



Home Health Care General & Professional Liability Questionnaire

Original Date:			
Company Name:			
Physical Address:		Suite #:	
City:	State:	Zip Code:	
Mailing Address (If Different):			
Phone:	Cell:	Fax:	
Email:			
Contact Person:			

Years in Business in operation:

**Property Insurance information: Building Information: \*\* If more than one location please list on separate sheet of paper**

Construction:       Masonry       Joisted Masonry       Frame       Fire Resistive       Other

Year Built:

Flood Zone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sprinkler System:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Alarm:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type:
Square Feet:			Number of Stories:

Building (if Applicable): \$

Business Personal Property (office contents including furniture, fixtures, tenant improvements, inventory, stock, or permanently installed equipment)

\$

**Business Automobile Insurance Information (If Applicable):**

Company/ Business Owned Vehicles: \*if more than 5 please attach a separate list

<u>Year</u>	<u>Make</u>	<u>Model</u>	<u>VIN #</u>	<u>Original Cost New</u>	<u>Garaged (Zip code)</u>	<u>GVW</u>



**Driver List**

Name	License Number	State Licensed	Date of Birth

**\*\*Please make note of any vehicle that is not titled in the Company Name\*\***

Number of Years in Operation :

Years under Present Management:

Description of Services Provided:

**A. Loss History**

1. Have you previously had claims or losses?  Yes  No

If "yes", provide specifics:

2. Has your license ever been suspended, revoked or voluntarily surrendered? Or, has the license holder or any employee been subject to investigation (including any other enforcement action), or convicted by any state / local authorities, CMS (Centers for Medicare and Medicaid Services) auditors, third party Medicare auditors, the OIG (Office of Inspector General), the FBI or Department of Justice?

Yes  No

If "yes", provide specifics and corrective action 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:



**B. 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



C. 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:

Table with 6 columns: Service, %, Service, %, Service, %. Rows include services like Adult Day Care, Certified Nurse Anesthetist, Chemotherapy, Clinical Care, Companion / Sitter, Dialysis, Dietician / Nutritionist, Home Health Aide, Hospice In Facility, Hospice In Home, Infant Care, Infusion Therapy, Meals on Wheels, Medical Equipment Supplier, Nurse Practitioner, Nursing (LPN / RN), Occupational Therapy, Pediatric Care, Pharmacy, Physical Therapy, Physician Assistant, Psychiatrist, Psychologist, Radiation Therapy, Rehabilitation, Respiratory Therapy, Speech Therapy, Ventilator, and Other.

Locations:

Percentage of your business that is conducted:

% In private homes :

% In clinics, hospitals, nursing homes and other facilities:

% Other (list locations: )



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Do you lease health care providers to other facilities for a fee?

Yes  No

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If "yes", please explain:

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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):

\_\_\_\_\_



D. Hiring Practices

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

Table with 5 columns: Hiring Practices, Yes, No, Completed Pre-Hire, Completed Post-Hire. Rows include: 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 employees? [ ] Yes [ ] No

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

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



E. Risk Management :

1. Do you utilize a formal written Risk Management Program?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you developed written protocols that govern:		
a.	Following the physician's treatment plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	Prospective patient assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	Patient treatment expectations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	Ongoing patient assessment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	Patient care documentation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	Employee training documentation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	Changes in patient condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	Formal incident reporting procedure over the past three years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	Medical waste disposal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are home aide providers certified as paraprofessionals through the National Association for Home Care and Hospice (NAHC)?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is the staff informed of AIDS/HIV patients?		<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do patient records include the following:		
a.	Physician's treatment plan, including follow-up plans?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	A signed patient informed consent and applicable living will documents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	Details of patient care home visits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	Patient's complete medical records?	<input type="checkbox"/> Yes <input type="checkbox"/> No





e.	Patient's medical records kept in compliance with state law?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	Changes in patient's condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	Administration of all medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	Explanation of services and fees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	Termination of services and discharge criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**F. Sexual Misconduct or Sexual Molestation Liability**

1.	Do you have crisis management plan for dealing with staff personnel, victims, family members, authorities, and media if you have an incident of abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If "yes", describe your plan:

2.	Do you discuss the following items at staff orientation:	
	Sexual Abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	How to recognize the physical and behavioral signs of abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

What does your business do if a staff member recognizes a sign of abuse or if a patient reports abuse?  
Please Explain:

3.	Are volunteers permitted to work directly with patients without an employee present?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If "yes", how are they monitored?	

4.	Have you ever had an incident which resulted in an allegation of sexual abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Was a claim made against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Was the case settled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Was the case taken to trial?	<input type="checkbox"/> Yes <input type="checkbox"/> No



G. 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

H. Automobile

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

At time of hire?  Yes  No

Annually?  Yes  No

Are minimum limits of \$100,000/\$300,000 required?  Yes  No

If "no", what limits are required?

2. Do you review 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?

Full Time :

Part Time:

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:

**M. Additional Comments:**

*This information is accurate and complete to the best of my knowledge and represents the operations and exposures of the above noted applicant.*

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**Applicant's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Agent's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Agency and Code Number**