INPRO INSURANCE GROUP
INSURANCE PROFESSIONALS

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HOME CARE & HOSPICE APPLICATION

APPLICANT INFORMATION

PLEASE INCLUDE THE FOLLOWING WITH YOUR COMPLETED APPLICATION:

- Loss Runs for current year and 4 years prior, currently dated
- Copies of current policy Declaration Pages
- Resumes of Director and all Management Team members
- Descriptive brochures, publications, and/or newsletters
- Current Financial Statements & ProForma Budget

Applicant /Entity Name

Physical Address

Mailing Address (if different)

Phone　　Fax　　Email

Website URL

Name and Phone number of person to contact for an inspection

Requested Effective Date:　　FEIN Number (Federal Employer ID)

Applicant type: ☐ Individual ☐ Corporation ☐ Partnership ☐ Non-Profit ☐ For Profit

Date Business started:　　How long under current management?

States in which you operate:

Are you a Franchisee?

Officers of Operating Company or General Partners				
Name	Title	Years of Health Experi-ence	Active	Inactive
			☐	☐
			☐	☐

	YES	NO
Does common ownership (over 50%) exist with any other operation or entity?	☐	☐

Total Annual Gross Revenues　　Total Receipts from Medicare

Total Receipts from Medicaid　　Total Receipts from Private Pay

Total Annual Payroll

PRESENT CARRIER INFORMATION

	Carrier Name	Limits	Expiration Date	Years Insured	Annual Premium
Property/Crime/Inland Marine					
General Liability					
Professional Liability					
Automobile					
Auto/Hired & Non-Owned					
Workers Compensation					
Umbrella					
Employment Practices Liability					
Other					

Item	Five Year History	YES	NO
1.	Have you ever been under investigation or convicted by any state or local authorities, the FBI or Department of Justice? If YES, please explain on the last page.	☐	☐
2.	Have any claims/suits been made against you within the last five years? If YES, please attach copy of insurance company loss reports for each claim or suit. Specify date, description, amount paid and amount outstanding for each claim.	☐	☐
3.	Are you aware of any circumstances which may result in any claim or suit made (including request for medical records)? If YES, please explain on the last page.	☐	☐
4	Has any company declined, cancelled, or refused to renew any of your Insurance? If Yes, please explain on the last page.	☐	☐
	Is the present General Liability Policy Claims-Made? Retro Date:	☐	☐
	Does the present liability policy have a deductible? If Yes, please state Amount:	☐	☐
	Have you (including owners, managers, partners, or administrators) ever been involved in a personal or business bankruptcy? If Yes, attach a complete explanation.	☐	☐

	YES	NO
Are you required to carry a Healthcare Agency license in each state in which you operate? Licensed by:	☐	☐
Has your license ever been suspended, revoked, voluntarily surrendered or undergone enforcement action? If YES, attach a copy of Authority's report, provide specifics, and corrective action taken.	☐	☐
Have there been any claims that allege negligence or failure to comply with any regulatory/licensing guidelines? If YES, provide details and explanation on last page.	☐	☐
Are you Medicare licensed and certified?	☐	☐
Are you Medicaid licensed and certified?	☐	☐

LOCATIONS WHERE SERVICES ARE PROVIDED, AND PERCENTAGE OF BUSINESS(MUST TOTAL 100%):					
Location	**Check if "yes"**	**%**	**Location**	**Check if "yes"**	**%**
Adult Day Care Facilities	☐		Assisted Living Facilites	☐	
Clinics	☐		Doctor's Offices	☐	
Hospices	☐		Hospitals	☐	
Laboratories	☐		Nursing Home/ Assisted or Independent Living Facilities	☐	
Outpatient Facilities	☐		Owned Facility	☐	
Prison Facilities	☐		Private Homes	☐	
Schools	☐		Other	☐	

If "Other," please describe and include percentage:

Current Accreditations and Memberships	YES	Membership Number
Accreditation Commission for Health Care (ACHD)	☐	
Community Health Accreditation Program (CHAP)	☐	
The Joint Commission (JCAHO)	☐	
CARF	☐	
COA	☐	
Other	☐	

National/State Professional Associations:

	YES	NO
Do you provide Skilled Care?	☐	☐
Do you provide Hospice Care?	☐	☐

NON-SKILLED CARE					
Service	Check if "yes"	%	Service	Check if "yes"	%
Bathing/Dressing/Eating Assistance	☐		Repositioning	☐	
Errand Running	☐		Restroom Aid	☐	
Housework/Laundry	☐		Supplemental Staffing	☐	
Meal Preparation	☐		Telehealth	☐	
Medical Staffing (not a PEO)	☐		Transport to/from Appointments	☐	
Medication Reminders	☐		Other	☐	
Oxygen Equipment Provider	☐		**TOTAL NON-SKILLED CARE**		

