PHILADELPHIA INSURANCE COMPANIES

A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

HOME MEDICAL EQUIPMENT SUPPLEMENTAL APPLICATION

Pages 1 – 5 must be completed on all submissions.

1. If you would like a quote for Abuse & Molestation, complete Page 6.
2. If you would like a quote for Automobile, complete Page 7.
3. If you would like a quote for Professional Liability, complete Page 8 -11.

Applicant Name:
DBA:
(If more than one entity/subsidiary, please attach description and % owned for each)

For Profit   Non-Profit   Partnership   Other (specify):

Address:
City: State: Zip:
Telephone: Fax:
Date business established: # of years under present management:
Federal Employer Tax I.D. Number:
Website address (if available):
Name and phone number of person to contact for inspection:

SUBMISSION REQUIREMENTS

- PHLY Home Medical Equipment Dealer Supplemental Application
- ACORD Applications (Applicant Information, including Crime and Umbrella)
- Currently valued insurance company loss runs for the current policy period and four prior years

APPLICANT INFORMATION

1. Limits of liability desired:
   $500,000/$1,000,0000 $1,000,000/$1,000,000 $1,000,000/$2,000,000 $1,000,000/$3,000,000
   Other: $ Occurrence / $ Aggregate

2. Has the Applicant ever carried insurance that was on a Claims Made basis? Yes No
   If yes, what is the Retro Date?

3. Total annual Gross Revenues: $
   Total receipts from Retail: $
   Total receipts from Rentals: $
   Total receipts from Wholesale: $
   Total receipts from Professional Services: $

4. Is the Applicant a member of any State Association? Yes No
   If yes, please provide the name of the State Association:

5. Is the Applicant a member of any other industry association(s)? Yes No
   Please specify:

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6. Does the applicant manufacture or directly import any products? Yes No
   If yes, please explain:

Products Offered: (percentages must equal 100%)					
Product		**Product**		**Product**	
Antibiotics Therapy	%	Liquid Oxygen	%	Safety bar / Grab bar installation	%
Apnea monitors	%	Medical gas piping	%	Safety bar / Grab bar sales	%
Apnea monitors - infant	%	Nebulizers	%	Sleep apnea Studies	%
Auto conversions / modifications	%	Orthotics & prosthetic sales or fitting	%	Stair lift - installation	%
Beds, commodes	%	Oxygen Concentrators	%	Stair lift – sales	%
Blood Cleansing or recirculation equipment	%	Oxygen Cylinders	%	Tens Units	%
Chemotherapy	%	Oxygen regulators and valves	%	Ventilators Do you instruct on the use of ventilators? Yes No	%
CPAP / BIPAP	%	Parenteral Therapy	%	Walkers, crutches, canes	%
CPM	%	Pharmacy Sales	%	Wheel chair - motorized	%
Diabetic Shoes	%	Photo therapy equipment - infants	%	Wheel chair – manual	%
Enteral Therapy	%	Scooters	%	Other:	%
Infant Beds or Cribs	%	Other:	%		
				ABOVE MUST TOTAL 100%:	

7. Is the Applicant named as an Additional Insured – Vendor on the manufacturer's or supplier's policy for products? Yes No

8. Does the Applicant obtain certificates of insurance from their product suppliers? Yes No

9. Has the Applicant ever distributed or directly imported products from a foreign manufacture? Yes No

10. Does the Applicant modify any product in any way from its intended use? Yes No
    If yes, please explain:

11. Does the Applicant repackage or re-label any items obtained from suppliers? Yes No

12. Do the manufacture's labels remain on the equipment? Yes No

13. Are serial numbers of the finished product shown on invoices and complete records of inventory kept? Yes No

14. Does the Applicant contract or subcontract labor for any installation, service or repair of any equipment? Yes No
    If yes, please explain.

15. If oxygen is offered, does the applicant offer a 24 hour service program? Yes No

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16. Does the Applicant service any products not sold or rented by you? Yes No
If yes, please explain:

17. Does the Applicant repair or perform maintenance on any medical supplies or equipment? Yes No
If yes, please explain:

18. Does the Applicant provide reconditioning service for mobility equipment? Yes No
If yes, please explain:

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FRAUD NOTICE STATEMENTS

NOTICE TO APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF ALASKA APPLICANTS: "A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY FILES A CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE PROSECUTED UNDER STATE LAW."

RESIDENTS OF ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF ARIZONA APPLICANTS: "FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES."

RESIDENTS OF DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

RESIDENTS OF FLORIDA RESIDENTS APPLICANTS: "ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

RESIDENTS OF KANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY "MATERIALLY" FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME."

RESIDENTS OF LOUISIANA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF MINNESOTA APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

RESIDENTS OF NEW YORK APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

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RESIDENTS OF OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF OKLAHOMA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

RESIDENTS OF OREGON APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW."

