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:	Entity Type: ☐ Corp. ☐Partnership ☐Individual ☐Joint Venture ☐ Non- Profit ☐For Profit ☐ Other:	

Is this entity owned by, associated with, or controlled by any other entity? ☐ Yes ☐ No

If yes, please list the name and address of the company:

Type of Firm (check all that apply): ☐ Home Health Care Agency ☐ Medical Personnel Staffing ☐ Other (specify):
☐ Visiting Nurse Agency ☐ Hospice

Are you: Certified for Medicare? ☐ Yes ☐ No Certified for Medicaid? ☐ Yes ☐ No

Licensed and certified as required by state and/or federal law? ☐ Yes ☐ No

A member of a state or national association? ☐ Yes ☐ No

If yes, please identify:

Affiliated or contracted with any HMO/PPO or Managed Care System? ☐ Yes ☐ No

If yes, please describe:

Please list all states and any foreign countries where you provide service:

Annual Gross Revenues:	Last 12 months _____	Estimated next 12 months _____
Annual Number of Client Visits:	Last 12 months _____	Estimated next 12 months _____

Current Insurance Information

Have you had previous insurance for this enterprise? ☐ Yes ☐ No

If yes, complete the following:

General Liability	Professional Liability
Current Carrier _____	Current Carrier _____
Policy Term _____	Policy Term _____
Premium _____	Premium _____
Retro Date if Claims Made _____	Retro Date if Claims Made _____

Has any applicant been cancelled or non-renewed in the last three years? ☐ Yes ☐ No

Do you want physical abuse/ sexual molestation coverage to protect you for alleged acts of your employees? ☐ Yes ☐ No

At what limits: ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000 ☐ Other

Has any applicant ever been cancelled or non-renewed in the past three years? ☐ Yes ☐ No

Has any license or accreditation ever been suspended, denied, or revoked? ☐ Yes ☐ No

Of what professional association(s) is Applicant a member in good standing? ☐ Yes ☐ 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 screening? ☐ Yes ☐ No

Are employment history checks a part of pre-employment screening? ☐ Yes ☐ No

Are licensure/certification checks a part of pre-employment screening? ☐ Yes ☐ No

Do all the above professionals have CPR/First Aid Training? ☐ Yes ☐ No

Are all the professionals licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
If no, please provide details:

Does your practice include Pain Management? ☐ Yes ☐ No
If yes, specify the percentage of your practice derived from Prescription Only Pain Management. %

Services

Please give the approximate percentage of total service time spent in the following locations:

_____% Patients Home
_____% Assisted Living Facility
_____% Nursing Home
_____% Laboratory
_____% Other (specify):
_____% Outpatient Clinic
_____% Surgery Center
_____% Operating Room
_____% Emergency Dept. of Hospital
_____% Hospital Ward (specify):
_____
_____% Physician Office (specify specialty):
_____

Please indicate the approximate division of your patients or clients among:

_____% Intensive Care
_____% Skilled Care
_____% Intermediate Care
_____% Personal Assistance
_____% Other (specify): _____
_____% Surgical
_____% Obstetrical
_____% Hemodialysis
_____% Diagnostic Imaging
_____% Physical Rehabilitation
_____% Addiction Rehabilitation
_____% Psychiatric

Number of residents in each age range: ____ 0–17 ____ 18–35 ____ 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 Program:

_____

List the associations in which you are a member: _____

Are background checks performed for all employees, independent contractors, and volunteers? ☐ Yes ☐ No
If yes, what level or type are the criminal background checks:
☐ Country ☐ State ☐ Federal ☐ Sexual Offender Registry
If no, provide details: _____

Are all employees, independent contractors and volunteers screened for drugs and alcohol? ☐ Yes ☐ No
If yes, how often are screens performed? _____

Does each patient have their own attending physician? ☐ 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? ☐ Yes ☐ No

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? ☐ 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? ☐ Yes ☐ No

Are nursing charts maintained regularly? ☐ Yes ☐ No

Do you have a supervision plan in place that monitors staff in daily relationships with clients? ☐ Yes ☐ No

Non-Owned Auto Information

Does your business own any vehicles? ☐ Yes ☐ No

What types of non-owned autos are used in your business? _____

How are they used? _____

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? ☐ Yes ☐ No

If yes, what are the minimum limits required? _____

Are MVRs checked for all drivers? ☐ Yes ☐ No

If yes, how frequently?