Age Group	# of Patients	%		Age Group	# of Patients	%
0 - 8 years				9 - 18 years		
19 - 55 years				56 + years		

Please describe the types of clients you serve:

Are any of your patients deemed medically fragile (i.e. feeding tubes, breathing ventilators)? ☐ YES ☐ NO

Staff Composition: F/T = Full Time (20+ hours/week), P/T = Part Time (less than 20 hours/week)							
Type	F/T	P/T	Estimated Annual Payroll	Type	F/T	P/T	Estimated Annual Payroll
Administrative/Clerical				Child Care Workers			
Clergy				Counselors			
Dentists				Home Health Aides			
Housekeepers				Interns			
LPN/LVN				Medical Directors (Admin)			
Management/Supervisors				Nurse Practitioners			
Nursing Aides				Nutritionists			
Occupational Therapists				Opticians			
Paramedic EMTs				Pediatricians			
Pharmacists				Physical Therapists			
Physicians Assistants				Physicians Hospice			
Physicians				Psychiatrists			
Psychologists				Registered Nurses			

Staff Composition: F/T = Full Time (20+ hours/week), P/T = Part Time (less than 20 hours/week)							
Type	**F/T**	**P/T**	**Estimated Annual Payroll**	**Type**	**F/T**	**P/T**	**Estimated Annual Payroll**
Resident Managers				Sitters/Companions			
Social Worker (BSW)				Social Worker (MSW)			
Sociologists				Speech/Hearing Therapist			
Teacher/Tutor/Aid				Other			

STAFF TOTALS

Total Number of Employees:

Employee Annual Turnover Rate %

Total Number of Full Time Employees

Total Number of Part Time Employees

Number of Union Employees

Number of Non-Union Employees

Total Number of Volunteers

Total Number of Annual Volunteer Hours

Are medical/health insurance benefits offered to full-time employees? ☐ YES ☐ NO

Do you anticipate any workforce reduction in the next six months? ☐ YES ☐ NO If YES, please detail on last page.

RISK MANAGEMENT

	YES	NO
Do you have a formal, written Quality Assurance Risk Management Program? If "NO," please explain:	☐	☐
Do you have a plan in place for a medical emergency?	☐	☐
Are files maintained to protect the confidentiality of clients?	☐	☐
Is there formal staff training?	☐	☐
Do you screen potential client locations for a safe work environment prior to assignment of staff?	☐	☐
Are formal written procedures in place for staff hiring?	☐	☐
Do you have a formal, written Safety Program?	☐	☐

If YES, check all that apply:	YES	NO		YES	NO
Formal Accident/Injury Investigation	☐	☐	Labor/Management Safety Committee	☐	☐
Formal Written Accident Report	☐	☐	Proper Lifting Techniques Instruction	☐	☐
Safe Handling/Disposal of Needles/Sharps	☐	☐	Blood Borne Pathogens/Infection Training	☐	☐
Drug Free Workplace Program	☐	☐	Home Site Safety Surveys Conducted	☐	☐
Loss Control Procedures in Place	☐	☐	Training & Incentive Program	☐	☐
Patient Handling/Transfer Training	☐	☐	Post Accident Drug Testing	☐	☐
Workplace Violence Training	☐	☐	Return to Work/Modified Duty Plan	☐	☐
Accident/Injury Investigation Procedures	☐	☐	Daily Work Reports Required	☐	☐

Check all Methods used in the Hiring/Screen Process	
Method	**Yes**
Drug & Alcohol Testing	☐
Criminal Background Checks - Federal (10 years data)	☐
Criminal Background Checks - State (10 years data)	☐
Reference Checks	☐
Personal Interview	☐
Sexual Abuse Registry	☐
Validate Work History	☐
Validate Education	☐
Verify Current Certifications/Professional Licenses	☐
Validate Driver's License	☐
Validate personal auto insurance and limits (if operating owned vehicle during company hours)	☐

Check all Methods used in the Hiring/Screen Process

Pre-Employment Physical	☐
Require Insurance Certificates for Independent Contractors	☐
Documentation of Pre-Existing Injuries	☐
Employee Orientation Program	☐
Specific Job Training Provided	☐

Reference Checks/Verifications are done: ☐ Before Hiring ☐ After Hiring ☐ Random

If not done prior to hiring, please explain:

What actions do you take if any of these reports are unfavorable?

