

Home Health Supplemental Application

A. Exposure Information

1. Please describe and give historical exposures (# of visits) by category of staff including contracted staff?

Type of Home Health Providers	Next 12 Months Projected	Current Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior	5 th Year Prior
Nurses (RN, LPN, LVN)							
Nurse Practitioner							
Physical/Speech/Occ Therapists							
Respiratory Therapist							
Social Worker							
Home Maker HHA							
Home Care (Companion)							
Pharmacy							
Other (Specify)							

2. Services Provided by Percentage of Gross Receipts (check all that apply)

Adult Day Care	_____%	Housekeeping	_____%	Maternal/Fetal Monitoring	_____%
Hospice	_____%	Wound Care	_____%	Infant Day Care	_____%
Cooking	_____%	Infusion Therapy	_____%	Dialysis	_____%
Dietician	_____%	Staffing	_____%	Drug Administration	_____%
Medical Lab	_____%	Nursing	_____%	Training	_____%
Hospital	_____%	Pers. Companion	_____%	Transportation	_____%
Pediatrics	_____%	Pediatric Infusion	_____%	Cardiac Monitoring	_____%
RehabTherapy	_____%	Ventilator Care	_____%	Durable Medical Equipment (if any complete Section C)	

3. What states does the applicant perform services in and provide percentage by state if more than one?

4. Does the applicant own, control, or staff any of the following?

Medical Laboratory (in house)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nursing Home	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rehabilitation Facility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospital – General Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Substance Abuse Programs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adult Day Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infusion/Respiratory/Radiation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rental and/or Leasing Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emergency Rooms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emergency Vehicles	<input type="checkbox"/> Yes	<input type="checkbox"/> No

B. Quality Assurance

Hiring/Screening/Employment Procedures:

- | | | |
|--|----------------------------------|---|
| 1. Are employee/contractor references checked prior to hiring? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. How are the references checked? | <input type="checkbox"/> Written | <input type="checkbox"/> Verbal <input type="checkbox"/> Both |
| 3. Are prospective employees screened for prior criminal records? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Are employees actively participating in CE programs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Are job descriptions provided for each employee? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Are professional employees required to carry their own insurance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- If Yes, what minimum limit is required? \$ _____

Accreditation:

Is the applicant a member or accredited by any of the following (If yes please attach copy of the most recent survey):

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| National Homecare Council | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| JCAHO | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| National Association of Home Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| CHAP | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other (please specify) _____ | | |

Risk Management:

- | | | |
|---|------------------------------|-----------------------------|
| 1. Does the applicant utilize a formal written QA/RM program?
If Yes, please provide a copy. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does the applicant have a Peer Review Committee? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Does the applicant conduct patient/client surveys? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Does the applicant provide continuing education programs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Are informed consent forms used?
If Yes, when _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Is there a written policy or procedure document describing: | | |
| a. patient acceptance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. advance directives (Living Will) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. employee training | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. safety for workers in offsite locations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. lifting requirements | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. patient evaluations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. incident reporting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. drug administration procedures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. food preparation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. medical equipment training | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. patient discharge procedures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. patients rights | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. medical records | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. termination of care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o. MD signing of orders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

C. Durable Medical Equipment (If Applicable)

Medical Equipment and Supplies (please attach product description for all products)

1. Does the applicant sell any medical equipment and/or supplies? Yes No
2. Does the applicant rent or lease any medical equipment and/or supplies? Yes No
3. If applicant answered Yes to either 1 or 2 above, then complete section below.

Category I. Expendable Items – intended for one time usage and disposal (i.e., adhesive tape, bandages, hypodermic needles, etc.)
Annual Sales: _____

Category II. Non-Expendable Items – Excluding diagnostic or treatment equipment or devices. This category includes but not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelers, etc., and prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment.
Annual Sales: _____ **Lease/Rental Receipts:** _____

Category III. Diagnostic or Treatment Devices – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment not used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, portable EKG machines, or sending devices.
Annual Sales: _____ **Lease/Rental Receipts:** _____

Category IV. Life Sustaining or Critical Life Monitoring Equipment, or Devices – This category includes dialysis or heart/lung machines, IV pumps, ventilators, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/devices or improper function of which could result in death or serious deterioration in health condition
(Please attach list of category IV equipment or devices)
Annual Sales: _____ **Lease/Rental Receipts:** _____

4. Does the applicant perform any maintenance or repairs on equipment sold or leased? Yes No

If Yes, please indicate the category (as described above):

Category I Category II Category III Category IV

5. Are all devices/equipment checked and documented as to condition prior to release? Yes No

6. Does the applicant perform, or has the applicant performed, preventive maintenance on all equipment/devices according to a written schedule? Yes No

7. Is the applicant named as an additional insured or vendor on the manufacturers policy for any/all products? Yes No

8. Does the applicant obtain certificates of insurance from their product suppliers? Yes No
9. Does the applicant currently or has the applicant ever imported products from foreign manufacturers?
If Yes, does the manufacturer have a US location? Yes No
 Yes No
10. Does the applicant modify the product in any way from its original form/use?
If Yes, please attach explanation. Yes No
11. Does the applicant do any re-packaging or re-labeling of items obtained from suppliers?
 Yes No
12. Does the applicant have its own sales staff? Yes No
13. Does the applicant repair or sell used equipment of others? Yes No
14. Does the applicant reuse/resell any single use devices?
If Yes, please attach a list of those devices. Yes No

NOTICE: This supplement is attached to and forms a part of the Miscellaneous Health Care Facility Professional Liability and Commercial General Liability Application and is subject to the same representations and conditions.

Signature of Applicant: _____

Title: _____

Date: _____