



Worldwide Facilities, Inc.

HOME HEALTH CARE QUESTIONNAIRE

Please attach an Acord® Application

Name of organization: \_\_\_\_\_

Website address (URL): \_\_\_\_\_

Date Business operations started: \_\_\_\_/\_\_\_\_/\_\_\_\_

CURRENT FORM OF INSURANCE:

- Professional Liability: [ ] Occurrence [ ] Claims Made
Commercial General Liability: [ ] Occurrence [ ] Claims Made

- Applicant is a: [ ] Corporation [ ] Partnership
[ ] Professional Association [ ] Sole Proprietorship
[ ] Joint Venture

- Applicant Operates: [ ] Other (Please Explain) \_\_\_\_\_
[ ] For Profit [ ] Not For Profit

TYPE OF FIRM:

- [ ] Home Health Care [ ] Visiting Nursing Associations [ ] Referrals Only
[ ] Medical Equipment Supplier [ ] Supplemental Staffing [ ] Nurse Registry

(Please note: Coverage is not available if you only provide referrals to other organizations or are a Nurse Registry)

State approximate % of gross income derived from the following (total should be 100%):

Table with 2 columns: % and Facility Type (Private Homes, Hospitals, Hospice, Nursing Homes, Assisted Living Facilities, Other)

- 1. State approximate percentage of referrals provided: \_\_\_\_\_%
2. Is the business licensed by regulatory authorities? YES [ ] NO [ ]
3. What was the date of last inspection by licensing agency? \_\_\_\_/\_\_\_\_/\_\_\_\_
4. Were any violations or deficiencies noted? YES [ ] NO [ ]
5. Are assessments and evaluations of clients documented thoroughly? YES [ ] NO [ ]
6. Are adverse incidents reported to a physician immediately? YES [ ] NO [ ]
7. Are all nursing staff certified and licensed in their state of operation? YES [ ] NO [ ]
8. Are all employees who visit clients bonded? YES [ ] NO [ ]
9. Does the agency provide the patient or family members with a written plan of care? YES [ ] NO [ ]
10. Is an informed consent document placed in the patient's medical record? YES [ ] NO [ ]
11. Is a medical record kept on every patient, beginning at the point of referral? YES [ ] NO [ ]
12. Does your agency have a written contract with service providers? YES [ ] NO [ ]
13. Total annual gross revenue/operating budget: \_\_\_\_\_
14. Total payroll of employees: \_\_\_\_\_
15. Annual number of home visits: \_\_\_\_\_
16. Total receipts of independent contractors: \_\_\_\_\_
17. Do you require and keep certificates of insurance for all independent contractors? YES [ ] NO [ ]
18. Describe the services performed by your LPNs / RNs: \_\_\_\_\_

19. Indicate percentage of revenue derived from IV therapy: \_\_\_\_\_%

20. Indicate percentage of revenue derived from Chemo therapy: \_\_\_\_\_%

21. Does your organization provide medical detoxification, non-medical detoxification, social detoxification or methadone detoxification/maintenance? YES  NO
22. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES  NO
23. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES  NO
24. Are all non-governmental service providers licensed by state? YES  NO
25. Does your agency verify that non-governmental service providers have insurance in place? YES  NO
26. Does your agency have a written contract with service providers? YES  NO
27. Are "hold harmless" agreements in your favor part of the contract between your organization and service providers? YES  NO
28. Does your organization require service providers name you as "additional insured" under the provider's policy? YES  NO

**ABUSE AND MOLESTATION COVERAGE:**

29. Abuse Limit requested: \$ \_\_\_\_\_
30. Type of abuse coverage currently in place:  
 None  
 Occurrence       Included in GL      or       Submit: \_\_\_\_\_  
 Claims Made       Included in GL      or       Submit: \_\_\_\_\_
31. Have any claims been filed or allegations been made, against your organization or anyone working on behalf of your organization alleging abuse? YES  NO
32. Are you aware of any occurrences that could lead to a claim? YES  NO   
**If yes,** to above, attach explanation
33. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? YES  NO

Total number of clients in each age range:

0-8 years: \_\_\_\_\_ 9-18years: \_\_\_\_\_ 19-39 years: \_\_\_\_\_ 40-65 years: \_\_\_\_\_ 66-79 years: \_\_\_\_\_ 80+ years: \_\_\_\_\_

|   | Employees  | Volunteers   |
|---|--|--|
| a. Is unsupervised contact allowed with clients?  | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| b. Education verified?  | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| c. Personal references checked?   | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| d. Written application required?  | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| e. State <b>10-digit fingerprint</b> criminal record check?                                 | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| f. Federal <b>10-digit fingerprint</b> criminal record check if in state less than 5 years? | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| g. Federal <b>10-digit fingerprint</b> criminal record check regardless of time in state?   | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| h. Are all controls indicated in d-g required prior to any client contact?                  | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| i. How long are records kept documenting all screening activities outlined above?           | _____ years  | _____ years  |

**Federal checks require a second set of 10-digit fingerprint cards**

**PROFESSIONAL LIABILITY COVERAGE:**

34. Is your organization aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy? YES  NO   
 If yes, are procedures in place to verify current licenses are maintained? YES  NO
35. Do you provide any procedures that are not supported by the American Medical Association (procedures that are experimental, are not used as prescribed by the AMA or are unsupported by AMA accepted clinical research) YES  NO
36. Do you supply medical equipment or are your personnel responsible for monitoring equipment? YES  NO   
 If yes, please explain: \_\_\_\_\_
37. Do you sell, lease, repair or maintain any medical equipment? YES  NO   
 If yes, please explain: \_\_\_\_\_

38. List number of employees (full or part-time) and contractors by position below:

| Name of Position                | Number of Employees | Number of Ind. Contractors | Est. Hours Worked |             | Est. Annual Payroll |             |
|---------------------------------|---------------------|----------------------------|-------------------|-------------|---------------------|-------------|
|                                 |                     |                            | Employees         | Contractors | Employees           | Contractors |
| Administrator                   |                     |                            |                   |             |                     |             |
| Child Care Worker               |                     |                            |                   |             |                     |             |
| Community Support Specialist    |                     |                            |                   |             |                     |             |
| Counselor                       |                     |                            |                   |             |                     |             |
| Dentist/Dental Hygienist        |                     |                            |                   |             |                     |             |
| Home Health Aide                |                     |                            |                   |             |                     |             |
| Medical Students                |                     |                            |                   |             |                     |             |
| Nurse Assistant                 |                     |                            |                   |             |                     |             |
| Nurse Practitioner              |                     |                            |                   |             |                     |             |
| Nurse - LPN                     |                     |                            |                   |             |                     |             |
| Nurse - RN                      |                     |                            |                   |             |                     |             |
| Nutritionist/Dietician          |                     |                            |                   |             |                     |             |
| Optometrist                     |                     |                            |                   |             |                     |             |
| Paramedic/EMT                   |                     |                            |                   |             |                     |             |
| Pharmacist                      |                     |                            |                   |             |                     |             |
| Physician Assistant             |                     |                            |                   |             |                     |             |
| Physician                       |                     |                            |                   |             |                     |             |
| Psychiatrist                    |                     |                            |                   |             |                     |             |
| Psychologist                    |                     |                            |                   |             |                     |             |
| Resident Home Care Provider     |                     |                            |                   |             |                     |             |
| Resident Manager                |                     |                            |                   |             |                     |             |
| Social Worker – Bachelors (BSW) |                     |                            |                   |             |                     |             |
| Social Worker – Masters (BSW)   |                     |                            |                   |             |                     |             |
| Teacher / Tutor / Aide          |                     |                            |                   |             |                     |             |
| Technician – Medical / Lab      |                     |                            |                   |             |                     |             |
| Therapist – Occupational        |                     |                            |                   |             |                     |             |
| Therapist – Physical            |                     |                            |                   |             |                     |             |
| Therapist – Speech / Hearing    |                     |                            |                   |             |                     |             |
| Therapist – Other               |                     |                            |                   |             |                     |             |
| Other Positions (specify)       |                     |                            |                   |             |                     |             |

