



*Insurance Questionnaire*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Business Name: \_\_\_\_\_

Federal ID #: \_\_\_\_\_

Annual Revenues (Estimated for new entities): \_\_\_\_\_

Number of Employees

Full Time \_\_\_\_\_

Part Time \_\_\_\_\_

Pre-employment screening procedures used

Prior employer check       Fingerprint       Criminal (arrest) record

Drug/substance testing       Personal Interview

Other, please explain: \_\_\_\_\_

How often do supervisors/managers accompany employees to customer's premises?

- Daily
- Weekly
- Monthly
- Twice a month
- On a spot check basis

Have you sustained any employee dishonesty losses in the last six years? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**X**

\_\_\_\_\_  
Applicant's signature



# Home Care Advantage

## HOME HEALTH CARE & STAFF RELIEF AGENCIES SUPPLEMENTAL APPLICATION

Hanover Agency Code \_\_\_\_\_

### A. APPLICANT INFORMATION

1. Named Insured: \_\_\_\_\_
2. Do you bill Medicare?  Yes  No  
If Yes, please enter your provider #: \_\_\_\_\_

### B. RISK UNDERWRITING—If Yes to any of the below, please attach a detailed explanation

1. Do you provide any skilled home healthcare services?  Yes  No  
If Yes, please list those services provided: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Do you provide services in any of the following locations: (please check all that apply)  
 Private Homes  Hospitals  Clinics  Nursing Homes  Assisted Living Facilities  Outpatient Facilities  
 Other: \_\_\_\_\_
3. Do you ever use independent contractors?  Yes  No  
If yes, do you require that all independent contractors maintain liability insurance & provide a copy?  Yes  No
4. Do you perform background checks on all personnel?  Yes  No
5. Are you accredited by CHAP, JCAHO, or any other accreditation organization?  Yes  No  
If Yes, please specify: \_\_\_\_\_
6. Has your state license or certification ever been revoked, suspended, cancelled, voluntarily surrender, or is any such action pending?  Yes  No  
If Yes, please explain: \_\_\_\_\_
7. Are all professional employees and/or contractors currently licensed in the states you operate?  Yes  No
8. Are incident reports completed by all staff members?  Yes  No
9. Do you employ or contract any medical professionals?  Yes  No

### C. SERVICES PROVIDED

1. What are your Total Annual Revenues: \$ \_\_\_\_\_
 

<input type="checkbox"/> Home Health Care _____ %	<input type="checkbox"/> Pharmacy _____ %
<input type="checkbox"/> Rehabilitation _____ %	<input type="checkbox"/> Adult Day Care _____ %
<input type="checkbox"/> Respiratory Therapy _____ %	<input type="checkbox"/> Skilled Care _____ %
<input type="checkbox"/> Infusion Therapy _____ %	<input type="checkbox"/> Dialysis _____ %
<input type="checkbox"/> Radiation Therapy _____ %	<input type="checkbox"/> Supplemental Staffing _____ %
<input type="checkbox"/> Nursing Registry _____ %	<input type="checkbox"/> Other Services (specify) _____ %

Other Services: \_\_\_\_\_



**D. PROFESSIONAL LIABILITY**

Professional Type	Full-Time Employees	Part-Time Employees	Full-Time Contractors	Part-Time Contractors
Registered Nurses (RN)				
Practical Nurses (LPN, LVN)				
Nurse Practitioners (NP)				
Home Health Aides				
Physical Therapists (PT)				
Respiratory Therapists (RT)				
Speech Therapists				
Occupational Therapists (OT)				
Social Workers				
Pharmacists				
EMT-Basic (BLS only)				
EMT-Intermediate/Paramedic (ALS)				
Other (specify):				
<b>TOTAL OF ALL CATEGORIES</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>