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
☐ Other (Please Explain) _____

Applicant Operates: ☐ 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%):**

%	Private Homes	%	Nursing Homes
%	Hospitals	%	Assisted Living Facilities
%	Hospice	%	Other: _____

1. State approximate percentage of referrals provided: _____**%**
2. Is the business licensed by regulatory authorities? **YES** ☐ **NO** ☐
   Attach copy of license.
3. What was the date of last inspection by licensing agency? _____/____/____
4. Were any violations or deficiencies noted? **YES** ☐ **NO** ☐
   If yes, attach copy of inspection report.
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 ☐ Sublimit:_____
    - ☐ Claims Made ☐ Included in GL or ☐ Sublimit:_____
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** ☐ **NO** ☐	**YES** ☐ **NO** ☐
b.	Education verified?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
c.	Personal references checked?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
d.	Written application required?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
e.	State **10-digit fingerprint** criminal record check?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
f.	Federal **10-digit fingerprint** criminal record check if in state less than 5 years?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
g.	Federal **10-digit fingerprint** criminal record check regardless of time in state?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
h.	Are all controls indicated in d-g required prior to any client contact?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
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** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Transport Clients				**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Home visitation				**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Home Meal Delivery				**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
Other _____ _____				**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐

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?
						☐ Yes ☐ No Retro Date _____
						☐ Yes ☐ No Retro Date _____
						☐ Yes ☐ No Retro Date _____
						☐ Yes ☐ No Retro Date _____
						☐ Yes ☐ No Retro Date _____

Please attach a copy of the following with your submission

- **Most recent state survey**
- **Current license**
- **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: _____