Print Form

HomeCare GUARD®

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www.homecareguard.com

Home Health Agency

Short Form Questionnaire for Indication of **Professional Liability** Premium Only

Quote Need By Date_____

Agency Name_____

Agency Address_____

Insured Name_____

Insured Address_____

Medicare Provider Number _____

Phone_____ **Email**_____ **Policy Inception Date**_____

Limits of Insurance Needed $_____ **Deductible** $_____ **Occurrence**☐ or **Claims Made**☐ **Retro-Date**_____

Current Insurance Co_____ **Premium$**_____ **Yrs with this Carrier:**_____

Have any claims/suits been made within the last five (5) years against you or are there any circumstances which may result in any claim or suit being made? ☐ Yes ☐ No

EMPLOYEES – ANNUAL STAFFING:

Employee(EE) Type	EE Hours	EE Payroll	1099 Hours	1099 Payroll
Nurse/Social Worker				
Medical Director				
Nurse Practitioner				
Physical Therapist				
Respiratory Therapist				
Occ./Speech Therapist				
Pharmacist				
Home Health Aide, CNA, Sitter, Homemaker, Companion				
Pharmacy Ass't/Techs				

Please check below ✓ locations where services are provided & the % of business (**TOTAL MUST EQUAL 100%**)

☐ Private Homes_____% ☐ Clinics_____% ☐ Nursing Homes_____% ☐ Doctor's Offices_____% ☐ Laboratories:_____%
☐ Hospitals_____% ☐Assisted/Independent Living_____% ☐ Prison Facilities_____% ☐ Schools_____%

Please check below ✓ types of services provided and the % of business (**TOTAL MUST EQUAL 100%**)

☐Personal Care/Companion_____% ☐Rehabilitation_____% ☐Clinics Owned/Operated_____% ☐Respiratory Therapy_____%
☐ Supplemental Staffing-Medical_____% ☐ Infant/Pediatric Care_____% ☐ Hospice_____% ☐ Infusion Therapy _____%

Does the agency/entity utilize a formal written Quality Improvement and Risk Management Program? ☐ Yes ☐ No

Your Name_____ Date_____ Phone Number_____

THIS PREMIUM INDICATION IS SUBJECT TO FULL UNDERWRITING AND A COMPLETED APPLICATION.