CareProviders Insurance Services
16301 Quorum Dr., Suite 100A
Addison, TX 75001
Tel: 800-761-7072 Fax: 800-224-7145

Email to: CPS-submissions@nsminc.com

Home Care Assistance & Hospice - Supplemental Application

Applicant Name: _____ Effective Date: _____

Address (City/State/Zip): _____

Website: _____ Phone #_____

Insurance Agent Information

Agency Name: _____ **City/State:** _____

Contact Person: _____ **Tel #:** _____ **Email:** _____

For Profit ☐ || **Non-Profit** ☐

Indicate all Programs administered by the Insured (check all that apply):

Non-Skilled Services – CNA, HHA			
Companion/ Sitter/ Personal Care	_____%	Mid-Wife	_____%
Dietician / Nutritionist	_____%	Palliative Care	_____%
Gastronomy (GT) Care	_____%	Respite Care	_____%
Hospice	_____%	Other (Specify)	_____%
Wound Care (Minor)	_____%	**Total Non-Skilled Services**	_____%

Skilled Care Services – LPN, RN			
Cardiac Care	_____%	Pain Management Care	_____%
Case Management	_____%	Post Surgical Care	_____%
Chemotherapy	_____%	Hospice Services	_____%
Clinical Trails	_____%	Palliative Care	_____%
Dialysis	_____%	Respite Care	_____%
Infusion Therapy	_____%	Special Care (Alzheimer's /Dementia)	_____%
Obstetrical/Doula	_____%	Rehabilitation: Physical, Occupational	_____%
Radiation Therapy	_____%	Speech Therapy	_____%
Gastronomy (GT) Care	_____%	Dietician / Nutritionist	_____%
Trach / Ventilator	_____%	Other (Specify):	_____%
Wound Care (Complex)	_____%		_____%
Catheter Care	_____%	**Total Skilled Care Services**	_____%

Miscellaneous Services			
Child daycare	_____%	Social services	_____%
Clergy	_____%	Supplemental staffing	_____%
Handyman	_____%	Training/Certification	_____%
Meals on Wheels	_____%	Telehealth	_____%
Medical equipment supplier	_____%	Thrift Shops	_____%
Pet therapy	_____%	Wet Nurse	_____%
Pharmacy	_____%	Other (Specify)	_____%
		Total Misc Services	_____%

General Information

FEIN # _____ # of Years in Business: _____ # of Years Experience: _____

Description of Operations: _____

_____

1. Total Number of Employees _____ Total Number of Volunteers _____
2. Do you have all required licenses? Yes ☐ No ☐ Are they current? Yes ☐ No ☐
3. Total Annual Gross Revenues: $_____ Total Payroll: $_____
4. Average annual number of non-ambulatory clients? _____
5. Is the Applicant licensed in all states in which it is operating? Yes ☐ No ☐
6. Are you Medicare and Medicaid licensed and or certified? Yes ☐ No ☐
7. Are you a member of any state associations? Yes ☐ No ☐
   If yes, which ones? _____
8. Do you contract with a hospital or skilled nursing facility for inpatient beds? Yes ☐ No ☐
   If yes, which ones? _____
9. Has Applicant's license ever been suspended, revoked, voluntarily surrendered or undergone enforcement action? Yes ☐ No ☐
   If "yes", provide specifics and corrective action taken:
   _____
10. Please provide locations of services provided and % at each location:

Private Home	Yes ☐ No ☐ _____%		Hospitals	Yes ☐ No ☐ _____%	
Doctor's Office	Yes ☐ No ☐ _____%		Clinics	Yes ☐ No ☐ _____%	
Nursing Home	Yes ☐ No ☐ _____%		Residential Facility	Yes ☐ No ☐ _____%	

11. Do you accept clients with any of the following disorders/issues? N/A ☐

Prader-Willi Syndrome	Yes ☐ No ☐ % Clients	Schizophrenia	Yes ☐ No ☐ % Clients
Velocardial Facial Syndrome	Yes ☐ No ☐ % Clients	Adjudicated Sex or Violent Offenders	Yes ☐ No ☐ % Clients
Lesche-Nyhan Syndrome	Yes ☐ No ☐ % Clients	'Profound' mental retardation.	Yes ☐ No ☐ % Clients

Hiring and Screening

1. 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 ☐
2. What is the average staff turnover rate: ____%
3. Are all employees screened to rule out drug, alcohol and sexual abuse? Yes ☐ No ☐
4. Check all methods used in hiring employees and independent contractors:

