AiA Associated Insurance Administrators

Home Health Care / Hospice Provider
Supplemental Application

Applicant Firm Name: _____

Physical Address: _____ _____ _____ _____
Street City State Zip

Contact: _____ Phone: _____ Email: _____

Company Overview

State of Operation: ☐ Non-Profit ☐ For Profit

Revenue Sources: ☐ Medicaid ☐ Medicare ☐ Private Pay Other:_____

Number of Full-Time Employees _____ Number of Part-Time Employees _____

Number of RN's on Staff _____ Number of CNA's on Staff _____

Number of Personal Care Aides on Staff _____ Number of Office Employees on Staff _____

Number of Volunteers _____ # of Clients Serviced per day per employee _____

Do volunteers receive wage compensation? _____ Radius of Operations _____ miles

Description of Operations:

Client Information

Age Range of Population Served: _____

Physical and Mental Diagnosis of Population Served:

Percentage of Population Served with:

Alzheimer's/Dementia _____% MR/Developmental Delays _____%

Schizophrenia/Bipolar _____% HIV/AIDS _____% Other _____

Employee Screening (check all that apply)

Written Applications ☐	Pre-Employment MVR Check ☐	Post-Offer Physical Examinations ☐
Reference Checks ☐	Pre-Employment Drug Screening ☐	Pre-Employment TB Screening ☐
Criminal Background Checks ☐	Written Job Descriptions ☐	New Employee Safety Orientation ☐

Employee Training (check all that apply)

Blood Born Pathogens ☐	Abuse and Negligence Prevention ☐	Fall Prevention ☐
Hazard Material Communication ☐	Infection Control ☐	Anger and Depression ☐
CPR ☐	First Aid ☐	Medication Administration ☐
Patient Transitioning ☐	Safe Driving Training ☐	Frequency of MVR checks _____

Employee Training (check all that apply)

Medical/Surgical Nursing Care	☐	Rehabilitation Care (OT/PT/Speech)	☐
Medication Administration-Oral	☐	Hospice/End of Life Care	☐
Medication Administration-IV	☐	Mental Health Counseling	☐
Full-Time/24 Hour Nursing Care	☐	Dementia/Alzheimer's Care	☐
Wound Care	☐	Stroke Rehabilitation	☐
Infectious Disease Care	☐	Substance Abuse Counseling	☐
Pain Management	☐	HIV/AIDS Assessment/Treatment	☐
Mobility Assistance	☐	Patient Education	☐
Personal Hygiene (Bathing)	☐	Home Maintenance	☐
Medication Reminders	☐	Shopping/Errands	☐
Meals on Wheels or Meal Prep.	☐	Conversation/Companionship	☐
Light Housekeeping	☐	Transportation of Clients	☐
		How often are Clients Transported? _____%	

Safety and Risk Management Programs (check all that apply)

Written Safety Program in Place	☐	Post-Accident Drug Testing Program	☐
Safety Committee in Place	☐	Formal Early Return to Work Program	☐
Pre-Employment Drug Screenings	☐	Formal Training & Orientation for New Hires	☐

Proper Lifting/Transfer Training

Formal written patient lifting/transfer program? ◯ Y / N ◯ Use of gait belts for all manual transfers? ◯ Y / N ◯

Company Claims Reporting

Are all injuries reported to your insurer?_____

Are all workplace accidents reported to your carrier within 24 hours? _____

Do you have a specific person responsible for reporting accidents? _____

Are you compliant with OSHA reporting policies? _____

Easy Return to Work

Is there a written return to work (RTW) program in place? _____

If not, would you be willing to implement one? _____

Applicant's signature: _____Title:_____ Date: _____
(Owner or Officer)

Agent's signature: _____Title:_____ Date: _____

SIGNATURE OF INDIVIDUAL COMPLETING FORM IS MANDATORY

SEND COMPLETED APPLICATIONS TO QUOTES@AIAMGA.COM