Mid America Specialty Markets
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Hospice Operations Questionnaire for each Location

Policy Number: **(Attach to an Acord Application)**

Applicant's Name _____

Address _____
Street City State Zip

Applicant's website address_____ Contact's email address _____

GENERAL INFORMATION

1) Location of premise: ☐Same as mailing address
   Address if different _____
   Address City County State Zip
2) Number of years under current ownership: _____
3) Please indicate the percent of operations for each classification:
   Hospice - In patient facility _____%
   Hospice - Out patient operations _____%
   Home Health Care (not Hospice) _____%
   Palliative Care (not Hospice) _____%
   All other operations _____% Please Describe:_____
4) In the past three years, have any complaints been filed with a Licensing Board against the facility or operations; or has the operating license been revoked, suspended or put on probation? ☐Yes ☐No
   If yes, please explain:_____

Please provide a copy of <u>all license(s) issued</u>, a copy of the <u>most recent state health inspection</u>, and the <u>corrective measures (if applicable) from the licensure</u>.

DESCRIPTION OF OPERATIONS

1) Please indicate the number of Hospice clients served: what is the average monthly number of hospice clients being served for hospice, (including inpatient and outpatient): _____
2) Does the Medical Director provide physician care to residents or patients? ☐Yes ☐No
   If yes, is the Medical Director an independent contractor ☐Yes ☐No
   Does the Medical Director have their own malpractice insurance for hospice clients? ☐Yes ☐No

LIABILITY INFORMATION

1) Has the hospice had any general liability, abuse, or professional liability claims or lawsuits in the past five (5) years? ☐Yes ☐No
   If yes, please explain:_____
2) Are you aware of any circumstances which may give rise to a general liability, abuse and/or professional liability claim? ☐Yes ☐No
   If yes, please explain:_____

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3) Are criminal background investigations, including sexual abuse or child abuse-related offenses, obtained for all:
   a. Prospective employees and volunteers? ☐Yes ☐No
   b. Existing employees and volunteers? ☐Yes ☐No
   How often? _____

4) Has there ever been an allegation of sexual abuse made against the hospice? ☐Yes ☐No

STAFF

1) Please indicate the number of personnel per class: (Personnel may have more than one description)

Classification	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Aides						
Counselors						
Medical Directors						
Nurses (all licenses)						
Physicians						
Psychiatrists						
Psychologists						
Social Workers						
Other_____						
Total	0	0	0	0	0	0

COVERAGE OPTIONS: check coverage desired

1) ☐ Property of Residents ($2500 per resident/ $25,000 aggregate)
2) ☐ Employee Theft of Residents Personal Property ($2500 per resident/$25,000 annual aggregate)
3) ☐ Residential Facility-Damage to Property of Others ($5000 per claim/$25,000 annual aggregate)

NOTE: (We do not write worker's compensation in this Hospice program.)

The information I have provided is true and accurate to the best of my knowledge. I have not willfully concealed or misrepresented any material fact(s) or information. I understand completion of this questionnaire does not compel the company to provide coverage.

_____ _____
Applicant's Signature Date

_____ _____ _____
Agent's Signature Agency Name Date

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