Drug Testing	Yes ☐ No ☐	Validate Work History	Yes ☐ No ☐
Criminal Background check (Federal/State)	Yes ☐ No ☐	Validate Education	Yes ☐ No ☐
Reference Checks	Yes ☐ No ☐	Verify certificate/professional license	Yes ☐ No ☐
Personal Interview	Yes ☐ No ☐	Validate Drivers License	Yes ☐ No ☐
Sexual Abuse Registry	Yes ☐ No ☐	Validate Personal Auto Insurance & Limits	Yes ☐ No ☐

Risk Management

1. Does the Applicant utilize a formal written Quality Assurance Risk Management Program? Yes ☐ No ☐

   If "no", please explain. _____

2. Has the Applicant developed written protocols that govern the admission and medical treatment of patients for the following policies and procedures?

   a. Complete treatment plan prescribed by the physician, including follow up plans? Yes ☐ No ☐

   b. Assessments of clients prior to and after accepting the clients? Yes ☐ No ☐

   c. Client's care and home visits documented? Yes ☐ No ☐

   d. Documentation of all homecare training? Yes ☐ No ☐

   e. All changes in the condition of the client or incidents involving the client documented in the records and reported to the family and physician? Yes ☐ No ☐

3. How is staff monitored? _____

4 Do you have written procedures in place to help prevent theft from client's homes? Yes ☐ No ☐

5. In the event that an assigned aide is unable to arrive on time, or unable to work that day, what is the procedure to ensure that a client is not left unattended? _____

   _____

6. Do you have formal HIPPA compliance procedures in place? Yes ☐ No ☐

7. Is the over responsibility for Risk Management assigned to one individual? Yes ☐ No ☐

   If yes, whom? (Name and Title) _____

   If no, how are these functions monitored? _____

8. Do the accepted patients have primary care physicians? Yes ☐ No ☐

   If no, who oversees the plan of care? _____

9. Does the Applicant have a formal accident report procedure in place? Yes ☐ No ☐

10. Describe the organization's policy for disposal of controlled substances:

    _____

11. Is there formal documented training in place for the following:

Crisis Management	Yes ☐ No ☐	Safe lifting, transferring & client handling	Yes ☐ No ☐
Disposal of medical waste	Yes ☐ No ☐	Blood borne pathogens	Yes ☐ No ☐
First Aid	Yes ☐ No ☐	Safe use of equipment	Yes ☐ No ☐
AED training	Yes ☐ No ☐	HIV/AIDS	Yes ☐ No ☐
Infusion Therapy	Yes ☐ No ☐		

12. Does the Applicant have current contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and/or assisted living homes in place? Yes ☐ No ☐

    If "yes" is there a review process requiring the following elements:

    a. Hold harmless and indemnification clauses favorable to the applicant? Yes ☐ No ☐

    b. Insurance requirements? Yes ☐ No ☐

    c. Confidentiality clause? Yes ☐ No ☐

    d. Terms and renewal conditions clearly outlines? Yes ☐ No ☐

    e. Defined roles and responsibilities? Yes ☐ No ☐

Professional Liability

1. Have you/the agency entered into any agreements relating to professional liability (such as a Professional service contract with any employee/contractor or intern) which contains either a hold harmless agreement, indemnification agreement, or any other professional agreement? Yes ☐ No ☐

2. Do you/the agency currently have a professional liability policy in place? Yes ☐ No ☐

   If yes, please complete the following:

   Name of Carrier:_____

   Expiration Date: _____/_____/_____ **Premium: $**_____ **Limit:** _____

   Type of Coverage: ☐ **Occurrence** ☐ **Claims Made (Retro Date** _____**)**

3. Annual Staffing – Employees & Independent Contractors

   Total number of: Full time employees:_____ Part Time Employees: _____ Volunteers: _____

Employee Breakdown (MUST BE COMPLETED)

Type of Professional	# of Employees		# Volunteers	# Contractors	# Interns	Annual Payroll
	F/T	P/T				
Counselor/Social Worker - Unlicensed						
Dietician/Nutritionist						
Home Health Aide						
Medical Director						
Nurse LPN						
Nurse Practitioner						
Nurse RN						
Pharmacists						
Psychiatrist/Optometrist/Dentist						
Psychology/Clergy						
Physicians/Physicians Assistant/ Paramedic/EMT						
Residential Manager or Care Provider						
Counselor/Social Worker - Licensed						
Teacher/Tutor/Child Care						
Therapist - Occupational						
Therapist – Physical, Speech. Hearing						
Other (describe)						
TOTALS						

*F/T = Full Time – over 20 hours per week/ ** P/T = Part Time – up to 20 hours per week

