Berkley Human Services
a Berkley Company

HOME HEALTH CARE AGENCY & HOSPICE QUESTIONNAIRE

SUBMISSION REQUIREMENTS

1. This form must be fully completed, signed and dated.
2. Attach a completed ACORD 125 and an ACORD application for each line of coverage applied for.
3. Attach a minimum of 5 years of currently valued, hard copy loss runs for each line of coverage applied for. (Provide details of any claim with an incurred value over $5,000.
4. Attach a copy of any brochures, literature or descriptive material provided to clients.
5. Copies of all licenses.

GENERAL INFORMATION

Date of Application:
Proposed Effective Date:
Coverages Desired:

General Liability ☐ Coverage Not Desired
☐ Occurrence ☐ Claims Made Retro Date: / /
☐ $300,000/$600,000 ☐ $1,000,000/$2,000,000
☐ $500,000/$1,000,000 ☐ $1,000,000/$3,000,000

Professional Liability ☐ Coverage Not Desired
☐ Occurrence ☐ Claims Made Retro Date: / /
☐ $500,000/$500,000 ☐ $1,000,000/$2,000,000
☐ $1,000,000/$1,000,000 ☐ $1,000,000/$3,000,000

Abuse or Molestation Liability Coverage ☐ Coverage Not Desired
☐ Occurrence ☐ Claims Made Retro Date: / /
☐ $100,000/$100,000 ☐ $1,000,000/$1,000,000
☐ $250,000/$250,000 ☐ $1,000,000/$2,000,000
☐ $500,000/$500,000 ☐ $1,000,000/$3,000,000

Employee Benefits Liability Coverage ☐ Coverage Not Desired
☐ Occurrence ☐ Claims Made Retro Date: / /
☐ $100,000/$100,000 ☐ $1,000,000/$1,000,000
☐ $250,000/$250,000 ☐ $1,000,000/$2,000,000
☐ $500,000/$500,000 ☐ $1,000,000/$3,000,000

☐ **Crime** ☐ **Business Auto**
(Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.)

APPLICANT & GENERAL INFORMATION

1. Applicant's Legal Name (including DBAs'):
2. Entity Type: ☐ Non-profit ☐ For-profit ☐ Governmental ☐ Religious Based
3. Organization Type: ☐ Corporation ☐ Individual ☐ Joint Venture ☐ LLC ☐ Other:
4. Date Business Established: ***If in business less than 3 years, attach principal's resume.***
5. How many years have you been in operation? Under present management: Website:

	Yes	No
6. Is the applicant a member of, or accredited by, any of the following organizations? (Check all that apply)	☐	☐

- ☐ Community Health Accreditation Program (CHAP)
- ☐ Joint commission on Accreditation of Health Care Organizations (JCAHO)
- ☐ Other:

7. Type of firm (check all that apply)

☐ * Closed Pharmacy	☐ Medical Equipment Rental/Sales	☐ Personal care/Support services
☐ Companion care provider	☐ * Medical Staffing	☐ * Retail Pharmacy
☐ Home Health Provider	☐ Non-Medical Staffing	☐ * Supplemental Staffing
☐ Hospice	☐ * Nurse Registry	☐ Visiting Nurse Agency
☐ Infusion Therapy		☐ Other (specify)

* *Indicates not eligible*

8. Describe any changes in operations planned within the year:

	Yes	No
9. Is this company a franchise?	☐	☐
If yes, does the franchisor provide additional training and education for the field employees after initial startup?	☐	☐
10. Has your license ever been suspended, revoked or placed under conditional status?	☐	☐

If yes, please explain:

	Yes	No
11. Have you discontinued any programs, goods or services or made major procedural changes in the past five (5) years or since your retro date?	☐	☐

If yes, please explain:

12.

Total annual gross revenues in the last 12 months:		Total annual gross revenues for next 12 months:	
From Medicare/Medicaid:	$	From Medicare/Medicaid:	$
From Charitable Contributions:	$	From Charitable Contributions:	$
From Private Pay:	$	From Private Pay:	$
From Other:	$	From Other:	$
Total:	$	Total:	$

13. What is the total annual payroll for all employees excluding clerical/administrative for the last 12 months? $
Next 12 months? $
14. Number of patient visits during the past 12 months? Next 12 months?
15. Number of skilled home health care patients/clients during the past 12 months? Next 12 months?

