**HOME HEALTHCARE APPLICATION**

**I. APPLICANT INFORMATION:**

1. Name of Applicant/Entity(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Physical Address (City, State, Zip Code) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Website(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. PROFESSIONAL SERVICE/PRODUCT AND MEDICAL STAFF PROFILE:**

1. Please provide a full description of services rendered.
2. **Locations where services are provided (total must equal 100%):**

\_\_\_\_\_% Private Home \_\_\_\_\_% Nursing Home \_\_\_\_\_% Assisted Living Facility

\_\_\_\_\_% Hospice \_\_\_\_\_% Hospital \_\_\_\_\_% Correctional Facility

\_\_\_\_\_% Other Facility (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Type of services (total must equal 100%):**

\_\_\_\_\_% Skilled Nursing \_\_\_\_\_% Sitter/Companion Care \_\_\_\_\_% Tracheostomy/Ventilator/Wound Care

\_\_\_\_\_% Other Service (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Age of Clients: What percentage of clients are below the age of** **18: \_\_\_\_\_\_\_%**
2. **Please provide the projected annual gross revenue for this insured: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Do you provide any 24 hr care? If yes, is it done in shift work or live in?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Employee** | **Full-Time** | **Part-Time** | **Independent Contractor** |
| Registered Nurses |  |  |  |
| Licensed Practical Nurses |  |  |  |
| Licensed Vocational Nurses |  |  |  |
| Nurse Practitioners |  |  |  |
| Certified Nurse Assistants |  |  |  |
| Home Health Aids |  |  |  |
| Sitters/Companions/Homemakers (non-medical) |  |  |  |
| Social Workers/Counsellors |  |  |  |
| Respiratory Therapists |  |  |  |
| Speech/Occupational/Physical Therapists |  |  |  |
| Other (specify) |  |  |  |

**III. COVERAGE/HISTORY:**

Does the insured have any prior coverage? If so, please advise the retro date needed to match:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please advise if the insured has had any prior claims or knowledge of any circumstances that could potentially lead to a claim:

 [ ]  YES [ ]  NO