Abuse & Molestation

1. Do all employees meet the minimum mandated education or professional experience level for the position assigned? Yes ☐ No ☐
2. Have any employees been the subject of a child abuse/neglect investigation? Yes ☐ No ☐
   If yes, what were the results of the investigation? _____
3. Have there ever been any alleged or actual incidents regarding any abuse or molestation? Yes ☐ No ☐
   If yes, please provide details: _____
4. What procedures have been instituted to prevent reoccurrences of previous events?
   _____
5. Is any counseling conducted off premises? Yes ☐ No ☐
   If yes, by whom and what type of clients? _____
6. What is your procedure on how allegations of abuse are handled?
   _____
7. Do volunteers work directly with clients? Yes ☐ No ☐
   If yes, please describe the degree of their job function and responsibilities: _____
   _____
8. What is the ratio of staff to clients: _____
9. Is there more than one person responsible for the welfare of any single client? Yes ☐ No ☐
10. Are there written complaint procedures? Yes ☐ No ☐

Alzheimer's Stages

Do you provide services to Alzheimer patients? (if yes, complete table below) Yes ☐ No ☐

Stage	Description	Percentage
1	No impairment – The person doesn't experience any memory problems. No evidence of symptoms of dementia.	
2	Very mild cognitive decline – The person may feel as if they are having memory lapses, such as forgetting familiar words or locations of everyday objects. No symptoms of dementia.	
3	Mild cognitive decline – Friends, family and co-workers begin to notice difficulties. Doctors may be able to detect problems in memory or concentration.	
4	Moderate cognitive decline – Clear symptoms in several areas, such as forgetfulness of recent events, difficulty performing complex tasks such as planning dinner or paying bills, forgetfulness of one's own personal history and becoming moody or withdrawn.	
5	Moderately severe cognitive decline – Gaps in memory and thinking are noticeable, and they begin to need help with day-to-day activities such as unable to recall their address/phone number, confused on what day it is, trouble with mental arithmetic, and needs help choosing clothing that is appropriate season.	
6	Severe cognitive decline – Memory worse, personality changes, need extensive help with daily activities. Client may lose awareness of recent events as well as their surroundings, difficulty remembering their personal history, trouble remembering faces/names of loved ones, need help dressing, major changes in sleep patterns, need help with going to the restroom, compulsive behaviors and a tendency to become lost or wander.	
7	Very severe cognitive decline – Final stage, loss of ability to respond to their environment, to carry on conversations and eventually lose control of movement, such as the ability to smile, hold head up, reflexes, swallowing, and muscles grow rigid. Need extensive daily assistance.	

TOTALS MUST EQUAL 100%

Products/Medical Supplies

1. Do you manufacture any products? Yes ☐ No ☐
2. Do you provide any durable medical equipment to clients? Yes ☐ No ☐
3. Do you sell any medical equipment? Yes ☐ No ☐

   Annual Sales? _____
4. Do you rent or lease any medical equipment? Yes ☐ No ☐

   Annual Sales? _____
5. Do you repair or perform maintenance on any medical supplies or equipment? Yes ☐ No ☐

Auto & Hired/Non-Owned

1. Do you obtain MVRs on all drivers? Yes ☐ No ☐
2. Does the insured maintain driver's record files? Yes ☐ No ☐

   Does it include:

Date of Hire	Yes ☐	No ☐	Reference Checks	Yes ☐	No ☐
Dates of Training	Yes ☐	No ☐	Accident information	Yes ☐	No ☐
Drug Test Results/Dates	Yes ☐	No ☐	Copy of insurance policy/ID card	Yes ☐	No ☐
MVRs	Yes ☐	No ☐	Travel logs on each employee	Yes ☐	No ☐

3. Are there any drivers under the age of 21 years of age? Yes ☐ No ☐
4. Do you furnish anyone with an auto? Yes ☐ No ☐

   If yes, are relatives ever allowed to operate an organization's auto? Yes ☐ No ☐
5. How many of your employees use their own vehicle in your business? _____

   a. What percentage of your employees/ volunteers using their own vehicle to transport clients around on errands or to and from doctor appointments? _____ %

   b. On average, how many days a week will they transport these clients? _____
6. Do you require that employees/volunteers using their own autos carry a liability of at least $100,000? Yes ☐ No ☐

   If yes, do you verify (with a photocopy of the policy or other)? Yes ☐ No ☐
7. Do you have an accident investigation program? Yes ☐ No ☐
8. Do you obtain written authorization to release driver information from all your staff? Yes ☐ No ☐
9. What are your procedures for dealing with driver accidents or violations?

