



HOME HEALTH CARE SUPPLEMENTAL APPLICATION

Applicant Name: _____

DBA: _____

(If more than one entity/subsidiary, please attach description and % owned for each)

For Profit Non-Profit Partnership Other (specify): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Date business established: _____ # of years under present management: _____

Federal Employer Tax I.D. Number: _____

Website address (if available): _____

Name and phone number of person to contact for inspection: _____

SUBMISSION REQUIREMENTS

- PHLI Home Health Care Supplemental Application
- ACORD Applications (Applicant Information, including Crime and Umbrella)
- 5 Years of currently valued carrier loss runs
- Copy of State(s) Home Health Care License(s) and most recent State Licensure survey
- Brochures
- Copy of all Federal and State complaint investigation reports in the last 12 months
- (If contracted with Nursing Homes, Assisted Living and Hospitals); Provide copies of Indemnification Agreement, Hold Harmless Agreement, Additional Insured Provisions

APPLICANT INFORMATION

1. List the Applicant's states of operation:

2. Is the Applicant licensed in all states in which it is operating? Yes No
If "no", please list states of operation where not licensed:

If "no", please describe how these functions are monitored?

3. Is the Applicant Medicare licensed and certified? Yes No

4. Is the Applicant Medicaid licensed and certified? Yes No

5. Has the Applicant's license ever been suspended, revoked, voluntarily surrendered or undergone enforcement action? Yes No
If "yes", provide specifics and corrective action taken: _____
6. Does common ownership (over 50%) exist with any other operation? Yes No
If "yes", give names and types of operations managed and owned: _____
7. Total annual Gross Revenues: \$ _____
Total receipts from Medicare: \$ _____
Total receipts from Medicaid: \$ _____
Total receipts from Private Pay: \$ _____
8. Does the Applicant contact with a hospital or skilled nursing facility for inpatient beds? Yes No
If "yes", please explain: _____
9. Is the Applicant a member of any State Association? Yes No
If "yes", please provide the name of the State Association: _____
10. Is the Applicant a member of any other industry association(s)? Yes No
Please specify: _____
Member #: _____

Types of Services Provided:		
Service	Service	Service
<input type="checkbox"/> Adult Day Care _____%	<input type="checkbox"/> Hospice _____%	<input type="checkbox"/> Pet Therapy _____%
<input type="checkbox"/> Chemotherapy _____%	<input type="checkbox"/> Infant Care _____%	<input type="checkbox"/> Pharmacy _____%
<input type="checkbox"/> Child Day Care _____%	<input type="checkbox"/> Infusion Therapy _____%	<input type="checkbox"/> Physical Therapy _____%
<input type="checkbox"/> Clergy _____%	<input type="checkbox"/> Meals on Wheels _____%	<input type="checkbox"/> Radiation Therapy _____%
<input type="checkbox"/> Clinical Care _____%	<input type="checkbox"/> Medical Equip. Supplier _____%	<input type="checkbox"/> Rehabilitation _____%
<input type="checkbox"/> Companion / Sitter _____%	<input type="checkbox"/> Nurse Practitioner _____%	<input type="checkbox"/> Respiratory Therapy _____%
<input type="checkbox"/> Dialysis _____%	<input type="checkbox"/> Occupational Therapy _____%	<input type="checkbox"/> Speech Therapy _____%
<input type="checkbox"/> Dietician / Nutritionist _____%	<input type="checkbox"/> Pediatric Care _____%	<input type="checkbox"/> Skilled Nursing Care _____%
<input type="checkbox"/> General Nursing (LPN/LVN) _____%	<input type="checkbox"/> Personal Care _____%	<input type="checkbox"/> Ventilator: _____%
<input type="checkbox"/> Home Health Care _____%	<input type="checkbox"/> Other: _____%	<input type="checkbox"/> Other: _____%
		ABOVE MUST TOTAL 100%: 0%

Location of Services Provided:		
Type	Type	Type
<input type="checkbox"/> Private Homes _____%	<input type="checkbox"/> Hospitals _____%	<input type="checkbox"/> Clinics _____%
<input type="checkbox"/> Doctor's Offices _____%	<input type="checkbox"/> Nursing Homes _____%	<input type="checkbox"/> Owned Facility _____%
<input type="checkbox"/> Assisted Living Facilities _____%	<input type="checkbox"/> Other: _____%	<input type="checkbox"/> Other: _____%
		ABOVE MUST TOTAL 100% 0%

Supplemental Services (Supplying health care providers to other facilities for a fee): IF "NO" check here:		
Type	Type	Type
<input type="checkbox"/> Private Homes _____%	<input type="checkbox"/> Hospitals _____%	<input type="checkbox"/> Clinics _____%
<input type="checkbox"/> Doctor's Offices _____%	<input type="checkbox"/> Nursing Homes _____%	<input type="checkbox"/> Owned Facility _____%
<input type="checkbox"/> Assisted Living Facilities _____%	<input type="checkbox"/> Other: _____%	<input type="checkbox"/> Other: _____%
		ABOVE MUST TOTAL 100% 0%

