Pierson & Fendley
INSURANCE

HOME HEALTH QUESTIONNAIRE

Applicant Name:_____

Agency Name:_____

Number of Years in Operation:_____ Years under Present Management:_____

Description of Service Provided:_____

A. **Additional information**: ACORD Application, Minimum of 3 years Loss history (hard copy)

B. **Loss History info:**

1) Have there been any claims or losses? Yes No
   If yes, details:_____
2) Has your license ever been suspended, revoked, or voluntarily surrendered? Or, has the license holder or any employee been subject to investigation, or convicted by any state/local authorities, CMS auditors, third party Medicare auditors, the Office of Inspector General, the FBI or Dept of Justice?
   Yes No
   If yes, provide details and actions taken:_____
   _____
3) Are you aware of any circumstances which may result in a claim or suit brought against you (including request for Medical Records)? Yes No
   If yes, please explain:_____
   _____

C. **Certification**

1) List the states of operation:_____
2) Are you licensed in all of these states? Yes No
3) Are you Medicare licensed and certified? Yes No
4) Are you Medicaid licensed and certified? Yes No
5) Are you an accredited 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) State Association (List:_____) Yes No
   d) Any other accrediting organization (List:_____) Yes No

D. Operations

Total Annual Gross Revenues: $ _____ Portion of receipts from Medicare/Medicaid _____ %

Type of Service: Mark an 'x' in all that apply, with the corresponding percentage of your business:

Service	%	Service	%	Service	%
☐ Adult Day Care		☐ Infusion Therapy		☐ Psychologist	
☐ Certified Nurse Anesthetist		☐ Meals on Wheels		☐ Radiation Therapy	
☐ Chemotherapy		☐ Medical Equipment Supplier		☐ Rehabilitation	
☐ Clinical Care		☐ Nurse Practitioner		☐ Respiratory Therapy	
☐ Companion / Sitter		☐ Nursing (LPN / RN)		☐ Speech Therapy	
☐ Dialysis		☐ Occupational Therapy		☐ Ventilator	
☐ Dietician / Nutritionist		☐ Pediatric Care		☐ Other:	
☐ Home Health Aide		☐ Pharmacy		☐ Other:	
☐ Hospice In Facility		☐ Physical Therapy		☐ Other:	
☐ Hospice In Home		☐ Physician Assistant			
☐ Infant Care		☐ Psychiatrist			
				Total (should be 100%)	

Locations:

Percentage of your business that is conducted:

_____ % In private homes
_____ % In clinics, hospitals, nursing homes and other facilities
_____ % Other (list locations): _____

Do you lease health care providers to other facilities for a fee? ☐ Yes ☐ No

If "yes", please explain: _____

Employee Payroll:

Employees / Independent Contractors / Volunteers							
	Number of Employees		Number of Independent Contractors		Annual Payroll		Total Payroll
	Full Time	Part Time	Full Time	Part Time	Employees	Independent Contractors	
Nursing Total					$	$	$
Includes (RN and LPN/LVN)							
Therapeutic Total					$	$	$
Includes (Physical, Occupational, Respiratory and Speech)							
Aide Total					$	$	$
Includes (Home Health Aide, Companion Sitter and Certified Nursing Assistant)							
Clerical					$	$	$
Volunteers							
Medical Director					$	$	$
Social Worker					$	$	$
Dietician					$	$	$
Psychologist					$	$	$
Pharmacist					$	$	$
Clergy					$	$	$
Other (specify below)					$	$	$
						Total Employee Payroll	$

Other types (specify): _____

E. Hiring Practices

Check the methods used in hiring all employees or independent contractors (and identify if it is completed prior to offer)

Hiring Practices			Completed	
	Yes	No	Pre-Hire	Post-Hire
1. Written Application	☐	☐		
2. Criminal Background Checks - Federal	☐	☐		
3. Criminal Background Checks - State	☐	☐		
4. Sexual Abuse Registry	☐	☐		
5. Drug Testing	☐	☐		
6. Reference Checks	☐	☐		
7. Personal Interview	☐	☐		
8. Validate Previous Work History	☐	☐		
9. Validate Educational Achievements	☐	☐		
10. Verify Current Certification / Professional License	☐	☐		
11. Validate Driver's License	☐	☐		

1. Do you verify that prospective employees have not had any previous involvement as defendants in professional malpractice litigation, have had their license revoked, or been subject to any disciplinary action against them?