LOCATION OF SERVICES PROVIDED

Location of services provided (total must equal 100%)

Adult Day Care Facilities	%	Hospital-Operating Rooms	%	Prisons	%
Assisted Living Facilities	%	Hospital-Wards	%	Private Homes	%
Clinics	%	Laboratories	%	Schools	%
Doctor's Offices	%	Nursing Homes	%	Other Facility: (specify)	%
Hospice	%	Outpatient Facilities	%		
Hospital-Emergency Dept.	%	Owned Facility	%	**Total (must equal 100%)**	%

SERVICES PROVIDED

1. Indicate which of the following health services are provided by your organization:

Adult Daycare	%	Personal Care/Companion	%
Cardiac Care	%	Pet Therapy	%
Case Management	%	Pharmacy	%
Child Daycare	%	Physical Therapy	%
Clinics Owned/Operated	%	Rehabilitation Services	%
Developmental Therapy	%	Respite Care	%
Durable Medical Equipment Supplier	%	Skilled Nursing Care	%
Gastrostomy Tube (GT) Care	%	Special Care (Alzheimer's/Dementia, etc.)	%
Hospice	%	Speech/Hearing Therapy	%
Infant Care	%	Supplemental Staffing	%
Infusion Therapy	%	Trach/ventilator	%
Medical Social Services	%	Training/Certification	%
Obstetrical/Doula Services	%	Other: (specify)	%
Occupational Therapy	%		
Palliative Care	%	**Total (must equal 100%)**	%
Pediatric Care	%		

2. What percentage of the services provided as indicated above are performed by volunteers? % ☐ N/A

	Yes	No
3. Do you participate in community wellness programs, including immunizations, flu shots or vaccination programs? If "yes," please provide the number of immunizations:	☐	☐
4. Do you provide live-in (more than 24 hours of continuous medical attention provided by the same caregiver) Home Health Care Service? If "yes," what percentage of your total services include live-in Home Health Care Service? %	☐	☐
5. Do you do any consulting work? If yes, explain:	☐	☐

STAFFING

	Employees				Independent Contractors				Volunteers		
Staff Type	**Full Time**	**Part Time**	**Annual Hours**	**Annual Payroll**	**Full Time**	**Part Time**	**Annual Hours**	**Annual Payroll**	**Full Time**	**Part Time**	**Annual Hours**
Administrator/Clerical/Office											
Clerical											
CNA (Certified Nursing Assistant)											
Counselor											
Home Health Aid											
Homemaker/Companion											
LPN/LVN											
Nurse (RN)											
Nurse Practitioner											

Nutritionist/Dietician											
Pharmacist											
Physician* Provide details if other than a Medical Director											
Sitter/Companion											
Social Workers - Bachelors											
Social Workers - Masters											
Therapist – Developmental											
Therapist – Occupational											
Therapist – Physical Therapy											
Therapist – Speech/Hearing											
Other:											

Describe any additional contracted home health care professionals (if different from above).

HIRING / SCREENING PRACTICES

1. Check all methods used in the hiring/screening process

	Employee	Contractors	Volunteers
Drug & Alcohol testing	☐	☐	☐
Criminal background checks - Federal	☐	☐	☐
Criminal background checks – State	☐	☐	☐
Reference checks	☐	☐	☐
Personal Interview	☐	☐	☐
Sexual abuse registry	☐	☐	☐
Validate work history	☐	☐	☐
Validate education	☐	☐	☐
Verify current certification / Professional license	☐	☐	☐
Validate driver's license	☐	☐	☐
Validate personal auto insurance and limits (if operating owned vehicle during company hours)	☐	☐	☐

	Yes	No
2. Are all of the above methods done prior to hiring?	☐	☐
3. Are there formal hiring procedures in place?	☐	☐
4. Do you obtain written employment applications for all staff and volunteer positions?	☐	☐
5. Does employment application request background information on conviction for any crime, including sex-related or child abuse related offenses?	☐	☐
6. Are any staff members under 18 years of age?	☐	☐
7. Are references ☐ Written ☐ Verbal ☐ Both		
8. Does the employment process include verification of whether the individual has ever been convicted of any Crime, including sex related or child-abuse related offenses, before an offer of employment is made?	☐	☐
9. Do volunteers work directly with patients?	☐	☐
If yes, do you order Criminal Background Checks on all volunteers who work directly with patients?	☐	☐
10. Are job descriptions provided for all professional and nonprofessional employees?	☐	☐

11. What is the average staff turnover rate?
12. When is drug testing performed? ☐ Pre-hire ☐ After Hire ☐ Random; How frequently thereafter?

