Clear form

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:	☐ Yes	☐ No	
Sprinkler System:	☐ Yes	☐ No	
Alarm:	☐ Yes	☐ 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

Year	Make	Model	VIN #	Original Cost New	Garaged (Zip code)	GVW

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:

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:

Age group breakdown of the clients served: 0-17 ____ % ; 18-55_____ % ; 56+ _____ %

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): _____

D. 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 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?	☐ 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

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?	☐ Yes ☐ No
If "yes", describe your plan:	
2. Do you discuss the following items at staff orientation:	
Sexual Abuse?	☐ Yes ☐ No
How to recognize the physical and behavioral signs of abuse?	☐ Yes ☐ 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?	☐ Yes ☐ No
If "yes", how are they monitored?	

4. Have you ever had an incident which resulted in an allegation of sexual abuse?	☐ Yes ☐ No
Was a claim made against you?	☐ Yes ☐ No
Was the case settled?	☐ Yes ☐ No
Was the case taken to trial?	☐ Yes ☐ 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.

Applicant's Signature **Date**

Agent's Signature **Date**

Agency and Code Number