



**Care Providers**  
Insurance Services

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Email to: [CPS-submissions@nsminc.com](mailto:CPS-submissions@nsminc.com)

## Home Care Assistance & Hospice – Renewal Questionnaire

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)	_____ %	<b>Total Non-Skilled Services</b>	_____ %

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	_____ %	<b>Total Skilled Care Services</b>	_____ %

<b>Miscellaneous Services</b>			
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)	_____ %
		<b>Total Misc Services</b>	_____ %

### **Location of Services Provided**

<b>Location</b>	<b>% of Clients</b>	<b>Location</b>	<b>% of Clients</b>
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/Optometrst/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)						
<b>TOTALS</b>						

\*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 <input type="checkbox"/> No <input type="checkbox"/> | Reference Checks                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Dates of Training       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Accident information             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Drug Test Results/Dates | Yes <input type="checkbox"/> No <input type="checkbox"/> | Copy of insurance policy/ID card | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| MVRs                    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Travel logs on each employee     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
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 <input type="checkbox"/> No <input type="checkbox"/> |
| Securing the wheelchair and patient.  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Unloading the wheelchair and patient. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
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)