   ☐ Yes ☐ No If "no", please explain: _____

2. Are written job descriptions provided for all professional and nonprofessional employees? ☐ Yes ☐ No

3. Do you employ relatives of the patient as their care provider? ☐ Yes ☐ No

   If "yes", what percentage of your staff is related to patients? _____ %

4. What is the Staff Turnover rate for the past 12 months? _____

F. Risk Management

1. Do you utilize a formal written Risk Management Program? ☐ Yes ☐ No

   If "yes", who is responsible for managing this program? _____

2. Do you retain certificates of insurance at minimum limits of $1M/2M for all independent contractors? ☐ Yes ☐ No

3. Have you developed written protocols that govern:

   a. Following the physician's treatment plan? ☐ Yes ☐ No
   b. Prospective patient assessment? ☐ Yes ☐ No
   c. Patient treatment expectations? ☐ Yes ☐ No
   d. Ongoing patient assessment? ☐ Yes ☐ No
   e. Patient care documentation? ☐ Yes ☐ No
   f. Employee training documentation? ☐ Yes ☐ No
   g. Changes in patient condition? ☐ Yes ☐ No
   h. Formal incident reporting procedure over the past three years? ☐ Yes ☐ No
   i. Medical waste disposal? ☐ Yes ☐ No

4. Are home aide providers certified as paraprofessionals through the National Association for Home Care and Hospice (NAHC)? ☐ Yes ☐ No

5. Do all contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and assisted living homes include a hold harmless agreement in your favor? ☐ Yes ☐ No

6. Is the staff informed of AIDS/HIV patients? ☐ Yes ☐ No

7. Do patient records include the following:

a.	Physician's treatment plan, including follow-up plans?	☐ Yes	☐ No
b.	A signed patient informed consent and applicable living will documents?	☐ Yes	☐ No
c.	Details of patient care home visits?	☐ Yes	☐ No
d.	Patient's complete medical records?	☐ Yes	☐ No
e.	Patient's medical records kept in compliance with state law?	☐ Yes	☐ No
f.	Changes in patient's condition?	☐ Yes	☐ No
g.	Administration of all medications?	☐ Yes	☐ No
h.	Explanation of services and fees?	☐ Yes	☐ No
i.	Termination of services and discharge criteria?	☐ Yes	☐ No

G. Professional Limits of Insurance (match GL limits)

☐ $500,000/$1,000,000 ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000

Select the coverage form option: ☐ Occurrence Form ☐ Claims-Made Form

Are you currently on a Claims-Made form? ☐ Yes ☐ No

Requested Retro Date _____

☐ Prior Acts Coverage (same limit as Occurrence)

Previous Professional Liability Insurance (List the past five years)					
Effective Date	Company	Limits of Liability Each Claim	Aggregate	Annual Premium	Retroactive Date
to					
to					
to					
to					
to					

H. General Liability Limits (match Professional limits) (include Acord 126 - GL)

☐ $500,000/$1,000,000 ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000

Are you currently on a Claims-Made form? ☐ Yes ☐ No

Requested Retro Date _____

Complete only if you are requesting General Liability Prior Acts Coverage (List the past five years)					
Effective Date	Company	Limits of Liability Each Claim	Aggregate	Annual Premium	Retroactive Date
to					
to					
to					
to					
to					

I. Sexual Misconduct or Sexual Molestation Liability

(Complete only if this coverage is desired. MI-1511 not needed)

1. Does your current insurance program include Sexual Abuse and Molestation coverage? ☐ Yes ☐ No

   If "yes", what are the limits? $_____

2. Limits Desired: (not to be higher than the General Liability limits of insurance)

   ☐ $100,000/$200,000 ☐ $500,000/$500,000 ☐ $500,000/$1,000,000 ☐ $1,000,000/$1,000,000

3. Do you have crisis management plan for dealing with staff personnel, victims, family members, authorities, and media if you have an incident of abuse? ☐ Yes ☐ No

If "yes", describe your plan: _____

4. Do you discuss the following items at staff orientation:

a. Sexual Abuse? ☐ Yes ☐ No
b. How to recognize the physical and behavioral signs of abuse? ☐ Yes ☐ No
c. What to do if a staff member recognizes a sign of abuse or if a patient reports abuse? ☐ Yes ☐ No

5. Are volunteers permitted to work directly with patients without an employee present? ☐ Yes ☐ No

If "yes", how are they monitored? _____

_____

6. Have you ever had an incident which resulted in an allegation of sexual abuse? ☐ Yes ☐ No

a. Was a claim made against you? ☐ Yes ☐ No
b. Was the case settled? ☐ Yes ☐ No
c. Was the case taken to trial? ☐ Yes ☐ No

J. Crime (Include Acord 141 - Crime)

Do you offer personal financial services to your patients? ☐ Yes ☐ No

Do your employees assist patients with writing checks or managing bills? ☐ Yes ☐ No

1. Employee Theft Limits (for higher limits, refer to company)

☐ $10,000/$250 ded. ☐ $25,000/$500 ded. ☐ $50,000/$1,000 ded.