RESIDENTS OF PENNSYLVANIA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF TEXAS APPLICANTS: IF A LIFE, HEALTH AND ACCIDENT INSURER PROVIDES A CLAIM FORM FOR A PERSON TO USE TO MAKE A CLAIM, THAT FORM MUST CONTAIN THE FOLLOWING STATEMENT OR A SUBSTANTIALLY SIMILAR STATEMENT: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

RESIDENTS OF VERMONT APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICTION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

RESIDENTS OF VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WASHINGTON APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WEST VIRGINIA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

Name (Please Print/Type)

Title
(MUST BE SIGNED BY THE PRESIDENT CHAIRMAN OR EXECUTIVE DIRECTOR)

____

Signature

Date

The above signed warrants that he/she is authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the **Applicant** and their respective Directors, Officers or other insured persons.

Produced By: (Section to be completed by Producer/Broker)

Producer

Agency

Producer License Number

Agency Taxpayer ID or SS Number

Address (Street, City, State, Zip)

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ABUSE AND MOLESTATION

1. Does the Applicant current insurance program include Abuse and Molestation coverage? Yes No
   If yes, what are the limits? $

2. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? Yes No

3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if you have an incident of abuse? Yes No

4. Are there written complaint procedures and are they displayed prominently? Yes No
   If no please explain:

5. Are there written procedures that monitors staff in day-to-day relationships with clients, both on and off premises? Yes No

6. Is there formal staff training on sexual abuse, including how to recognize the signs? Yes No

7. Is there more than one person responsible for the welfare of any single patient? Yes No

8. Have any incidents resulted in an allegation of sexual abuse? Yes No

9. Was the case settled? Yes No

10. Was the case taken to trial? Yes No

11. Amount paid for damages to the victim: $

12. Does the Applicant provide equipment, services or therapy to minors? Yes No
    If yes, explain:

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AUTO INFORMATION

1. Does the Applicant own or lease any vehicles? Yes No

2. Does the Applicant need coverage for non-owned automobiles? Yes No

3. Does the Applicant have a program to monitor an employee's personal auto liability insurance program?
   a. At time of hire? Yes No
   b. Annually? Yes No

4. Does the Applicant run MVRs on all employees?
   a. At time of hire? Yes No
   b. Annually? Yes No
   c. Randomly (based on accidents or suspicions) Yes No

5. What action is taken if an "unacceptable" driver is identified?

6. Do all Applicant's employees or volunteers transport clients in their own automobiles (appointments or errands)? Yes No

7. Does the Applicant transport non-ambulatory clients? Yes No

8. Does the Applicant contract with an ambulance or livery service to transport clients? Yes No

9. How many drivers used personal vehicles for business? F/T* P/T** Vol.
   *F/T = Full Time – over 20 hours per week
   **P/T = Part Time – up to 20 hours per week

10. What is the maximum and minimum age of drivers allowed to drive clients? Max Min

11. Does the Applicant allow personal use of a company-owned vehicle? Yes No

12. Does the Applicant make sure travel logs are kept for all drivers? Yes No

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PROFESSIONAL LIABILITY

Supplemental Services (Supplying health care providers to other facilities for a fee): IF "NO" check here:			
Type		**Type**	
Private Homes	%	Hospitals	%
Doctor's Offices	%	Nursing Homes	%
Assisted Living Facilities	%	Other:	%

Professional Liability Employees / Independent Contractors – Annual Staffing:

	Employees		Independent		Annual Payroll	
	Full Time	Part Time	Full Time	Part Time	Employees	Independent Contractors
Acupuncturist						
Certified Nurse Anesthetist						
Clergy / Chaplain						
Clerical						
Dietitian						
Nurses (RN)						
Homemaker / Home Health Aid						
LPN / LVN						
Medical Director						
Nurse Practitioner						
Occupational Therapist						
Pharmacist						
Physical Therapist						
Physician						
Physician Assistant						
Psychiatrist						
Psychologist						
Respiratory Therapist						
Social Worker						
Speech Therapist						
Volunteers						
Other (specify):						
Total:						

1. Describe any additional contracted Home Health Care operations (if different from above types):

2. Describe any changes in operations planned within the next year:

3. Has the Applicant ever been under investigation or convicted by any state or local authorities, the FBI or Department of Justice? Yes No
   If yes, please explain:

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4. Have any claims / suits been made within the last five years against the Applicant? Yes No
If yes, please attach copy of insurance company loss reports for each claim or suit. (Specify date, description, amount paid and amount outstanding for each claim).

