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Rehabilitation 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.)

This questionnaire should be completed if your facility provides any of the following rehabilitation services:

- Cardiac Rehabilitation
- Physical or Occupational Rehabilitation
- Trauma Rehabilitation

A. General Information

1. Specify where services are provided:

☐ Inpatient Acute Care Hospital ☐ Outpatient Clinic ☐ Skilled Nursing Facility
☐ Inpatient Rehabilitation Facility ☐ Long-Term Care Facility ☐ Patient's Home
☐ Other (specify): _____

2. Check all services provided:

☐ Aquatic Therapy ☐ Occupational Therapy ☐ Social Services
☐ Athletic Training ☐ Orthotics/Prosthetics ☐ Speech/Language/Audiology
☐ Cardiac Rehabilitation ☐ Physical Therapy ☐ Sports Medicine
☐ Cognitive Therapy ☐ Recreational Therapy ☐ Trauma Rehabilitation
☐ Driving, Adaptive ☐ Sexuality Therapy ☐ Vocational Training
☐ Hippotherapy ☐ Other (describe): _____

3. What types of patient populations are served?

☐ Children (birth through age 12) _____%
☐ Adolescents (ages 13 through 18) _____%
☐ Adults (ages 19 through 64) _____%
☐ Geriatrics (age 65 and older) _____%

4. Do all practitioners responsible for patient care have an educational concentration, licensure or certification specific to the age group they are treating? ☐ Yes ☐ No

If no, provide level of education requirements:

_____

5. Are diagnostic services provided? ☐ Yes ☐ No

If yes, indicate the type of diagnostic services provided and the percentage of total patients being diagnosed:

_____ _____%

6. Do any patients require skilled medical care and/or life support apparatus? ☐ Yes ☐ No

If yes, indicate the type of patients and the percentage of total patients requiring this type of care:

_____ _____%

B. Cardiac Rehabilitation

Complete this section if the Applicant provides cardiac rehabilitation services. Please indicate if not applicable: ☐ N/A

1. Are AACVPR guidelines followed? ☐ Yes ☐ No
2. Is a physician available on the premises when the program is in operation? ☐ Yes ☐ No
3. Are patients screened with a stress test? ☐ Yes ☐ No
4. Are all exercises prescribed by a physician or exercise physiologist? ☐ Yes ☐ No
5. Is staff certified in BLS and ACLS? ☐ Yes ☐ No
6. Is emergency equipment (defibrillator, O_2, emergency medications) available? ☐ Yes ☐ No
7. How often is emergency equipment checked? _____
8. Are there written emergency protocols? ☐ Yes ☐ No
9. Are mock code drills conducted? ☐ Yes ☐ No

Explain all no answers in the Comments section.

C. Overnight Care

Complete this section if the Applicant provides overnight care. Please indicate if not applicable: ☐ N/A

1. If inpatient services are provided, indicate the length of stay and annualized number of patients:

Length of Stay	Annualized number of patients
☐ Short stay (up to 14 days)	
☐ Mid-term (15 to 29 days)	
☐ Long-term (30 days or more)	

2. Provide staffing levels, qualifications and patient to staff ratio: _____

_____

3. Describe how patient populations are separated: _____

_____

D. Pools

Complete this section if the Applicant uses a pool. Please indicate if not applicable: ☐ N/A

1. Is the pool owned by the applicant? ☐ Yes ☐ No
2. Is it open to the public? ☐ Yes ☐ No
3. Is a certified lifeguard present? ☐ Yes ☐ No
4. Is the area secured when the pool is not in use? ☐ Yes ☐ No
5. What is the depth of the pool? _____feet
6. Is there an emergency call system in close proximity? ☐ Yes ☐ No
7. Where is the pool located? ☐ Inside ☐ Outside ☐ Other_____
8. Are employees allowed to access the pool? ☐ Yes ☐ No
9. Is there a life saving flotation device near the pool? ☐ Yes ☐ No
10. How is access controlled? _____

E. Comments

Section and Number	Comments

Applicant Signature _____ Title _____ Date _____