Employees / Independent Contractors – Annual Staffing:						
	Employees		Independent Contractors		Annual Payroll	
	Full Time	Part Time	Full Time	Part Time	Employees	Independent Contractors
Acupuncturist						
Certified Nurse Anesthetist						
Clergy / Chaplain						
Clerical						
Dietitian						
Nurses (RN)						
Homemaker / Home Health Aid						
LPN / LVN						
Medical Director						
Nurse Practitioner						
Occupational Therapist						
Pharmacist						
Physical Therapist						
Physician						
Physician Assistant						
Psychiatrist						
Psychologist						
Respiratory Therapist						
Social Worker						
Speech Therapist						
Volunteers						
Other (specify): _____						
Total:	0	0	0	0	0	0

11. Describe any additional contracted Home Health Care operations (if different from above types):

12. Describe any changes in operations planned within the next year:

13. Is the Applicant accredited or a member of the following Health Care Organizations:

a. Community health Accreditation Program (CHAP)?

Yes No

b. Joint Commission on Accreditation of Health Care Organizations (JCAHO)?

Yes No

c. Any other accrediting organization (please specify)?

Yes No

Member #: _____

14. Has the Applicant ever been under investigation or convicted by any state or local authorities, the FBI or Department of Justice?

Yes No

If "yes", please explain:

15. Have any claims / suits been made within the last five years against the Applicant? Yes No
 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).

16. Is the Applicant aware of any circumstances which may result in any claim or suit made (including request for medical records)? Yes No
 If "yes", please explain:

17. Has any company declined, canceled or refused to renew any of the Applicant's Professional Liability Insurance? Yes No
 If "yes", please explain:

18. Previous Professional Liability Insurance (past five years):

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made only)
			\$		
			\$		
			\$		
			\$		
			\$		

19. Limits of Liability Desired:
 \$500,000 / \$1,000,000
 \$1,000,000 / \$1,000,000
 \$1,000,000 / \$2,000,000
 \$1,000,000 / \$3,000,000
 Other: \$ _____ Occurrence / \$ _____ Aggregate

HIRING / SCREENING

1. Are all employees and contractors screened to rule out drug, alcohol and sexual abuse? Yes No

2. Check all methods used in hiring all employees or independent contractors:

- Drug Testing Yes No
- Criminal Background Checks – Federal Yes No
- Criminal Background checks – State Yes No
- Reference Checks Yes No
- Personal Interview Yes No
- Sexual Abuse Registry Yes No
- Validate Work History Yes No
- Validate Education Yes No
- Verify Current Certification / Professional License Yes No
- Validate Driver's License Yes No
- Validate Personal Auto Insurance and Limits (if operating owned vehicle during company hours) Yes No

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

4. Are all of the above methods done prior to hiring? Yes No
If "no", please explain: _____

5. Are job descriptions provided for all professional and nonprofessional employees? Yes No

6. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? Yes No

7. What is the average staff turnover rate: _____

8. Does the Applicant question prospective employees about any previous involvement as defendants in professional malpractice litigation? Yes No
If "no", please explain: _____

9. 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

RISK MANAGEMENT

1. Does the Applicant utilize a formal written Quality Assurance Risk Management Program? Yes No
If "no", please explain: _____

2. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? Yes No

3. Are employees required to carry their own individual professional liability coverage? Yes No
Limits of Liability: \$ _____

4. Are independent contractor's required to carry their own individual professional liability coverage? Yes No
Limits of Liability: \$ _____

5. Are certificates of insurance maintained on file for all employees and independent contractors and updated annually? Yes No