PROCEDURES

	Yes	No
1. Are written job descriptions in place for all staff positions?	☐	☐
2. Name of executive director/manager: # of years experience in this field: ; # of years at this facility: Special training/education:		
3. Are employees and independent contractors required to carry their own individual professional liability coverage? Limits:	☐	☐
	Yes	**No**
4. Are certificates of insurance maintained on file for all employees and independent contractors and updated annually?	☐	☐
5. Are procedures in place to report ALL incidences that may result in a claim?†	☐	☐
If yes, are written records kept†	☐	☐
Are these records reviewed?	☐	☐
Are clients referred to specialists when appropriate?†	☐	☐
6. Do you have a formal HIPAA compliance procedure in place?	☐	☐
7. Is there a peer and/or committee who reviews the incident reports to improve upon any allegations previously outlined in surveys or reports?	☐	☐
8. Do you have formal documented training in place for the following:		
- AED training?	☐	☐
- Blood borne pathogen?	☐	☐
- Crisis management?	☐	☐
- Disposal of medical waste?	☐	☐
- First aid?	☐	☐
- Infusion therapy?	☐	☐
- Safe lifting, transferring, and client handling?	☐	☐
- Safe use of equipment?	☐	☐
9. Are staff informed of AIDS/HIV Patients?	☐	☐
10. Are the following in place?		
- 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 documented in detail?	☐	☐
- Medical records maintained on all patients?	☐	☐
- All changes in condition and incidents documented to the physician and family?	☐	☐
- Patient records kept on file for a minimum of 6 years?	☐	☐
- Medications & dosage, including documentation of administering medications?	☐	☐
- Copies of literature are given to clients explaining services and fees?	☐	☐
- Termination of services and discharge of criteria?	☐	☐
- Documentation of all homecare training provided?	☐	☐
- Are files maintained to protect confidentiality of clients?	☐	☐
11. Are standard client contracts used?	☐	☐
12. Are medications kept in a locked area/cabinet to prevent tampering?	☐	☐
13. Do you teach/certify home health aides?	☐	☐
14. Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional?	☐	☐

SEXUAL ABUSE LIABILITY (Complete if coverage is desired)

	Yes	No
1. Do you have a written zero tolerance sexual abuse and molestation policy?	☐	☐
If yes, does your written policy include the following?		
– A zero tolerance statement?	☐	☐

- Definition of sexual abuse/molestation ☐ ☐
- Reporting procedures with at least two persons to report to internally? ☐ ☐
- Incident reporting procedures? ☐ ☐
- Investigation procedures? ☐ ☐
- Disciplinary Procedures? ☐ ☐
- Anti-Retaliation warning? ☐ ☐
- Are they updated yearly? ☐ ☐

2. Is the policy consistently enforced, requiring annual review by each employee and/or volunteer, mandating Individual signoff that he or she has read the policy, has received appropriate training and agrees to adhere to the policy? ☐ ☐
3. Is there a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if there is an incident of abuse? ☐ ☐
4. Are there written complaint procedures and are they displayed prominently? ☐ ☐
   If "no" please explain:
5. Is there formal staff training on sexual abuse, including how to recognize the signs? ☐ ☐

Attach a copy of your current abuse and molestation prevention policy.

HIRED AND NON-OWNED AUTO (Complete if coverage is desired)

	Yes	No
1. Do you hire vehicles? If yes, what type:	☐	☐
2. Average # of hired vehicles per year: Annual average cost to hire vehicles: $		
3. Number of individuals that drive their personal vehicle for business regularly: Full time Part Time Volunteer		
4. Number of individuals that drive their personal vehicle for business occasionally: Full time Part Time Volunteer		
5. Are clients transported in personal vehicles? † If yes, provide details:	☐	☐
6. Does your employee / volunteers maintain auto liability limits of at least $100,000 Combined Single Limits?	☐	☐
7. Are all drivers at least 21 years of age? † How many driver's aged 21 to 25 transport clients?	☐	☐
8. How many drivers are over age 65?	☐	☐
9. Do you obtain MVR's on all drivers (staff and volunteers)?	☐	☐
10. Do you have a written guideline on what are acceptable driving records?	☐	☐
11. Do you have a driver safety program?	☐	☐
12. Is training provided for employees/volunteers prior to their being allowed to transport clients/residents? †	☐	☐

