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## Home Companion Care, Personal Care, Health Care & Hospice Supplement

(To be attached to ACORD applications)

NAMED INSURED: \_\_\_\_\_

1. Total annual gross revenues: \$ \_\_\_\_\_ Is the applicant licensed and certified by Medicare? \_\_\_\_\_  
 Total receipts from Medicare: \$ \_\_\_\_\_ Is the applicant licensed and certified by Medicaid? \_\_\_\_\_  
 Total receipts from Medicaid: \$ \_\_\_\_\_  
 Total receipts from private pay: \$ \_\_\_\_\_  
 Total payroll: \$ \_\_\_\_\_  
 Number of full-time employees: \_\_\_\_\_  
 Number of part-time employees: \_\_\_\_\_  
 Average number of weekly client contacts: \_\_\_\_\_

2. Please list the names of any state associations of which the applicant is a member:  
 \_\_\_\_\_

3. Is the applicant accredited or certified by any of the following health care organizations:
- a. American Board of Hospice and Palliative Medicine (ABHPM)?  Yes  No
  - b. Community Health Accreditation Program (CHAP)?  Yes  No
  - c. Joint Commission on Accreditation of Health Care Organizations (JCAHO)?  Yes  No
  - d. National Association for Home Care and Hospice (NAHC)?  Yes  No
  - e. National Board for the Certification of Hospice Nurses (NBCHN)?  Yes  No
  - f. Health Industry Distributors Association (HIDA)?  Yes  No
  - g. National Hospice and Palliative Care Organization (NHPCO)?  Yes  No
  - h. Please list any other accrediting organization(s) or industry association(s) of which the applicant is a member:  
 \_\_\_\_\_

4. Please enter the percentage of revenue provided by each type of service. If any of the services below are not provided, enter 0%. The total must equal 100%.

Companion/sitter: _____%	Pediatric care: _____%
Dialysis: _____%	Personal care: _____%
Dietician/nutritionist: _____%	Pet therapy: _____%
General nursing (LPN/LVN): _____%	Physical therapy: _____%
Hospice: _____%	Rehabilitation: _____%
Infant care: _____%	Respiratory therapy: _____%
Infusion therapy: _____%	Speech therapy: _____%
Meals on Wheels: _____%	Skilled nursing care: _____%
Medical equipment supplier: _____%	Ventilator: _____%
Nurse practitioner: _____%	Other: _____%
Occupational therapy: _____%	Please describe: _____

5. Please enter the percentage of revenue provided by each location. If any of the locations below do not provide revenue, enter 0%. The total must equal 100%.

Private homes:	_____%	Nursing homes:	_____%
Doctor's offices:	_____%	Clinics:	_____%
Assisted-living facilities:	_____%	Owned facility:	_____%
Hospitals:	_____%		

6. Does the applicant utilize a formal written quality assurance risk management program that monitors day-to-day operations and client/patient satisfaction?  Yes  No

If no, please explain: \_\_\_\_\_

7. Has the applicant developed written protocols that govern:

- a. Implementation of a complete treatment plan prescribed by the treating physician, including follow-up plans?  Yes  No
- b. Assessments before and after accepting clients?  Yes  No
- c. Documentation of client's care and home visits?  Yes  No
- d. Documentation of all home care training?  Yes  No
- e. Recording and reporting of all changes in the condition of the client or incidents involving the client, including reports to the family and treating physician?  Yes  No
- f. Procedures for securing a substitute when the regular aid is absent?  Yes  No

8. 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. Food preparation according to dietary constraints?  Yes  No
- j. Other (specify): \_\_\_\_\_  Yes  No

9. Are records maintained for emergency contacts for clients?  Yes  No

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

11. Does the applicant manufacture or perform maintenance on any durable medical equipment or provide supplies to clients?  Yes  No

If yes, please describe: \_\_\_\_\_

## Hospice Care

Please complete if you have any hospice care.

1. Applicant's total annual gross receipts (show detail below): \$ \_\_\_\_\_  
In-home hospice care (routine home care, assisted living, or nursing home): \$ \_\_\_\_\_  
Institutional hospice care (provided in hospitals or inpatient center): \$ \_\_\_\_\_  
Inpatient respite (short-term—up to 5 days—to give the caregiver a break) \$ \_\_\_\_\_  
Crisis care (brief period of care in the event of a medical/psychological crisis) \$ \_\_\_\_\_  
Other (specify): \_\_\_\_\_ \$ \_\_\_\_\_
  
2. Type of organization (check all that apply):  
 Hospice (adult care)                       Infusion therapy firm  
 Hospice (infants and children)       Nurse registry  
 Home health care firm                       Visiting nurse agency  
Other (specify): \_\_\_\_\_
  
3. Does the applicant conduct training for all employees and volunteers on the following:
  - a. Basic hospice philosophy?  Yes  No
  - b. Patient rights and responsibilities?  Yes  No
  - c. Symptom control?  Yes  No
  - d. Communication skills?  Yes  No
  - e. Bereavement counseling?  Yes  No
  - f. HIPPA?  Yes  No
  
4. Has the applicant developed written protocols that govern:
  - a. Palliative care services?  Yes  No
  - b. Specific interdisciplinary team duties and therapy treatment for each team member?  Yes  No
  - c. Physician-prescribed and -directed medical care?  Yes  No
  - d. Home care and coordinated inpatient respite care to provide relief for primary caretaker?  Yes  No
  - e. Bereavement counseling?  Yes  No
  - f. Nursing services supervised by a registered nurse?  Yes  No
  
5. 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? (may vary by state)  Yes  No
  - c. Assessments before and after accepting the patient?  Yes  No
  - d. Patient home care visits meticulously documented?  Yes  No
  - e. Complete medical records maintained on all patients?  Yes  No
  - f. Documentation of all changes in condition and incidents provided to the physician and family?  Yes  No
  - g. Documentation of all home care training provided?  Yes  No
  - h. A copy of the physician referral, including a certified prognosis?  Yes  No
  - i. Documentation of administered medications and dosages?  Yes  No
  - j. A copy of literature given to clients explaining services and fees?  Yes  No
  - k. Patient rights explanation to family?  Yes  No
  - l. Termination of services and discharge criteria?  Yes  No
  - m. Advance directives, living wills, and durable power of attorney?  Yes  No

- n. Written grievance procedures from hospice patient?  Yes  No
  - o. Written consent from hospice patient allowing non-emergency care?  Yes  No
6. Does the applicant keep patient records on file for a minimum of 6 years? (hardcopy or electronic)  Yes  No
7. Are medications ordered by a licensed physician and administered under the close supervision of a qualified medical professional?  Yes  No