6. Does the Applicant have formal HIPAA compliance procedures in place? Yes No

7. 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

8. Is the overall responsibility for Risk Management assigned to one individual in your organization? Yes No
 If "yes", please list name and title: _____
 If "no", please describe how these functions are monitored: _____
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9. Does the Applicant have a formal incident report procedure in place? Yes No
10. Is there a peer or committee who review the incident reports to improve upon any allegations previously outlined in the surveys or reports? Yes No
11. Does the Applicant have formal documented training in place for the following:
- a. Crisis Management Yes No
 - b. Disposal of Medical waste Yes No
 - c. First Aid Yes No
 - d. AED Training Yes No
 - e. Infusion Therapy Yes No
 - f. Safe lifting, transferring, and client handling Yes No
 - g. Blood borne Pathogen Yes No
 - h. Safe use of equipment Yes No
 - i. Other (please list): _____ Yes No
12. Are companion care providers certified through the National Association for Home Care and Hospice (NAHC)? Yes No
13. Do all contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and assisted living homes include a hold harmless agreement? Yes No
14. Is the staff informed of AIDS/HIV Patients? Yes No
15. Do patient records include the following:
- a. A complete treatment plan prescribed by a physician, including follow-up plans? Yes No
 - b. An "informed consent" document obtained and placed in the patient's medical record? (informed consent laws vary by state) Yes No
 - c. Patient care home visits meticulously documented? Yes No
 - d. Complete medical records maintained on all patients? Yes No
 - e. Patient records kept on file (hardcopy of electronic) for a minimum of 6 years? Yes No
 - f. All changes in condition and incidents documented to the physician and family? Yes No
 - g. Is documentation of all homecare training provided? Yes No
 - h. Medications & dosage, including documentation of administering medications? Yes No
 - i. A copy of literature given to clients explaining services and fees? Yes No
 - j. Termination of services and discharge criteria? Yes No
16. Does the Applicant conduct patient / client surveys? Yes No
17. Are the results of patient / client surveys used to improve day to day operations? Yes No
18. Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional? Yes No
19. Are medications kept in a locked area to prevent tampering? Yes No
20. Describe the organization's policy for disposal of controlled substances? _____
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ABUSE AND MOLESTATION

- 1. Does your current insurance program include Abuse and Molestation coverage?
If "yes", what are the limits? \$ _____ Yes No
- 2. Does the Applicant's employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses? Yes No
- 3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if you have an incident of abuse? Yes No
- 4. Are there written complaint procedures and are they displayed prominently?
If "no" please explain: Yes No

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- 5. Are there written procedures that monitors staff in day-to-day relationships with clients, both on and off premises? Yes No
 - 6. Is there formal staff training on sexual abuse, including how to recognize the signs? Yes No
 - 7. Is there more than one person responsible for the welfare of any single patient? Yes No
 - 8. Have any incidents resulted in an allegation of sexual abuse? Yes No
 - 9. Was the case settled? Yes No
 - 10. Was the case taken to trial? Yes No
 - 11. Amount paid for damages to the victim: \$ _____

AUTO INFORMATION

- 1. Does the Applicant own or lease any vehicles? Yes No
 - 2. Does the Applicant need coverage for non-owned automobiles? Yes No
 - 3. Does the Applicant have a program to monitor an employee's personal auto liability insurance program?
 - a. At time of hire? Yes No
 - b. Annually? Yes No
 - 4. Does the Applicant run MVRs on all employees?
 - a. At time of hire? Yes No
 - b. Annually? Yes No
 - c. Randomly (based on accidents or suspicions) Yes No
 - 5. What action is taken if an "unacceptable" driver is identified?
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- 6. Do all Applicant's employees or volunteers transport clients in their own automobiles (appointments or errands)? Yes No

7. Does the Applicant transport non-ambulatory clients? Yes No
8. Does the Applicant contract with an ambulance or livery service to transport clients? Yes No
9. How many drivers used personal vehicles for business regularly? ___ F/T ___ P/T ___ Vol.
10. How many drivers use personal vehicles for business occasionally? ___ F/T ___ P/T ___ Vol.
11. What is the maximum and minimum age of drivers allowed to drive clients? ___ Max ___ Min
12. Does the Applicant allow personal use of a company-owned vehicle? Yes No
13. Does the Applicant make sure travel logs are kept for all drivers? Yes No

MEDICAL SUPPLIES

1. Does the Applicant manufacture any products?
If "yes", please describe: Yes No
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2. Does the Applicant provide any durable medical equipment to clients?
If "yes", please describe: Yes No
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3. Does the Applicant sell any medical supplies or equipment?
If "yes", please describe: Yes No
-
- Total annual Sales: \$ _____
4. Does the Applicant rent or lease any medical supplies or equipment to others?
Total rental or leasing receipts: \$ _____ Yes No
5. Does the Applicant repair or perform maintenance on any medical supplies or equipment? Yes No
6. Is the Applicant named as an Additional Insured – Vendor on the manufacturer's or supplier's policy for any products? Yes No
7. Does the Applicant obtain certificates of insurance from their product suppliers? Yes No
8. Has the Applicant ever distributed or directly imported products from a foreign manufacturer? Yes No
9. Does the Applicant modify any product in any way from its intended use?
If "yes" please explain: Yes No
-
10. Does the Applicant repackage or re-label any items obtained from suppliers? Yes No
11. Do the manufacturer's labels remain on the equipment? Yes No
12. Are serial numbers of the finished product shown on invoices and complete records of inventory kept? Yes No

Fraud Notice

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO KENTUCKY APPLICANTS: 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 WHICH IS A CRIME.

NOTICE TO MINNESOTA AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO NEBRASKA AND OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO MAINE AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

Insured Signature : _____ Date: _____
Agent Signature: _____ Date: _____