How are references checked? ☐ written ☐ Verbal ☐ Both. If verbal only, please explain:

	YES	NO
Do you employ relatives of the patient as their care provider?	☐	☐
Do you require job applicants to complete an employment application? If yes, please attach a copy.	☐	☐
Do you conduct a personal interview for each prospective staff member?	☐	☐
Do you have 24-hour employee exposure such as live-in care for clients?	☐	☐
Do you verify if potential employees and/or independent contractors have ever had their license revoked or suspended, or disciplinary action taken against them?	☐	☐
Do you have written procedures on how to prevent theft from the client's home?	☐	☐
Are written job descriptions provided for all professional and non-professional employees?	☐	☐

	YES	NO
Do you have an employee handbook or statement of work rules, and is it given to all employees? If YES, please check the items that are included.	☐	☐

☐ Anti-Sexual Harassment Policy ☐ Anti-Discrimination Policy ☐ Written Grievance/Complaint Procedures

☐ Drug & Alcohol Policy ☐ "Open Door" Policy ☐ ADA Policy ☐ Employment-at-Will Statement

Do you obtain signed employee acknowledgement?	☐	☐
Do employees actively participate in continuing education programs?	☐	☐
If contracted professionals are used, do you require them to sign a *hold harmless* or indemnification agreement? If YES, attach a copy of the standard agreement.	☐	☐
Do you have a formal incident report procedure in place?	☐	☐
Is the staff required to report to the administrator all incidents that may result in a claim?	☐	☐
Are written records of all incidents kept by the administrator?	☐	☐
Are all incidents reviewed?	☐	☐

	YES	**NO**
Do you have formal, documented training in place for the following?		
• Crisis Management?	☐	☐
• Disposal of Medical Waste?	☐	☐
• First Aid?	☐	☐
• AED Training?	☐	☐
• Infusion Therapy?	☐	☐
• Safe Lifting?	☐	☐
• Transferring & Client Handling?	☐	☐
• Blood Borne Pathogens?	☐	☐
• Safe use of equipment?	☐	☐
Are companion care providers certified through the National Association for Home Care and Hospice (NAHC)?	☐	☐
Do you have current contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and assisted living homes?	☐	☐
Is the staff informed of AIDS/HIV patients?	☐	☐
Do you prominently display all posters required by state and federal law such as but not limited to anti-discrimination, wage and hours, etc?	☐	☐
Do patient records include the following?		

	YES	NO
• A complete treatment plan prescribed by a physician, including follow-up plans?	☐	☐
• An "informed consent" document obtained and placed in the patient's medical record?	☐	☐
• Patient care home visits meticulously documented?	☐	☐
• Complete medical records maintained on all patients?	☐	☐
• Patient records kept on file (hardcopy or electronic) for a minimum of six years?	☐	☐
• All changes in condition and incidents documented to the physician and family?	☐	☐
• Medications and dosage, including documentation of administering medications?	☐	☐
• A copy of literature given to clients explaining services and fees?	☐	☐
• Termination of services and discharge criteria?	☐	☐
• Are standard client contracts used? If YES please attach a copy.	☐	☐
Do you conduct patient/client surveys?	☐	☐
Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional?	☐	☐

	YES	NO
Are medications kept in a locked area to prevent tampering? If YES, answer the following:	☐	☐
• Where are the medications stored?		
• Who has the authority to dispense medications?		
• Can over-the-counter medicines be dispensed without written permission from a doctor?	☐	☐

ABUSE & MOLESTATION

	YES	NO
Does your current insurance program include Abuse & Molestation coverage? If yes:	☐	☐

☐ Claims Made ☐ Retro Date Effective Date ☐ Limit of Liability

Carrier:

	YES	NO
Does your organization have a written "zero tolerance" sexual abuse molestation policy? If YES, check which items are included:	☐	☐

☐ Definition of Sexual Abuses/Molestation ☐ Incident Reporting Procedures

☐ Investigative Procedures ☐ Disciplinary Procedures ☐ Retaliation Warning

	YES	NO
Do you have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if you have an incident of abuse?	☐	☐
Are there written complaint procedures and are they displayed prominently? If NO please explain below.	☐	☐
Are there written procedures that monitor staff in day-to-day relationships with clients, on and off premises?	☐	☐
Is there documented, formal staff training on sexual abuse, including how to recognize the signs and how to report a known or suspected incident?	☐	☐
Is there more than one person responsible for the welfare of any single patient?	☐	☐
Are you aware of ANY claims, allegations, and/or incidences (including abuse & molestation) made against your organization, or against anyone working on your behalf that may give rise to a claim against you in the last five years or is currently an open/closed claim? If YES, check the appropriate boxes and provide requested information.	☐	☐

☐ Case was Settled ☐ Case Went to Trial Amount Paid for Damages to the Victim

Please provide details including dates, current status, amount paid/incurred, and resulting organizational/policy changes implemented as a result (attach additional page). Please attach a copy of your current abuse and molestation prevention policy.

