Western Heritage
Insurance Company

Home Health Care Agencies Supplemental Application

(Complete in addition to the ACORD Application)

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE"

Applicant's Name: _____

1. **Applicant operates as:** ☐ Profit ☐ Nonprofit Number of years in operation: _____

2. **How long under present management?** _____ (If fewer than five years, attach principals' resumes. If principals in the firm do not have a health care background, then also include the resume of the individual responsible for hiring, screening and monitoring the work activities of your employees.)

   Is facility owned or operated by physician(s)? ☐ Yes ☐ No

   Do you contract or employ physicians? ☐ Yes ☐ No

3. **Has license ever been revoked?** ☐ Yes ☐ No

   If yes, explain: _____

   _____

4. **Have you ever had a code violation?** ☐ Yes ☐ No

   If yes, explain: _____

   _____

5. **Operations conducted in the following states:**

State	Licensed with State?	License No.

6. **Type of operation:**

   ☐ Professional Services provided by licensed nurses (RN, LVN, LPN) or physical therapists.

   ☐ Non-Professional Services provided by Nurse's Aides or Home Health Aides

   Annual receipts for employed Professional Services: _____ Number Employed: _____

   Annual receipts for contracted Professional Services: _____ Number Contracted: _____

   Annual receipts for employed Non-Professional Services: _____ Number Employed: _____

   Annual receipts for contracted Non-Professional Services: _____ Number Contracted: _____

   Do you carry Workers Compensation Insurance? ☐ Yes ☐ No

   If utilizing contracted personnel do you require insurance coverage, including professional coverage, with limits equal to or greater than your own? ☐ Yes ☐ No

   If yes, required limits: _____

   Do you require certificates of insurance naming you as an additional insured? ☐ Yes ☐ No

   If yes, how long do you keep certificates on file: _____

   Do you use volunteers? ☐ Yes ☐ No

   If yes, number utilized: _____

7. Are the following background checks performed?

All prior employers? ☐ Yes ☐ No
All educational institutions? ☐ Yes ☐ No
Drivers license information? ☐ Yes ☐ No
Drug screening required? ☐ Yes ☐ No
Federal, State (if possible) and County criminal record search? ☐ Yes ☐ No
Social Security No. verification ☐ Yes ☐ No
Home telephone verification? ☐ Yes ☐ No
Professional licensing verification? ☐ Yes ☐ No
Residency information? ☐ Yes ☐ No
Reference Checks? ☐ Yes ☐ No
Sex offender registry search? ☐ Yes ☐ No

8. **Name all subsidiary companies/locations and others that are under applicant's control** (if none, please state):

_____

_____

9. **Is at least one of the principals or an Administrator/Director involved in the operation on a full-time basis?** ☐ Yes ☐ No

10. **Fill in receipts for services performed or offered in:**

Type of Service	Annual Receipts	Type of Service	Annual Receipts
Assisted Living Facilities		Nurse—General (LPN, LVN)	
Blood Transfusions		Nurse—Practitioner	
Clinics Owned/Operated		Nurse—Registered (RN)	
Convalescent/Nursing Home		Nurse—Student	
Dietician/Nutritionist		Nurses Aides (CAN, STNA, NA/R)	
Detention or Jail Centers		Patient Care Assistants	
Health care case management (providing personnel or systems for diagnosing, tracking statistics or handling billing issues)		Physicians Offices	
Homemaker Health Aides		Therapist (Occupational, Physical, Respiratory or Speech)	
Hospice		Transportation of clients	
Hospital		Other: (Please list)	
Infant/Pediatric Care			
Infusion Therapy			
Medical Equipment Rental			
Medical Equipment Supplier			
Midwives/Doula			

11. **Are 24 hour services provided?** ☐ Yes ☐ No

If yes, percentage of operations? _____%

If yes, is this Live-in? ☐ Yes ☐ No

Shift work? ☐ Yes ☐ No

12. **Are employees required to complete daily work reports?** ☐ Yes ☐ No

If patient is receiving skilled care, does patient have a current and regularly updated physician treatment plan on file with your agency? ☐ Yes ☐ No

Does applicant utilize a formal Quality Assurance/Risk Management program? ☐ Yes ☐ No

Does applicant conduct patient/client surveys? ☐ Yes ☐ No

Is there an informed consent process in place? ☐ Yes ☐ No

Are there written policies in place for:

Drug administration procedures? ☐ Yes ☐ No		Patient acceptance? ☐ Yes ☐ No	
Emergencies in the field? ☐ Yes ☐ No		Patient rights? ☐ Yes ☐ No	
Employee training? ☒ Yes ☐ No		Physician orders? ☐ Yes ☐ No	
Food preparation? ☐ Yes ☐ No		Proper lifting? ☐ Yes ☐ No	
Handling of complaints? ☐ Yes ☐ No		Reporting of suspected sexual/physical abuse? ☐ Yes ☐ No	
Medical equipment training? ☐ Yes ☐ No		Termination of care? ☐ Yes ☐ No	

13. **Are employees authorized to use their personal vehicles to transport residents or patients?** ☐ Yes ☐ No

Do you verify that all employees have auto coverage? ☐ Yes ☐ No

Do you have a written documentation process for verifying insurance on employees with autos, including Motor Vehicle Record requirements? ☐ Yes ☐ No

If yes, what are the requirements? _____

_____

14. **Do you transport clients in an owned vehicle?** ☐ Yes ☐ No

If yes, do you:

Have commercial automobile insurance with limits equal or greater than the general liability limits? ☐ Yes ☐ No

15. **Are there any contractual agreements wherein you assume the liability of others?** ☐ Yes ☐ No

If yes, attach a list of each entity and the type of services(s) applicant provides.

This application does not bind the applicant nor the Company to an agreement. However, the information stated on the application shall be the basis of the contract should a policy be issued. The application does not provide coverage or limits and may reflect different coverages or limits than offered by the Company.

FRAUD WARNINGS: Attach completed WHI APP-152, State Fraud Notification Compliance form.

APPLICANTS NAME AND TITLE: _____

APPLICANT'S SIGNATURE _____ DATE: _____

PRODUCER'S NAME: _____ DATE: _____