or had disciplinary action taken against them?

I certify that all the statements above in question 2 are verified: **Yes – I certify this**

3. The applicant has formal documented training in place for the following:
 - a. Crisis Management.
 - b. Disposal of medical waste, controlled substances, contaminated supplies or equipment.
 - c. First Aid, CPR and AED training.
 - d. Infusion Therapy.
 - e. Safe lifting, transferring and client handling.
 - f. Blood borne pathogens.
 - g. Safe use and operation of equipment.

I certify that all the statements above in question 3 are verified: **Yes – I certify this**

4. The applicant has written protocols in place for the following policies and procedures:
 - a. Complete treatment plan prescribed by the physician including follow-up plans.
 - b. Assessments of clients prior to and after accepting the clients.
 - c. Client care and home visits are documented.
 - d. Documentation of all homecare training.
 - e. All changes in the condition of the client are documented in the records and reported to the family and physician.
 - f. Client incident report procedure in place with notification given to family and physician.
 - g. Medications and dosage, including documentation of administering medications.
 - h. Termination of services and discharge criteria.
 - i. Arrangement for medical emergencies (i.e. M.D. on call, transfer arrangement with hospital, etc).

I certify that all the statements above in question 4 are verified: **Yes – I certify this**



Capitol Indemnity Corporation
 Capitol Specialty Insurance Corporation
 Platte River Insurance Company

IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLWEDE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

Applicant Signature	Title	Date
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Producer Signature	Date
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