



Care Providers Business Insurance
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CareProvidersBusinessInsurance.com

Care Providers Business Insurance Questionnaire

Company Name _____ Date _____
(Legal entity)

1. Please provide the following information about your current Property, General Liability, and Professional Liability coverages.

- Insurer:
[] AIG [] Colony Insurance [] Hospice and Community Care
[] Interstate Fire & Casualty [] Scottsdale Insurance [] Western World
[] Western Heritage [] United National [] Other: _____

Annual premium _____ Effective date _____

- Any losses?
If Yes, please describe briefly _____

2. Please provide the following information about your current Worker's Compensation coverage.

- Insurer:
[] AIG [] Guarantee Insurance [] Midwest Insurance
[] Missouri Employer's Mutual [] Missouri Retailer's Trust [] Travelers/Assigned Risk
[] Other: _____

Annual premium _____ Effective date _____

- Experience Modification, if known _____
Any losses?
If Yes, please describe briefly _____

3. Are you a member of any State Association(s) and/or industry association(s)? [] Yes [] No

If Yes, please provide the name of the association(s) and member number(s), if applicable:

4. Do you contract with a hospital or skilled nursing facility for inpatient beds? Yes No

If Yes, please provide detail _____

5. Please provide information about the services you provide:

Types of Services Provided:					
<input type="checkbox"/> Adult Day Care	_____%	<input type="checkbox"/> Hospice	_____%	<input type="checkbox"/> Pharmacy	_____%
<input type="checkbox"/> Chemotherapy	_____%	<input type="checkbox"/> Infant Care	_____%	<input type="checkbox"/> Physical Therapy	_____%
<input type="checkbox"/> Child Day Care	_____%	<input type="checkbox"/> Infusion Therapy	_____%	<input type="checkbox"/> Radiation Therapy	_____%
<input type="checkbox"/> Clergy	_____%	<input type="checkbox"/> Meals on Wheels	_____%	<input type="checkbox"/> Rehabilitation	_____%
<input type="checkbox"/> Clinical Care	_____%	<input type="checkbox"/> Medical Equipment Supplier	_____%	<input type="checkbox"/> Respiratory Therapy	_____%
<input type="checkbox"/> Companion/Sitter	_____%	<input type="checkbox"/> Nurse Practitioner	_____%	<input type="checkbox"/> Speech Therapy	_____%
<input type="checkbox"/> Dialysis	_____%	<input type="checkbox"/> Occupational Therapy	_____%	<input type="checkbox"/> Skilled Nursing Care	_____%
<input type="checkbox"/> Dietician/Nutritionist	_____%	<input type="checkbox"/> Pediatric Care	_____%	<input type="checkbox"/> Ventilator	_____%
<input type="checkbox"/> General Nursing (LPN/LVN)	_____%	<input type="checkbox"/> Personal Care	_____%	<input type="checkbox"/> Other _____	_____%
<input type="checkbox"/> Home Health Care	_____%	<input type="checkbox"/> Pet Therapy	_____%	<input type="checkbox"/> Other _____	_____%
Above must total 100%					_____%

Location of Services Provided:					
<input type="checkbox"/> Private Homes	_____%	<input type="checkbox"/> Hospitals	_____%	<input type="checkbox"/> Clinics	_____%
<input type="checkbox"/> Doctor's Offices	_____%	<input type="checkbox"/> Nursing Homes	_____%	<input type="checkbox"/> Owned Facility	_____%
<input type="checkbox"/> Assisted Living Facilities	_____%	<input type="checkbox"/> Other _____	_____%	<input type="checkbox"/> Other _____	_____%
Above must total 100%					_____%

6. Please provide the following information about your organization:

Federal Employer Identification Number (FEIN): _____

Total annual gross revenues: \$ _____

Total annual receipts from Medicare: \$ _____

Total annual receipts from Medicaid: \$ _____

Total annual receipts from private pay: \$ _____

7. Please provide staffing and payroll details:

Employees/Independent Contractor Annual Staffing and Annual Payroll:	# of Employees		# of Independent Contractors		Annual Payroll \$	
	Full Time	Part Time	Full Time	Part Time	Employees	Independent Contractors
Acupuncturist						
Certified Nurse Anesthetist						
Clergy/Chaplin						
Clerical						
Dietician						
Nurses (RN)						
Homemaker/Home Health Aid						
LPN/LVN						
Medical Director						
Nurse Practitioner						
Occupational Therapist						
Pharmacist						
Physical Therapist						
Physician						
Physician Assistant						
Psychiatrist						
Psychologist						
Respiratory Therapist						
Social Worker						
Speech Therapist						
Volunteers						
Other (specify): _____						
Other (specify): _____						
Totals:						

Thank you! We look forward to discussing your insurance coverage with you. We'll contact you promptly with information about this exciting insurance package designed just for home health care professionals.

Questionnaire completed by:

Name _____ Position/Title _____
(Please print)

Telephone _____ Email Address _____

Signature _____ Preferred Method of Contact
 Telephone Email

Please note: A postage paid envelope is enclosed for your convenience.

FOR OFFICE USE Care Providers Review by _____ Review Date _____