## **JIA Insurance Agency, LLC** Home Healthcare & Hospice Application

Applicant Information						
Applicant Name:	DBA:			Tax ID/SSN:		
Mailing Address:						
Location Address(es):						
Level of Service:						
Risk Management Contact: Name/Title Email Address Telephone						
Date Established:		Corp. □Partnersh Ion- Profit □For Profit	-		ure	
Is this entity owned by, associated with, or control	olled by any other entit	y?		□ Yes	🗆 No	
If yes, please list the name and address of the con						
Type of Firm (check all that apply):  Home Health Care Agency           Usiting Nurse Agency                 Usiting Nurse Agency						
Are you: Certified for Medicare?	∃Yes □No	Certified for Med	dicaid? 🛛 Yes	s 🗆 No		
Licensed and certified as required by state and/or	federal law?			$\Box$ Yes	🗆 No	
A member of a state or national association?				$\Box$ Yes	□ No	
If yes, please identify:						
Affiliated or contracted with any HMO/PPO or M	/lanaged Care System?			$\Box$ Yes	🗆 No	
If yes, please describe: Please list all states and any foreign countries wh	ere vou provide cervie	e.				
	Last 12 months		Estimated next 1	2 months		
Annual Gross Revenues.	Lust 12 months			2 monuis		
Annual Number of Client Visits:	Last 12 months	Estimated next 12 month		2 months		
Current Insurance Information						
Have you had previous insurance for this enterpr	ise?			$\Box$ Yes	🗆 No	
If yes, complete the following:						
<u>General Liability</u>			Professional Lia	bility		
Current Carrier	_	Current Carrier				
Policy Term		Policy Term				
Premium	_	Premium				
Retro Date if		Retro Date if				
Claims Made		Claims Made				
Has any applicant been cancelled or non-renewed	d in the last three years	?		$\Box$ Yes	□ No	
Do you want physical abuse/ sexual molestation	coverage to protect yo	u for alleged acts of your er	mployees?	□ Yes	🗆 No	
At what limits:  \$\Box \$25,000/\$50,000 \$\Box \$50,000/\$100,000 \$\Box \$100,000/\$300,000 \$\Dox Other \$\Dot \$100,000/\$300,000 \$\Dot \$00000 \$\Box \$100,000 \$\Box						
Has any applicant ever been cancelled or non-renewed in the past three years? $\Box$ Yes $\Box$ No						
Has any license or accreditation ever been suspended, denied, or revoked? $\Box$ Yes $\Box$ No						
Of what professional association(s) is Applicant a member in good standing? $\Box$ Yes $\Box$ No						

Exposures							
	Full	Time	Part Time		Annual Hours Worked		
	Employees	Contracted	Employees	Contracted	Employees	Contracted	
Registered Nurses							
Certified Nurse Assistants							
Nurse Aides							
Home Health Aides/ Caregivers							
Nurse Practitioners							
Physician Assistants							
Nurse Anesthetists							
Pharmacists							
Psychologists							
Counselors							
Social/Case Workers							
Physical Therapists							
Dieticians							
Laboratory Technicians							
Administrative Personnel							
Other (describe):							
Total Number of Employees/							
Independent Contractors	_						
Are criminal record checks a part of pre-employment screenin	0				□ Yes		
Are employment history checks a part of pre-employment scre	ening?				$\Box$ Yes	s 🗆 No	
Are licensure/certification checks a part of pre-employment sc	reening?				□ Yes	□ No	
Do all the above professionals have CPR/First Aid Training?				□ Yes	🗆 No		
Are all the professionals licensed in accordance with applicabl	e state and fe	deral regulation	ns?		□ Yes	🗆 🗆 No	
If no, please provide details:	e state and re	aerar regulation					
Does your practice include Pain Management?					□ Yes	□ No	
If yes, specify the percentage of your practice derived from Pr	escription On	ly Pain Manag	ement			%	
Services		. <u>, , , , , , , , , , , , , , , , , , , </u>					
	4 4 6 1	1					
Please give the approximate percentage of total service time sp				0/11 411			
	% Outpatient Clinic			% Hospital Ward (specify):			
	% Surgery Center						
	% Operating Room % Emergency Dept. of Hospital			% Physician Office (specify specialty):			
/ Laboratory // En	nergency Dep	i. of Hospital			· · · · · · · · · · · · · · · · · · ·		
	ents among						
Please indicate the approximate division of your patients or clients among: % Intensive Care % Surgical % Physical Rehabilitation							
	% Surgical % Obstetrical			% Addiction Rehabilitation			
	emodialysis			% Psychiatri		l	
	•	ing					
% Personal Assistance % Diagnostic Imaging							
% Other (specify):         Number of residents in each age range:       0–17         18-	25	06.65	(())				
Number of residents in each age range:0-1718-	-333	36-65	_ 66+				
Risk Management							
Are you accredited by any accrediting organizations?					□ Yes	🗆 No	
If yes, provide details:							
Explain your Quality Assurance and Risk Management Progra	m:				-		
List the associations in which you are a member:					_		
Are background checks performed for all employees, independent contractors, and volunteers?			ers?		$\Box$ Yes	🗆 No	
If yes, what level or type are the criminal background checks:							
$\Box$ Country $\Box$ State $\Box$ Federal	🗆 Sexual O	ffender Regist	ry				
If no, provide details:							
Are all employees, independent contractors and volunteers screened for drugs and alcohol?			?		$\Box$ Yes	🗆 No	
If yes, how often are screens performed?							
Does each patient have their own attending physician?					$\Box$ Yes	🗆 No	
If no, provide details:							

Describe your procedures for matching staff to patients. Who does the matching/assigning of staff to client, and what is his/her experience?					
Who does the supervising of staff, and what is his/her experience?					
Are you equipped with an emergency 24-hour telephone call line for all staff and patients? Do you maintain a written clinical record showing the total number of visits by each category or staff for each patient?	□ Yes	□ No			
Do you have a policy in place to prevent sexual abuse or allegations of sexual abuse?	$\Box$ Yes	□ No			
If yes, explain and advise how often it is reviewed:					
Medication and Procedures					
Do you have a standard system to handle patients'/ clients' complaints or suggestions?	□ Yes	□ No			
In case of emergency, is management available 24 hours a day, 7 days a week?	□ Yes	□ No			
Do you have policies and procedures in place regarding medications?		🗆 No			
Are nursing charts maintained regularly?	□ Yes	□ No			
Do you have a supervision plan in place that monitors staff in daily relationships with clients?	$\Box$ Yes	🗆 No			
Non-Owned Auto Information					
Does your business own any vehicles? What types of non-owned autos are used in your business? How are they used?	□ Yes	□ No			
Are non-owned autos used for transporting clients or patients?	□ Yes	🗆 No			
If yes, please explain:					
Are employees/contractors required to carry their own auto liability insurance?		🗆 No			
If yes, what are the minimum limits required?					
Are MVRs checked for all drivers?	$\Box$ Yes	🗆 No			
If yes, how frequently?					