- a. How many of the above positions are skilled (perform injections, actively monitoring patient's conditions)? \_\_\_\_\_  
 b. How many are unskilled (little or no intrusion in the human body)? \_\_\_\_\_

39. Of the professionals listed, do any carry their own professional liability insurance? YES  NO
40. Do you maintain copies of licenses for all employed professionals that are required to be licensed? YES  NO
41. Are services provided under contract by professionals who are not your employees? **If yes:** YES  NO
- a. What services are provided? \_\_\_\_\_
- b. Do you maintain a copy of current certificate of insurance and state license? YES  NO

**AUTO COVERAGE:**

42. Does your organization own or lease vehicles? YES  NO
43. Are all owned or leased vehicles being submitted to us for coverage? YES  NO
- If yes, attach Acord® Auto applications.**
44. Do you provide transportation to and from your facility? YES  NO
45. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following:
- a. More than 2 moving violations and/or accidents within a 3 year period? YES  NO
- b. Reckless driving, DUI or any felony driving conviction within a 5 year period? YES  NO
46. Are any vehicles equipped with wheelchair lifts? YES  NO
- If yes, have employees been trained in use?** YES  NO
47. Is **hired auto liability** coverage desired? YES  NO
- If yes, does your annual vehicle rental expense exceed \$2,500?** YES  NO
- If yes, what is your annual vehicle rental expense?** \_\_\_\_\_
48. Is **non-owned auto liability** coverage desired? YES  NO
- If yes, Total number of: \_\_\_\_\_ employees \_\_\_\_\_ volunteers**
49. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization.**

| Usage                | Number of Volunteers | Number of Employees | Average trips per week (total for all employees & Volunteers) | Annual MVR Required?                                     | Proof of Personal Auto Insurance Required on a Renewal Basis? | 100/300 or 300 CSL Personal Auto Limits Required?        |
|----------------------|----------------------|---------------------|---|--|---|--|
| Errands              |                      |                     |   | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>      | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Transport Clients    |                      |                     |   | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>      | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Home visitation      |                      |                     |   | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>      | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Home Meal Delivery   |                      |                     |   | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>      | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Other _____<br>_____ |                      |                     |   | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/>      | YES <input type="checkbox"/> NO <input type="checkbox"/> |

**CLAIMS HISTORY:**

50. Are you aware of any circumstance which may result in a general liability (including Abuse and Molestation) or professional liability claim or suit being made against you? **YES**  **NO**
51. Please list the general liability (including Abuse and Molestation) and/or professional liability carrier for each of the past five years. If none, state "none."

| Insurance Company | Policy Number | Limits of Liability | Deductible | Premium | Policy Period | Claims-Made?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Retro Date _____ |
|-------------------|---------------|---------------------|------------|---------|---------------|--|
|                   |               |                     |            |         |               | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Retro Date _____                 |
|                   |               |                     |            |         |               | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Retro Date _____                 |
|                   |               |                     |            |         |               | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Retro Date _____                 |
|                   |               |                     |            |         |               | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Retro Date _____                 |
|                   |               |                     |            |         |               | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Retro Date _____                 |

**Please attach a copy of the following with your submission**

- i **Most recent state survey**
- i **Current license**
- i **Loss Runs**

**WARRANTY, AUTHORIZED SIGNATURE AND CONTINUING DUTY TO UPDATE**

The undersigned is an authorized representative of the prospective Named Insured, and acknowledges that the information provided with the Application, including all questionnaires, supplements, attachments, and replies to underwriter inquiries, and applications from other insurance companies which have been submitted to Great American and made part of this application:

1. Will be relied upon by Great American Insurance Group insurers in determining the acceptability of the prospective Named Insured and the premium amount to be charged;
2. Are true, accurate and complete; and
3. Will be considered an integral part of any resultant insurance contract.

The undersigned further agrees that the prospective Named Insured has a continuing duty, through the date of policy inception, to update this Application, including all questionnaires, supplements, attachments and replies to underwriter inquiries.

Signature, printed name and title of authorized representative of applicant and date signed:

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_