EMPLOYMENT PRACTICES LIABILITY

	YES	NO
Have you had any cases of inappropriate employment acts, discrimination, wrongful termination or sexual harassment in the last five years? If YES, please complete the following:	☐	☐
Do you currently carry Employment Practices Liability Insurance? If YES, Limit of Insurance $ Deductible $	☐	☐

	Year	Type Claim/Suit	$ Legal Expense	$ Claim Payment	Claim Now Closed
1.			$	$	☐
2.			$	$	☐

AUTOMOBILE

	YES	NO
Do you have a Commercial Business Auto Policy for owned autos?	☐	☐

If YES, in what names are the vehicles titled?

If NO, do you wish to apply for Hired and Non-Owned Auto Liability? ☐ YES ☐ NO

Vehicle Year, Make, Model, VIN:

Driver Name, DOB, Drivers License#, State

Driver Name, DOB, Drivers License#, State

Do you have a written driver safety program and/or driver training? ☐ YES ☐ NO

What are the limits of liability required to be carried by your employees?

Do you allow employees to drive the client's vehicle? ☐ ☐

If YES, how do you verify patient and/or client owned automobile liability insurance coverage is in force?

Do you have a program to monitor an employee's personal auto liability insurance program? ☐ ☐

If YES, is the employee's insurance monitored ☐ At Time of Hire ☐ Annually

Do you run MVRs on all employees? ☐ ☐

If YES, are MVRs run: ☐ At Time of Hire ☐ Annually ☐ Randomly

Do you obtain a copy of drivers licenses for all employees and volunteers? ☐ ☐

Are there criteria/consequences for "bad" drivers? ☐ ☐

If YES, please explain:

	YES	NO
Do employees use personal vehicles for company business?	☐	☐
Do your employees or volunteers transport clients in their own automobiles (appointments or errands)?	☐	☐

If YES, please indicate: ☐ Car ☐ Truck ☐ Van ☐ Bus

How many clients? For What Purpose?

Radius of Operations (in miles): ☐ Less than 10 ☐ 11 - 50 ☐ 51 - 100 ☐ 101 - 300 ☐ 301 - 500

Do you transport non-ambulatory clients? ☐ ☐

Do you contract with an ambulance or livery service to transport clients? ☐ ☐

What is the maximum and minimum age of drivers allowed to drive vehicles? Maximum Minimum

Do you allow personal use of a company-owned vehicle? ☐ ☐

Do you make sure travel logs are kept for all drivers? ☐ ☐

Do you transport clients/consumers for private or government agencies? If YES, please explain on last page. ☐ ☐

If YES, is this transportation for a fee? ☐ ☐

REMARKS:

WORKERS COMPENSATION SECTION

Corporate Officers

Name	Title	% Owner-ship	Duties	Included or Excluded

Estimated Annual Payroll by Classification:

Clerical/Admin $

Direct Care Staff $

Other $ Please detail

Current Experience Modification Factor

Any Workers Compensation Claims in the past 5 years? Yes ☐ No ☐
If YES, include 5-year claim history provided by prior carrier(s).

THE APPLICANT WARRANTS THAT INFORMATION IN THIS APPLICATION IS TRUE TO THE BEST OF ITS KNOWLEDGE AND INCLUDES ALL MATERIAL INFORMATION.

APPLICANT ALSO WARRANTS THAT IF INFORMATION MATERIAL TO THE NATURE OF THIS INSURANCE CHANGES, APPLICANT WILL IMMEDIATELY NOTIFY INPRO INSURANCE GROUP.

I AUTHORIZE INPRO INSURANCE GROUP TO OBTAIN OUR EXPERIENCE MODIFICATION FACTOR DATA FOR THE PURPOSE OF QUOTINGWORKERS COMPENSATION INSURANCE.

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Applicant Signature

Electronic Signature—type your full legal name to sign electronically:

Date:

It is understood and agreed that the completion of this supplemental application does not bind the company to issue, nor the Applicant to purchase, the insurance.

If you have answered YES to any questions requiring explanation, please use the space below or attach additional sheets.