1717 Arch Street, 45th Floor
Philadelphia, PA 19103

HOME HEALTH CARE SERVICES SUPPLEMENTAL APPLICATION

Applicant Name: _____
DBA: _____
(If more than one entity/subsidiary, please attach description and % owned for each)

☐For Profit ☐Non-Profit ☐Partnership ☐Other (specify): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Date business established: _____ # of years under present management: _____

Federal Employer Tax I.D. Number: _____

Website address (if available): _____

Name and phone number of person to contact for inspection: _____

SUBMISSION REQUIREMENTS

- PHLY Home Health Care Supplemental Application
- ACORD Applications (Applicant Information, including Crime and Umbrella)
- 5 Years of currently valued carrier loss runs
- Copy of State(s) Home Health Care License(s) and most recent State Licensure survey
- Brochures
- Copy of all Federal and State complaint investigation reports in the last 12 months
- (If contracted with Nursing Homes, Assisted Living and Hospitals); Provide copies of Indemnification Agreement,
- Hold Harmless Agreement, Additional Insured Provisions

APPLICANT INFORMATION

1. List the Applicant's states and territories radius of operation from main address:
   _____
2. Is the Applicant licensed in all states in which it is operating? ☐Yes ☐No
   If "no", please list states of operation where not licensed:
   _____
   If "no", please describe how these functions are monitored?
   _____
3. Is the Applicant Medicare licensed and certified? ☐Yes ☐No
4. Is the Applicant Medicaid Licensed and certified? ☐Yes ☐No

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5. Has the Applicant's license ever been suspended, revoked, voluntarily surrendered or undergone enforcement action? ☐Yes ☐No
   If "yes", provide specifics and corrective action taken:

6. Does common ownership (over 50%) exist with any other operation? ☐Yes ☐No
   If "yes", give names and types of operations managed and owned:

7. Total annual Gross Revenues: $ _____
   Total receipts from Medicare: $ _____
   Total receipts from Medicaid: $ _____
   Total receipts from Private Pay: $ _____

8. Does the Applicant contact with a hospital or skilled nursing facility for inpatient beds? ☐Yes ☐No
   If "yes", please explain:

9. Is the Applicant a member of any State Association? ☐Yes ☐No
   If "yes", please provide the name of the State Association:

10. Is the Applicant a member of any other industry association(s)? ☐Yes ☐No
    Please specify: _____
    Member #: _____

Types of Services Provided:					
Service		**Service**		**Service**	
☐Adult Day Care	%	☐Hospice	%	☐Pet Therapy	%
☐Chemotherapy	%	☐Infant Care	%	☐Pharmacy	%
☐Child Day Care	%	☐Infusion Therapy	%	☐Physical Therapy	%
☐Clergy	%	☐Meals on Wheels	%	☐Radiation Therapy	%
☐Clinical Care	%	☐Medical Equip. Supplier	%	☐Rehabilitation %	%
☐Companion / Sitter	%	☐Nurse Practitioner	%	☐Respiratory Therapy	%
☐Dialysis	%	☐Occupational Therapy	%	☐Speech Therapy	%
☐Dietician / Nutritionist	%	☐Pediatric Care	%	☐Skilled Nursing Care	%
☐General Nursing (LPN/LVN)	%	☐Personal Care	%	☐Ventilator:	%
		☐Other:	%	☐Other:	%
				ABOVE MUST TOTAL 100%:	%

Location of Services Provided:					
Type		**Type**		**Type**	
☐ Private Homes	%	☐ Hospitals	%	☐ Clinics	%
☐ Doctor's Offices	%	☐ Nursing Homes	%	☐ Owned Facility	%
☐ Assisted Living Facilities	%	☐ Other:	%	☐ Other:	%
				ABOVE MUST TOTAL 100%:	%

Supplemental Services (Supplying health care providers to other facilities for a fee): IF "NO" check here:					
Type		**Type**		**Type**	
☐ Private Homes	%	☐ Hospitals	%	☐ Clinics	%
☐ Doctor's Offices	%	☐ Nursing Homes	%	☐ Owned Facility	%
☐ Assisted Living Facilities	%	☐ Other:	%	☐ Other:	%
				ABOVE MUST TOTAL 100%:	%

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Employees / Independent Contractors – Annual Staffing:						
	Employees		Independent		Annual Payroll	
	Full Time	Part Time	Full Time	Part Time	Employees	Independent Contractors
Acupuncturist						
Certified Nurse Anesthetist						
Clergy / Chaplain						
Clerical						
Dietitian						
Nurses (RN)						
Homemaker / Home Health Aid						
LPN / LVN						
Medical Director						
Nurse Practitioner						
Occupational Therapist						
Pharmacist						
Physical Therapist						
Physician						
Physician Assistant						
Psychiatrist						
Psychologist						
Respiratory Therapist						
Social Worker						
Speech Therapist						
Volunteers						
Other (specify):						
Total:	**0**	**0**	**0**	**0**	**0**	**0**

11. Describe any additional contracted Home Health Care operations (if different from above types):

_____

12. Describe any changes in operations planned within the next year:

_____

13. Is the Applicant accredited or a member of the following Health Care Organizations:
    a. Community health Accreditation Program (CHAP)? ☐Yes ☐No
    b. Joint Commission on Accreditation of Health Care Organizations (JCAHO)? ☐Yes ☐No
    c. Any other accrediting organization (please specify)? ☐Yes ☐No
    Member #: _____

14. Has the Applicant ever been under investigation or convicted by any state or local authorities, the FBI or Department of Justice?
    If "yes", please explain:

_____

15. Have any claims / suits been made within the last five years against the Applicant? ☐Yes ☐No
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).

