Social Services - Hospice/Caregiver Supplemental Application

HOSPICE

Name of applicant:_____

1. Type of organization (check that which applies)

   ☐ In-home hospice ☐ Institutional hospice

2. Does the organization contract with physicians or nurses? ○ Yes ○ No

   If "yes," are certificates of general liability and medical malpractice insurance provided by these professionals to the hospice? ○ Yes ○ No

3. Does the organization provide hospice care services to adults (18 and over) only? ○ Yes ○ No

4. Does the organization own and operate a pharmacy? ○ Yes ○ No

5. Is the the organization involved in the manufacture, sale or leasing of medical equipment or with the maintenance of medical equipment for others? ○ Yes ○ No

6. Does the hospice organization utilize the services of personnel who are licensed or experienced in treating terminally ill patients? ○ Yes ○ No

7. If an institutional hospice, does the organization have controls in place to assure a proper staff to patient ratio? ○ Yes ○ No

8. If an institutional hospice, does building exceed one story? ○ Yes ○ No

   If "yes," are all patients located on the first floor? ○ Yes ○ No

9. If an institutional hospice, does the organization have a building evacuation plan that is posted and illuminated emergency exits that are clearly marked and free of obstructions? ○ Yes ○ No

10. Does the hospice organization comply with the rules and regulations of the Federal Drug Enforcement Agency? ○ Yes ○ No

11. Does the organization have a physician on call 24 hours per day? ○ Yes ○ No

12. Does the organization have an established plan to deal with emergencies? ○ Yes ○ No

13. Does the organization require medical charting and keep medical records on all patients? ○ Yes ○ No

14. Does the organization provide respite care? ○ Yes ○ No

15. Does the organization have a formal procedure in place for reporting accidents or incidents involving patients? ○ Yes ○ No

16. Does the organization have formal, documented training and procedures in place for the following:

    a. Disposal of medical waste? ○ Yes ○ No

    b. AED (Automated External Defibrillator) training? ○ Yes ○ No

    c. Use of medical equipment? ○ Yes ○ No

    d. First aid? ○ Yes ○ No

    e. Food preparation according to dietary constraints? ○ Yes ○ No

Caregivers

17. Does the caregiver organization provide caregiver/home companion services on an overnight stay basis? ○ Yes ○ No

18. Does the caregiver organization provide services to non ambulatory clients or clients afflicted with dementia? ○ Yes ○ No

19. Does the caregiver organization provide legal or financial services to clients? ○ Yes ○ No

20. Does the caregiver organization have in excess of 100 employed/volunteer caregivers? ○ Yes ○ No

21. Does the caregiver organization provide medical treatment? ("Medical Treatment" can be defined as treatment other than first aid that is administered by a physician or any other professional treatment provider). ○ Yes ○ No

This Supplemental Application is incorporated into and is deemed a part of the other Application(s) submitted in connection with the requested insurance. Any and all notices and representations included in other such Application(s) are incorporated by reference in this Supplemental Application as though fully set forth herein.

Applicant's signature: _____ Title: _____ Date: _____
Principal, Officer or Partner

Print name: _____