



HOME HEALTH CARE / HOSPICE / DME SUPPLEMENTAL APPLICATION

This application must be completed in conjunction with the CNA Allied Health Care Facilities Common Application.

Instructions:

1. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

1. **Name of Applicant:** _____

2. **Type of Operations** (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Home Health Care |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Infusion Therapy | <input type="checkbox"/> Medical Equipment Supplier |
| <input type="checkbox"/> Nurse Registry/Staffing Agency | <input type="checkbox"/> Oxygen Supplier | <input type="checkbox"/> Pharmacy Retail |
| <input type="checkbox"/> Pharmacy Closed | <input type="checkbox"/> Respiratory Therapy | <input type="checkbox"/> Telemonitoring (Describe) |

Other (Describe): _____

3. **Where do you provide services?**

- | | | |
|---------------------|-------------------------------|-----------------------|
| Private Home _____% | Doctor's Office/Clinic _____% | Hospital _____% |
| Hospice _____% | Nursing Home _____% | Child Day Care _____% |
| Surgicenter _____% | Adult Day Care _____% | |
| Other _____% | Describe: _____ | |

4. **Current Number of Patients:** _____

- a. Typical % of pediatric patients _____%
- b. Typical % of adult patients _____%

5. **Indicate % of Gross Receipts by Type of Care and Visits.** "Visits" are defined as the number of patients entering the facility for health related services per year.

Services	% of Gross Receipts	Projected Annual Number of Visits
Activities of Daily Living	%	
Apnea Monitor	%	
Behavioral Health	%	
Dialysis	%	
Handy Man Services	%	
Home Dialysis	%	
Hospice Care – Homebound	%	
Hospice Care –Institutional	%	# of Beds
Infusion Therapy	%	



Services	% of Gross Receipts	Projected Annual Number of Visits
Medical Equipment Suppliers	%	\$ Receipts
Nurse Registry/Staffing Agency	%	
Oxygen Supplier	%	
Prenatal	%	
Pediatric	%	
Postpartum	%	
Prenatal Care	%	
Prosthetic/Orthotic	%	
Rehabilitation	%	
Respiratory Therapy, including trach care and ventilator dependent patients	%	
Skilled Medical Care	%	
Telemonitoring	%	
Transportation personal/patient	%	
Other (_____)	%	
Other (_____)	%	

6. How are all clients in your program initially assessed and reassessed for appropriateness? _____

7. Do you provide a flu shot program? yes no

If "yes", what are the expected number of clients? _____

Do you provide a follow-up phone number to the patients in the event of a reaction to the vaccination? yes no

8. Do you accept non-physician referrals? yes no

If "yes" describe referral sources: _____

9. Is a physician designated for each patient receiving skilled care? yes no

10. How are visits shared with the ordering physician? _____

How often is that information shared? _____

11. Describe back-up procedures if assigned staff is not available to make a scheduled visit (e.g. how absence is detected, who is assigned to cover, timeliness, etc.):

12. How does your agency inform patients who to contact if their scheduled care provider does not arrive:

13. What is the typical daily visit load for a full-time nurse (e.g. number of patients seen per day): _____



14. Does your facility utilize criminal background checks? yes no

a. If "yes", check those applicable: pre-hire search current employees all employees

b. If "yes", at what level are criminal background checks conducted?
 State/County Federal Misdemeanor Convictions

Describe Process: _____

If not all employees are subject to criminal background checks, describe employee categories not checked: _____

15. Has any employee or contractor been convicted for an act committed in violation of any law or ordinance other than a traffic offense? yes no

If "yes", provide details: _____

16. Do you use volunteers? yes no

If "yes", what type of services do they provide? _____

Do you do a criminal background check on volunteers? yes no

17. Do you transport patients? yes no

If "yes" how do you transport patients? Agency Vehicle Employee Vehicle Other: _____

18. Do you own or operate a Pharmacy? yes no

a. If "yes", Receipts Retail \$ _____ Receipts Closed Pharmacy \$ _____

b. If the Applicant is a distributor are the prescriptions: pre-packaged, or compound mixture

c. Is the Applicant packaging, compounding, or performing admixture?

d. Does the pharmacy compound medications? yes no

e. Does the pharmacy dispense controlled narcotics? yes no

f. Does the HHA deliver medications to patients? yes no

g. Does the pharmacy provide medications to other organizations? yes no

If "yes", describe: _____

19. If you provide Pediatric Care, please answer the following:

a. Provide examples of the type(s) of skilled services you provide: _____

b. What is the minimum training and experience requirement for nurses doing this work? _____

c. Do you conduct any form of electronic monitoring other than Apnea? yes no

If "yes", explain: _____

20. Does the Applicant provide Hospice Services? yes no

If "yes" complete the following:

a. Where do you provide hospice services?

Private Home _____% Your Own Facility _____% Hospital _____%

Nursing Home _____% Assisted Living _____% Other _____%

Describe if "Other": _____



- b. Number of hospice visits expected (12 months): _____
- c. Number of occupied beds expected (12 months): _____
- d. Does each patient have his or her own attending physician? yes no
IF "no", who oversees their plan of care: _____

AUTHORIZATION

Signature in full

Date

Name - please print

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

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