   _____
10. How often are non-owned autos used in your business? Daily ☐ Weekly ☐ Monthly ☐
11. Do employees transport non-ambulatory clients? Yes ☐ No ☐

    Are any of the vehicles equipped with wheelchair lifts? Yes ☐ No ☐

    Is training provided for:

Operation of the lift or ramp system.	Yes ☐	No ☐
Securing the wheelchair and patient.	Yes ☐	No ☐
Unloading the wheelchair and patient.	Yes ☐	No ☐

12. Does anyone other than employees and volunteers drive your vehicles? Yes ☐ No ☐
13. Do you hire a transportation company to transport clients? Yes ☐ No ☐
14. Are you listed as additional insured on their policy? Yes ☐ No ☐

Hospice

Are informed consent papers obtained from all patients prior to acceptance into care? Yes ☐ No ☐

Type of Services Offered

Services Provided	Percentage	Services Provided	Percentage
Clergy		Pharmacy	
Companion/Sitter		Physical Therapy	
Clinical Care		Radiation Therapy	
Dialysis		Speech Therapy	
Dietician/Nutritionist		Ventilator	
General Nursing (LPN/LVN)		Nurse Practitioner	
Infusion Therapy/Pain Management		Other (describe)	

TOTALS MUST EQUAL 100%

Hospice Model

Freestanding	A hospice inpatient facility that is administratively and physically freestanding. This type of hospice operates a home care program for the inpatient.	☐
Hospital Based	A hospice administratively or physically linked to a hospital. This type of hospice operates a home care program and may also operate an inpatient unit.	☐
Nursing-Home Based	A hospice administratively or physically linked to a nursing home or long-term care facility. This type of hospice operates a home care program and an inpatient unit.	☐
Community Based	A hospice home care program that operates under an autonomous administration. This type of hospice may be affiliated with an inpatient unit.	☐
Home Health Agency Based	A hospice administratively or physically linked to a Hospital Based or Home Health Agency. This type of hospice may contract for inpatient services.	☐

Hospice Type

Routine Home Care	As long as the patient's symptoms are under control, the hospice team supports the caregivers in providing this level of care in the home setting, whether that is a private residence, assisted living or nursing home. # of patients for type of service (12 months time) _____ # of visits for type of service (12 months time) _____	☐
Crisis Care	In the event of a medical or psychosocial crisis, 24 hour care can be provided in the home for brief periods. # of patients for type of service (12 months time) _____ # of visits for type of service (12 months time) _____	☐
Inpatient Respite Care	Caregivers occasionally need to take short breaks to maintain their own health. In this instance, the patient can be transferred to a short-term care unit while the caregiver takes a break. Respite care is provided in a nursing home setting. # of patients for type of service (12 months time) _____ # of visits for type of service (12 months time) _____	☐
General Inpatient Care	When symptoms can't be controlled in a home setting, this level of care may be provided in many hospitals or the patient can be moved to an inpatient center for a short-term stay until symptoms are under control. This level of care is also offered in select nursing homes. Patients residing in such nursing homes may be moved to an inpatient bed within the same facility. In all the nursing homes, patients may be moved to an inpatient center or to a nearby hospital. # of patients for type of service (12 months time) _____ # of visits for type of service (12 months time) _____	☐

Pharmacy

1. If Applicant owns or operates a pharmacy what are the total receipts from:
   a. Retail pharmacy $_____
   b. Closed pharmacy $_____
   c. Mail Orders $_____
   d. Does the pharmacy compound medications? Yes ☐ No ☐
   e. Does the pharmacy dispense controlled narcotics? Yes ☐ No ☐
   f. Does the pharmacy dispense medications to patients? Yes ☐ No ☐
   g. Does the pharmacy provide medication to other organizations? Yes ☐ No ☐
      If "yes", please describe:
      _____

Home Healthcare/In-Home Support Services

Type	Percentage	Type	Percentage
Developmental Disabled/Autism/MRDD		Medical Recovery Assistance	
Dementia Care		Alzheimer's Care	
New Parent Assistance		Other (describe)	

TOTALS MUST EQUAL 100%

Type of Services Offered

Services Provided	Percentage	Services Provided	Percentage
Bathing/Dressing/Feeding/Bathroom Assistance		Companionship/Sitter	
Laundry/Cleaning/Light Housekeeping		Running Errands/Driving Clients to Appts	
Meal Preparation		Medication Reminders	
Social Work		Speech/Physical/Hearing Therapy	
Unskilled Nursing (Non-medical HHA or CNA)		Skilled Nursing (medical RN, LPN)	
Respite Care		Other (describe)	
Assistive Technology (Personal Emergency Response Systems, Medication Dispensing Systems, etc.)		Home Modification & Installations (Installation of ramps, special walkways, railings, support bars, etc)	

TOTALS MUST EQUAL 100%

NOTICE TO APPLICANTS:

In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information or who, for the purpose of misleading, conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime.

_____ _____
(Applicant Signature) **(Date)**

_____ _____
(Agent's Signature) **(Date)**