



HOME HEALTH CARE QUESTIONNAIRE

Name of organization: _____

Website address (URL): www. _____

Year Business operations started: ____/____/____

Type of Firm:

- Home Health Care Visiting Nursing Associations Other: _____
 Medical Equipment Supplier Supplemental Staffing Nurse Registry

(Please note: Coverage is not available if you only provide referrals to other organizations or are a Nurse Registry)

1. Does your agency ONLY provide referrals to other organizations? YES NO
2. Is the business licensed by regulatory authorities? YES NO
 Attach copy of license.
3. What was the date of last inspection by licensing agency? ____/____/____
4. Were any violations or deficiencies noted? YES NO
If yes, attach copy of inspection report.
5. Are assessments and evaluations of clients documented thoroughly? YES NO
6. Are adverse incidents reported to a physician immediately? YES NO
7. Do you employ any medical doctors, psychiatrists, or dentists? YES NO
8. Are all nursing staff certified and licensed in their state of operation? YES NO
9. Are all employees who visit clients bonded? YES NO
10. Does the agency provide the patient or family members with a written plan of care? YES NO
11. Is an informed consent document placed in the patient's medical record? YES NO
12. Is a medical record kept on every patient, beginning at the point of referral? YES NO
13. Does your agency have a written contract with service providers? YES NO
14. Total receipts of independent contractors: _____
15. Do you require and keep certificates of insurance for all independent contractors? YES NO
16. Describe the services performed by your LPN's / RN's: _____

18. Indicate percentage of revenue derived from IV therapy: _____%
19. Indicate percentage of revenue derived from Chemo therapy: _____%
20. Does your organization provide medical detoxification, non-medical detoxification, social detoxification or methadone detoxification/maintenance? YES NO
21. Has any agency employee ever been reprimanded, refused admission or suspended by any association or administrative agency? YES NO
22. Has the agency's license ever been suspended, revoked or made conditional by any association, administrative or regulatory agency? YES NO
23. Are all non-governmental service providers licensed by state? YES NO
24. Does your agency verify that non-governmental service providers have insurance in place? YES NO
25. Does your agency have a written contract with service providers? YES NO
26. Are "**hold harmless**" agreements in your favor part of the contract between your organization and service providers? YES NO
27. Does your organization require service providers name you as "additional insured" under the provider's policy? YES NO



28. **As respects professional liability coverage**, is your organization aware of any circumstances that may result in a claim being made or any claims or suits which have been made during the past five years against your organization or any individual to be covered by this policy? YES NO
If yes, are procedures in place to verify current licenses are maintained? YES NO
29. Do you provide any procedures that are not supported by the American Medical Association (procedures that are experimental, are not used as prescribed by the AMA or are unsupported by AMA accepted clinical research) YES NO
30. Do you supply medical equipment or are your personnel responsible for monitoring equipment? YES NO
 If yes, please explain: _____
31. Do you sell, lease, repair or maintain any medical equipment? YES NO
 If yes, please explain: _____

32. List the number of employed medical professionals:

Position	Number of Employees	Number of Independent Contractors/ Service Providers	Do all Workers carry their own insurance
RN			YES <input type="checkbox"/> NO <input type="checkbox"/>
LPN / CNA / Nurse Aides			YES <input type="checkbox"/> NO <input type="checkbox"/>
Nurse Practitioner			YES <input type="checkbox"/> NO <input type="checkbox"/>
Physical Therapist			YES <input type="checkbox"/> NO <input type="checkbox"/>
Occupational or Speech Therapist			YES <input type="checkbox"/> NO <input type="checkbox"/>

- a. How many of the above positions are skilled (perform injections, actively monitoring patient's conditions)? _____
- b. How many are unskilled (little or no intrusion in the human body)? _____
33. Of the professionals listed, do any carry their own professional liability insurance? YES NO
34. Do you maintain copies of licenses for all employed professionals that are required to be licensed? YES NO
35. Are services provided under contract by professionals who are not your employees? YES NO
If yes,
 a. What services are provided? _____
- b. Do you maintain a copy of current certificate of insurance and state license? YES NO
- As respects abuse**,
36. Have any claims been filed or allegations been made, against your organization or anyone working on behalf of your organization alleging abuse? YES NO
37. Are you aware of any occurrences that could lead to a claim? YES NO
If yes, to above, attach explanation
38. Does your organization have written policies that require known or suspected abuse incidents be reported to proper authorities? YES NO

Provide the following information:

Abuse coverage currently in place:

- None
 Occurrence
 Claims Made
- Sublimit: _____
 Sublimit: _____

Total number of clients: _____



	Employees	Volunteers
a. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. State 10-digit fingerprint criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Federal 10-digit fingerprint criminal record check if in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal 10-digit fingerprint criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Are all controls indicated in d-g required prior to any client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

Federal checks require a second set of 10-digit fingerprint cards

AUTO COVERAGE:

39. Does your organization own or lease vehicles? YES NO
40. Do you provide transportation to and from your facility? YES NO
41. Does your organization prohibit employees and volunteers from driving on your behalf if their MVR indicates any of the following:
- a. More than 2 moving violations and/or accidents within a 3 year period YES NO
 - b. Reckless driving, DUI or any felony driving conviction within a 5 year period YES NO
42. Is **hired auto liability** coverage desired? YES NO
- If yes**, does your annual vehicle rental expense exceed \$2,500? YES NO
- If yes**, what is your annual vehicle rental expense? _____
43. Is **non-owned auto liability** coverage desired? YES NO
- If yes**,
- a. Total number of: _____ employees _____ volunteers
44. Complete the following chart, indicating number of employees and volunteers that **use their personal vehicles on behalf of your organization.**

Type of Usage	Number of Employees with Daily or Weekly Usage	Number of Volunteers with Daily or Weekly Usage	Annual MVR Required?	Proof of Personal Auto Insurance Required on a Renewal Basis?	100/300 or 300 CSL Personal Auto Limits Required?
Errands			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Transport children or others			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

45. Are any vehicles equipped with wheelchair lifts? YES NO
- If yes**, have employees been trained in use? YES NO

Completed by: _____

Date: ____/____/____