19111 N. Dallas Parkway, Suite 250, Dallas, TX 75287

Tel: 800-620-9314 Fax: 800-224-7145

Email to: CPS-submissions@nsminc.com

Home Care Assistance & Hospice Renewal Application

Applicant Name: ____ Effective Date: _______________
Address (City/State/Zip): ____
Website: ____________________________________ Phone ____________________________

Agency Name: ________________________________ **City/State:** ____________________

Contact Person: __________________ **Tel #:** ______________ **Email:** __________________

For Profit ☐ || **Non-Profit** ☐

General Information

FEIN # _____________ # of Years in Business: __________ # of Years Experience: __________

Describe any changes in operations during the last year: ____
____

1. Total Number of Employees _______ Total Number of Volunteers _______
2. Do you have all required licenses? Yes ☐ No ☐ Are they current? Yes ☐ No ☐
3. Total Annual Gross Revenues: $______________ Total Payroll: $______________
4. Office(s) Sq ftg: ________(if multiple locations, attach schedule)
5. **Indicate all Programs administered by the Insured (check all that apply):**

Non-Skilled Services – CNA, HHA			
Companion/ Sitter/ Personal Care	_______%	Mid-Wife	_______%
Dietician / Nutritionist	_______%	Palliative Care	_______%
Gastronomy (GT) Care	_______%	Respite Care	_______%
Hospice	_______%	Other (Specify)	_______%
Wound Care (Minor)	_______%	**Total Non-Skilled Services**	_______%

Skilled Care Services – LPN, RN			
Cardiac Care	_______%	Pain Management Care	_______%
Case Management	_______%	Post Surgical Care	_______%
Chemotherapy	_______%	Hospice Services	_______%
Clinical Trails	_______%	Palliative Care	_______%
Dialysis	_______%	Respite Care	_______%
Infusion Therapy	_______%	Special Care (Alzheimer's /Dementia)	_______%
Obstetrical/Doula	_______%	Rehabilitation: Physical, Occupational	_______%
Radiation Therapy	_______%	Speech Therapy	_______%
Gastronomy (GT) Care	_______%	Dietician / Nutritionist	_______%
Trach / Ventilator	_______%	Other (Specify):	_______%
Wound Care (Complex)	_______%		_______%
Catheter Care	_______%	**Total Skilled Care Services**	_______%

Miscellaneous Services			
Child daycare	_______%	Social services	_______%
Clergy	_______%	Supplemental staffing	_______%
Handyman	_______%	Training/Certification	_______%
Meals on Wheels	_______%	Telehealth	_______%
Medical equipment supplier	_______%	Thrift Shops	_______%
Pet therapy	_______%	Wet Nurse	_______%
Pharmacy	_______%	Other (Specify)	_______%
		Total Misc Services	_______%

Location of Services Provided

Location	**% of Clients**	**Location**	**% of Clients**
Private Homes	_______%	Nursing Homes	_______%
Doctor's Offices	_______%	Clinics	_______%
Assisted Living Facilities	_______%	Residential Facility	_______%
Hospitals	_______%	Other	_______%

Professional Liability

Employee Breakdown (MUST BE COMPLETED)

Type of Professional	# of Employees		# Volunteers	# Contractors	# Interns	Annual Payroll
	F/T	P/T				
Counselor/Social Worker - Unlicensed						
Dietician/Nutritionist						
Home Health Aide						
Medical Director						
Nurse LPN						
Nurse Practitioner						
Nurse RN						
Pharmacists						
Psychiatrist/Optometrist/Dentist						
Psychology/Clergy						
Physicians/Physicians Assistant/ Paramedic/EMT						
Residential Manager or Care Provider						
Counselor/Social Worker - Licensed						
Teacher/Tutor/Child Care						
Therapist - Occupational						
Therapist – Physical, Speech. Hearing						
Other (describe)						
TOTALS						

*F/T = Full Time – over 20 hours per week/ ** P/T = Part Time – up to 20 hours per week

Auto & Hired/Non-Owned

1. Do you obtain MVRs on all drivers? Yes ☐ No ☐
2. Does the insured maintain driver's record files? Yes ☐ No ☐

   Does it include:

Date of Hire	Yes ☐	No ☐	Reference Checks	Yes ☐	No ☐
Dates of Training	Yes ☐	No ☐	Accident information	Yes ☐	No ☐
Drug Test Results/Dates	Yes ☐	No ☐	Copy of insurance policy/ID card	Yes ☐	No ☐
MVRs	Yes ☐	No ☐	Travel logs on each employee	Yes ☐	No ☐

3. Are there any drivers under the age of 21 years of age? Yes ☐ No ☐
4. Do you furnish anyone with an auto? Yes ☐ No ☐

   If yes, are relatives ever allowed to operate an organization's auto? Yes ☐ No ☐
5. How many of your employees use their own vehicle in your business? __________

   a. What percentage of your employees/ volunteers using their own vehicle to transport clients around on errands or to and from doctor appointments? ____________ %

   b. On average, how many days a week will they transport these clients? _____________
6. Do you require that employees/volunteers using their own autos carry a liability of at least $100,000? Yes ☐ No ☐

   If yes, do you verify (with a photocopy of the policy or other)? Yes ☐ No ☐
7. Do you have an accident investigation program? Yes ☐ No ☐
8. Do you obtain written authorization to release driver information from all your staff? Yes ☐ No ☐
9. What are your procedures for dealing with driver accidents or violations?

   ____
10. How often are non-owned autos used in your business? Daily ☐ Weekly ☐ Monthly ☐
11. Do employees transport non-ambulatory clients? Yes ☐ No ☐

    Are any of the vehicles equipped with wheelchair lifts? Yes ☐ No ☐

    Is training provided for:

    Operation of the lift or ramp system. Yes ☐ No ☐
    Securing the wheelchair and patient. Yes ☐ No ☐
    Unloading the wheelchair and patient. Yes ☐ No ☐
12. Does anyone other than employees and volunteers drive your vehicles? Yes ☐ No ☐
13. Do you hire a transportation company to transport clients? Yes ☐ No ☐
14. Are you listed as additional insured on their policy? Yes ☐ No ☐

Products/Medical Supplies/Additional Services

1. Do you manufacture any products? Yes ☐ No ☐
2. Do you provide any durable medical equipment to clients? Yes ☐ No ☐
3. Do you sell any medical equipment? Annual Sales? ________________________ Yes ☐ No ☐
4. Do you rent or lease any medical equipment? Yes ☐ No ☐
5. Do you provide installation/monitoring of Personal Emergency Response Systems? Yes ☐ No ☐
6. Do you repair or perform maintenance on any medical supplies or equipment? Yes ☐ No ☐
7. Do you install or service any home modification products (e.g. ramps, railings, support bars, lift devices, stair assistance devices, etc.? Yes ☐ No ☐

Changes

1. I have reviewed the expiring policy and subsequent endorsements, if any.
   Please QUOTE per expiring: Yes ☐ No ☐
2. I have reviewed the expiring policy and subsequent endorsements, if any.
   Please QUOTE with the following changes: ____

   ____

Losses

1. Have you had any losses in the past 12 months? Yes ☐ No ☐
   If yes, please describe: ____

   ____

NOTICE TO APPLICANTS:

In most states, any person who knowingly, with intent to defraud, files an application for insurance containing any materially false information or who, for the purpose of misleading, conceals information concerning any fact material hereto, commits a fraudulent act, which is a crime.

______________________________ ______________________

(Applicant Signature) **(Date)**

______________________________ ______________________

(Agent's Signature) (Date)