AUTOMOBILE (Complete if coverage is desired)

	Yes	No
1. Are all vehicles listed on the ACORD application titled to the applicant? If no, explain:	☐	☐

2. Where are owned vehicles stored? ☐ †Garage ☐ †Driveway ☐ Parking Lot ☐ Other:
3. Provide details where any employee is allowed personal use of vehicle or take vehicle home at night:

4. If personal use or vehicle taken home at night, do you restrict use by other family members in using the vehicles?† ☐ ☐
5. Are keys locked and secured away from non-drivers when not in use?† ☐ ☐
6. Do you provide transportation for: † ☐ Staff ☐ Clients/Residents † ☐ Visitors/ Public
   If yes, is more than one staff member required in the vehicle? ☐ ☐
7. Are vehicles checked after passengers disembark to make sure no one is left behind?† ☐ ☐
8. Do you require seat belts to be worn by all occupants?† ☐ ☐
9. Are vehicles maintained regularly? ☐ ☐
10. Do you run MVR's on all homecare providers? ☐ ☐
11. Do you have a written procedure regarding hands free driving and no texting policy? ☐ ☐
    If yes, how often: ☐ At time of hire ☐ Annually ☐ Randomly
    What action is taken if an "unacceptable" driver is identified?

12. Do you require all homecare providers who use their own vehicles for company business to carry personal auto insurance? ☐ ☐
    If yes, what limits are required? $
13. Do you obtain certificates of insurance or a copy of the declarations page from the homecare providers automobile insurer? ☐ ☐
    If yes, who maintains these records?
14. Are all independent contractors required to list the Applicant as an additional insured? ☐ ☐
15. Are all drivers at least 21 years of age?† ☐ ☐
16. †How many driver's aged 21 to 25 transport clients? ☐ ☐
17. How many drivers are over age 65? ☐ ☐
18. Is there a driver safety program in place? ☐ ☐
19. Is training provided for employees/volunteers prior to their being allowed to transport clients/residents? ☐ ☐
20. If you transport clients please indicate the following .
    How often is transportation required: ☐ Frequently ☐ Occasionally ☐ Rarely
    Do you require evidence of regular preventive vehicle maintenance? ☐ ☐
    Are the clients non-ambulatory? ☐ ☐
    Are drivers trained on wheelchair securement protocols & procedures? ☐ ☐
21. Does anyone besides employees or volunteers drive your vehicles?† ☐ ☐
22. Do you allow employees to operate a patient or client's vehicle? ☐ ☐
    If yes, do you verify patient and/or client owned automobile liability is in force? ☐ ☐
23. Do you keep travel logs for all drivers? ☐ ☐
24. Do you contract with an ambulance or livery service to transport clients? ☐ ☐
    If yes, please provide a copy of the contract.

PRIOR LOSS HISTORY AND CLAIMS ☐ NONE

	Yes	No
1. Have any incidents resulted in an allegation of negligence?†	☐	☐
Was the case settled?†	☐	☐
Was case taken to trial?†	☐	☐
What was outcome?		
Amount paid to victim: $		
2. Do you have knowledge of any incidents or claims that allege failure to comply with any regulatory/licensing guidelines?	☐	☐
3. Do you have any knowledge of an event, circumstance, or occurrence prior to the effective date of the proposed policy that may give rise to a claim?	☐	☐
If yes, describe the event and indicate the reason for the anticipated claim:		

Date(s)	Description	Total Incurred Losses (Reserves and Payments	Status (Open or Closed)	Measures in place to prevent future losses

PREVIOUS LIABILITY INSURANCE (PAST 5 YEARS)

Line of Business	Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made or Occurrence Form	Retroactive Date (Claims Made Only)
☐ GL ☐ SAM ☐ PL				$		
☐ GL ☐ SAM ☐ PL				$		
☐ GL ☐ SAM ☐ PL				$		
☐ GL ☐ SAM ☐ PL				$		
☐ GL ☐ SAM ☐ PL				$		
☐ GL ☐ SAM ☐ PL				$		
☐ GL ☐ SAM ☐ PL				$		

GL = General Liability, SAM = Sexual Abuse or Molestation, PL = Professional Liability

SIGNATURES

Insured Signature _____ Date _____

Producer Signature _____ Date _____