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Home Care/Hospice/Medical Registry Questionnaire

Instructions:

- This questionnaire must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue in the Comments Section of this questionnaire or attach a separate sheet of paper.
- Coverage will not be considered until this questionnaire and the general application are completed and all required documents are provided.

Name of Applicant: _____
(Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

Indicate the type of service(s) provided by the Applicant and complete the sections as instructed.

TYPE OF SERVICE	QUESTIONNAIRE INSTRUCTIONS
☐ Home Health Care	Complete Section A only
☐ Hospice Care	Complete Section A only
☐ Medical Registry	Complete Section B only

A. Home Health Care/Hospice

☐ Check here if not applicable.

1. Specify the current number of patients: _____

   Average percentage of pediatric patients (ages birth through 18): _____%
   Average percentage of adult patients (ages 19 and older) _____%

2. Are services provided under the direction and supervision of a physician based on physician orders and plan of care? ☐ Yes ☐ No

3. How often are status reports given to the ordering physicians? _____

4. Describe back-up procedures if assigned staff is not available to make a scheduled visit (include how absence is detected, who is assigned to cover and timeliness):

5. What is the typical daily visit load for a full-time nurse (include number of patients seen per day): _____

6. Are patients being transported? ☐ Yes ☐ No
   If yes, how are they transported? ☐ Agency Vehicle ☐ Employee Vehicle ☐ Other: _____

7. Are volunteers utilized? ☐ Yes ☐ No
   If yes, what type of services do they provide? _____
   Are criminal background checks performed on volunteers? ☐ Yes ☐ No

9. Is there annual in-service training documented for all healthcare staff related to:
   ☐ High-technology equipment areas ☐ Safe client lifting, transferring and ambulating techniques
   ☐ Proper use of equipment ☐ Infection control and safety
   ☐ Managing emergencies ☐ Other (explain) _____

10. Are assessments and/or evaluations of staff performed? ☐ Yes ☐ No If yes, how often: _____
    Are assessments/evaluations documented in writing? ☐ Yes ☐ No

11. Are hospice services provided? ☐ Yes ☐ No

If yes, where are they provided?

☐ Private Home ☐ Your Own Facility ☐ Hospital
☐ Nursing Home ☐ Assisted Living ☐ Other _____

B. Medical Registry

Complete this section if the Applicant operates a medical registry. Please indicate if not applicable: ☐ N/A

1. Indicate the number and type of staff working on behalf of the Applicant:

Personnel Type	Part-Time	Full-Time
Nursing (RN, LPN, LVN)		
Other (specify):		
Other (specify):		

2. Specify where services are provided:

☐ Hospital ☐ Outpatient Clinic ☐ Patient's Home
☐ Physician Office ☐ Long Term Care Facility ☐ Other: _____

3. Provide a detailed description of the services provided in the Comments section.

C. Comments Section

Section and Question	Comments

_____ _____ _____
Applicant Signature Title Date