LCI WORKERS' COMP

Home Health Supplemental Questionnaire

Name of Applicant: _____

1. Any prior coverage? Yes ☐ No ☐
   If so, forward loss runs for the last 5 years.

2. What is the breakdown of the types of services that are or may be provided according to the following exposures?

Hospice _____%	Home Infusion _____%	Assisted Living _____%
Home Health _____%	Staffing Agency _____%	Homemaker _____%
Thrift Shop _____%	Pharm Services _____%	Services _____%

   Other: _____

3. What are the company's criteria for accepting home care patients? _____
   _____

4. What is the breakdown of employed and/or contracted personnel according to the following jobs performed?

	Number Employed	Number Contracted	Hospital Percent	Nursing Home	Client's Home
Aides:	_____%	_____%	_____%	_____%	_____%
LPN's:	_____%	_____%	_____%	_____%	_____%
RN's:	_____%	_____%	_____%	_____%	_____%
Nurse Practitioner:	_____%	_____%	_____%	_____%	_____%
Other:	_____%	_____%	_____%	_____%	_____%

   If other, please explain: _____

5. Are all visits to patient's homes documented by employees accurately with report logs? Yes ☐ No ☐
   If so, how often are reports submitted to management? _____

6. What type of duties are employees required to perform? _____
   _____

7. What specific types of training do employees receive? _____
   _____

8. Is updated training provided on a regular basis? Yes ☐ No ☐
   If so, how often? _____

9. What type of vehicles are used in the insured's operation? _____

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10. What is the radius of travel? _____

11. Are travel logs maintained? Yes ☐ No ☐

12. Are MVR's reviewed on a regular basis? Yes ☐ No ☐
    If so, what is the maximum amount of allowable moving and/or major violations? _____

13. Are background checks performed on prospective new professional hires? Yes ☐ No ☐

14. Are background checks performed on prospective new non-professional hires? Yes ☐ No ☐

15. Does the company maintain a written safety program? Yes ☐ No ☐

16. Are any patients not ambulatory? Yes ☐ No ☐

17. What is the maximum allowable ratio between ambulatory/non-ambulatory patients? _____

18. Any lifting of patients? Yes ☐ No ☐
    If so, are back braces worn? Yes ☐ No ☐
    Is team lifting practiced? Yes ☐ No ☐
    Are lifts used? Yes ☐ No ☐
    Are there any formal lifting procedures in place? Yes ☐ No ☐
    If so, please explain: _____
    _____

19. Is medication administered? Yes ☐ No ☐

20. Is wound care offered? Yes ☐ No ☐

21. Are any specific guidelines in place for the use of medical equipment? Yes ☐ No ☐
    If so, please explain: _____

22. List specific accreditations held by the company as well as any held by professional employees: _____
    _____
    _____

_____ _____
Signature of Applicant Date