5. Is the Applicant aware of any circumstances which may result in any claim or suit made (including request for medical records)? Yes No
If yes, please explain:

6. Has any company declined, canceled or refused to renew any of the Applicant's Professional Liability Insurance? Yes No
If yes, please explain:

7. Previous Professional Liability Insurance (past five years):

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made only)
			$		
			$		
			$		
			$		
			$		

8. Limits of Liability Desired:
$500,000/$1,000,000 $1,000,000/$1,000,000 $1,000,000/$2,000,000 $1,000,000/$3,000,000
Other: $ Occurrence / $ Aggregate

PROFESSIONAL LIABILITY HIRING / SCREENING

1. Are all employees and contractors screened to rule out drug, alcohol and sexual abuse? Yes No

2. Check all methods used in hiring all employees or independent contractors:
   - Drug Testing Yes No
   - Criminal Background Checks – Federal Yes No
   - Criminal Background Checks – State Yes No
   - Reference Checks Yes No
   - Personal Interview Yes No
   - Sexual Abuse Registry Yes No
   - Validate Work History Yes No
   - Validate Education Yes No
   - Verify Current Certification / Professional License Yes No
   - Validate Driver's License Yes No
   - Validate Personal Auto Insurance and Limits (if operating owned vehicle during company hours) Yes No

3. How are references checked: Written Verbal Both
If verbal only, please explain:

4. Are all of the above methods done prior to hiring? Yes No
If "no", please explain:

5. Are job descriptions provided for all professional and nonprofessional employees? Yes No

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6. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? Yes No

7. What is the average staff turnover rate:

8. Does the Applicant question prospective employees about any previous involvement as defendants in professional malpractice litigation? Yes No
   If no, please explain:

9. Does the Applicant verify if potential employees and or independent contractors have ever had their license revoked or suspended, or disciplinary action taken against them? Yes No

PROFESSIONAL LIABILITY RISK MANAGEMENT

1. Does the Applicant utilize a formal written Quality Assurance Risk Management Program? Yes No
   If no, please explain:

2. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? Yes No

3. Are employees required to carry their own individual professional liability coverage? Yes No
   Limits of Liability: $

4. Are independent contractor's required to carry their own individual professional liability coverage? Yes No
   Limits of Liability: $

5. Are certificates of insurance maintained on file for all employees and independent contractors and updated annually? Yes No

6. Does the Applicant have formal HIPAA compliance procedures in place? Yes No

7. Has the Applicant developed written protocols that govern the admission and medical treatment of patients for the following policies and procedures:
   a. Complete treatment plan prescribed by the physician, including follow up plans? Yes No
   b. Assessments of clients prior to and after accepting the clients? Yes No
   c. Client's care and home visits documented? Yes No
   d. Documentation of all homecare training? Yes No
   e. All changes in the condition of the client or incidents involving the client documented in the records and reported to the family and physician? Yes No

8. Is the overall responsibility for Risk Management assigned to one individual in your organization? Yes No
   If yes, please list name and title:
   If no, please describe how these functions are monitored:

9. Does the Applicant have a formal incident report procedure in place? Yes No

10. Is there a peer or committee who review the incident reports to improve upon any allegations previously outlined in the surveys or reports? Yes No

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11. Does the Applicant have formal documented training in place for the following:
    a. Crisis Management Yes No
    b. Disposal of Medical waste Yes No
    c. First Aid Yes No
    d. AED Training Yes No
    e. Infusion Therapy Yes No
    f. Safe lifting, transferring, and client handling Yes No
    g. Blood borne Pathogen Yes No
    h. Safe use of equipment Yes No
    i. Other (please list): Yes No

12. Are companion care providers certified through the National Association for Home Care and Hospice (NAHC)? Yes No

13. Do all contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and assisted living homes include a hold harmless agreement? Yes No

14. Is the staff informed of AIDS/HIV Patients? Yes No

15. Do patient records include the following:
    a. A complete treatment plan prescribed by a physician, including follow-up plans? Yes No
    b. An "informed consent" document obtained and placed in the patient's medical record? (informed consent laws vary by state) Yes No
    c. Patient care home visits meticulously documented? Yes No
    d. Complete medical records maintained on all patients? Yes No
    e. Patient records kept on file (hardcopy of electronic) for a minimum of 6 years? Yes No
    f. All changes in condition and incidents documented to the physician and family? Yes No
    g. Is documentation of all homecare training provided? Yes No
    h. Medications & dosage, including documentation of administering medications? Yes No
    i. A copy of literature given to clients explaining services and fees? Yes No
    j. Termination of services and discharge criteria? Yes No

16. Does the Applicant conduct patient / client surveys? Yes No

17. Are the results of patient / client surveys used to improve day to day operations? Yes No

18. Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional? Yes No

19. Are medications kept in a locked area to prevent tampering? Yes No

20. Describe the organization's policy for disposal of controlled substances?

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