2. Client's Property Limit (for higher limits, refer to company)

☐ $1,000/$250 ded. ☐ $2,500/$500 ded. ☐ $5,000/$1,000 ded. ☐ $10,000/$1,000 ded.

K. Automobile (Include Acord 127 - Automobile)

1. Do you obtain proof of personal automobile insurance for employees? ☐ Yes ☐ No

a. At time of hire? ☐ Yes ☐ No
b. Annually? ☐ Yes ☐ No
c. Are minimum limits of $100,000/$300,000 required? ☐ Yes ☐ No

If "no", what limits are required? _____

2. Do you run MVRs on all employees at least annually? ☐ Yes ☐ No

3. Do your employees or volunteers transport patients in their own automobiles? ☐ Yes ☐ No

If "yes", how many employees perform this service? _____

Describe usage (Appointments, errands, etc.) _____

4. Do your employees or volunteers transport non-ambulatory patients? ☐ Yes ☐ No

If "yes", how many employees perform this service? _____

Describe procedure: _____

5. How many drivers use personal vehicles for business? _____ F/T _____ P/T _____ Volunteers

6. Do you contract any transportation of patients? ☐ Yes ☐ No

If "yes", are certificates of insurance with at least $1,000,000 limits obtained and kept on records? ☐ Yes ☐ No

7. Do you have a written driver safety program? ☐ Yes ☐ No

If "no" please explain how safe driving is enforced: _____

_____

L. **Medical Equipment and Supplies**

1. Do you manufacture any products? ☐ Yes ☐ No

   If "yes", please describe: _____

   _____

2. Do you provide, sell, rent or lease any medical supplies or equipment to patients or others? ☐ Yes ☐ No

   If "yes", please provide sales and receipts as indicated in categories below:

   a. Expendable Items (Intended for one-time usage) Sales $ _____

   b. Non-Expendable Items Lease/Rental Receipts $ _____ Sales $ _____

   (Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to: hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.)

   c. Diagnostic or Treatment Devices

   Lease/Rental Receipts $ _____ Sales $ _____

   (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, blood pressure gauges, IV pumps, portable EKG machines or sending devices.)

   d. Life-Sustaining or Critical Life-Monitoring Equipment or Devices

   Lease/Rental Receipts $ _____ Sales $ _____

   (This category includes dialysis or heart/lung machines, apnea monitors or any other life-dependent monitors or any other equipment or devices that could malfunction or improperly function of which could result in death or serious deterioration in health condition.)

3. Do you repair, modify, repackage or re-label any medical supplies or equipment? ☐ Yes ☐ No
4. Are you named as Additional Insured - Vendor on the manufacturer's or supplier's policy? ☐ Yes ☐ No
5. Do you obtain certificates of insurance from the product suppliers? ☐ Yes ☐ No
6. Have you ever distributed or directly imported products from a foreign manufacturer? ☐ Yes ☐ No
7. Do you distribute Oxygen?

   If "yes", please detail quantities: _____

8. Do you mix any pharmaceuticals? ☐ Yes ☐ No

   If "yes", please provide details: _____

M. **Additional Comments:**

FRAUD STATEMENTS

APPLICABLE IN COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN THE DISTRICT OF COLUMBIA
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.

APPLICABLE IN FLORIDA
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.

APPLICABLE IN HAWAII
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN KANSAS
Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN MARYLAND
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT
Any person who knowingly and with intent to defraud any insurance company or another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

APPLICABLE IN MINNESOTA
Any person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN OHIO
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.

APPLICABLE IN OKLAHOMA
WARNING: 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.

APPLICABLE IN WASHINGTON
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.

GENERAL FRAUD STATEMENT
Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and [NY: substantial] civil penalties. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN, and VA, insurance benefits may also be denied)

Applicant's Signature **Date**

Agent's Signature **Date**

Agency and Code Number

Agent's Name and License Number (Florida only)