Care Providers
Insurance Services

Email to: CPS-submissions@novacore.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 ☐

Virus/Communicable Disease

1. Do you follow all proper protocols/procedures, including the continuous release of updated CDC guidelines to ensure you are in compliance with all virus/communicable disease prevention control methods? (i.e., client s screening procedures, social distancing, use of PPE, sanitizing and cleaning of facilities and equipment, 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)**