16. Is the Applicant aware of any circumstances which may result in any claim or suit made (including request for medical records)? ☐Yes ☐No
If "yes", please explain:

17. Has any company declined, canceled or refused to renew any of the Applicant's Workers' Compensation, Professional, or General Liability Insurance? ☐Yes ☐No
If "yes", please explain:

HIRING / SCREENING

1. Are all employees and contractors screened to rule out drug, alcohol and sexual abuse? ☐Yes ☐No

2. Check all methods used in hiring all employees or independent contractors:
   - Drug Testing ☐Yes ☐No
   - Criminal Background Checks – Federal ☐Yes ☐No
   - Criminal Background checks – State ☐Yes ☐No
   - Reference Checks ☐Yes ☐No
   - Personal Interview ☐Yes ☐No
   - Sexual Abuse Registry ☐Yes ☐No
   - Validate Work History ☐Yes ☐No
   - Validate Education ☐Yes ☐No
   - Verify Current Certification / Professional License ☐Yes ☐No
   - Validate Driver's License
   - Validate Personal Auto Insurance and Limits (if operating owned vehicle during company hours) ☐Yes ☐No

3. How are references checked: ☐Written ☐Verbal ☐Both
If verbal only, please explain:

4. Are all of the above methods done prior to hiring? ☐Yes ☐No
If "no", please explain:

5. Are job descriptions provided for all professional and nonprofessional employees? ☐Yes ☐No

6. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? ☐Yes ☐No

7. What is the average staff turnover rate:

8. Does the Applicant verify if potential employees and or independent contractors have ever had their license revoked or suspended, or disciplinary action taken against them? ☐Yes ☐No

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RISK MANAGEMENT

1. Does the Applicant utilize a formal written Loss Prevention, Quality Assurance, or Risk Management Program? ☐Yes ☐No
   If "no", please explain:

   _____

2. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? ☐Yes ☐No

3. Are independent contractor's required to carry their own workers' compensation coverage? ☐Yes ☐No
   Limits of Liability: $ _____

4. Are certificates of insurance maintained on file for all employees and independent contractors and updated annually? ☐Yes ☐No

5. Is the overall responsibility for Risk Management assigned to one individual in your organization? ☐Yes ☐No
   If "yes", please list name and title: _____
   If "no", please describe how these functions are monitored:

   _____

6. Does the Applicant have a formal workplace injury report procedure in place? ☐Yes ☐No

7. Does the Applicant have formal documented training in place for the following:
   a. Crisis Management ☐Yes ☐No
   b. Disposal of Medical waste ☐Yes ☐No
   c. First Aid ☐Yes ☐No
   d. AED Training ☐Yes ☐No
   e. Infusion Therapy ☐Yes ☐No
   f. Safe lifting, transferring, and client handling ☐Yes ☐No
   g. Blood borne Pathogen ☐Yes ☐No
   h. Safe use of equipment ☐Yes ☐No
   i. Other (please list):_____ ☐Yes ☐No

8. Are companion care providers certified through the National Association for Home Care and Hospice (NAHC)? ☐Yes ☐No

9. Is the staff informed of AIDS/HIV Patients? ☐Yes ☐No

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AUTO INFORMATION

1. Does the Applicant own or lease any vehicles? ☐Yes ☐No

2. Does the Applicant need coverage for non-owned automobiles? ☐Yes ☐No

3. Does the Applicant have a program to monitor an employee's personal auto liability insurance program?
   a. At time of hire? ☐Yes ☐No
   b. Annually? ☐Yes ☐No

4. Does the Applicant run MVRs on all employees?
   a. At time of hire? ☐Yes ☐No
   b. Annually? ☐Yes ☐No
   c. Randomly (based on accidents or suspicions) ☐Yes ☐No

5. What action is taken if an "unacceptable" driver is identified?

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6. Do all Applicant's employees or volunteers transport clients in their own automobiles (appointments or errands)? ☐Yes ☐No

Does the Applicant transport non-ambulatory clients? ☐Yes ☐No

Does the Applicant contract with an ambulance or livery service to transport clients? ☐Yes ☐No

How many drivers use personal vehicles for business regularly? ____F/T ____P/T ____Volunteer

How many drivers use personal vehicles for business occasionally? ____F/T ____P/T ____Volunteer

What is the maximum and minimum age of drivers allowed to drive clients? ____ Max ____Min

Does the Applicant allow personal use of a company-owned vehicle? ☐Yes ☐No

Does the Applicant make sure travel logs are kept for all drivers? ☐Yes ☐No

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FRAUD NOTICE

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

RESIDENTS OF NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

_____

Insured Signature Date

_____

Agent Signature Date