HOME HEALTH SUPPLEMENTARY
WORKERS COMPENSATION APPLICATION

LEMIC INSURANCE COMPANY
C/O CCMSI
PO BOX 6967 METAIRIE, LA 70009
PHONE: (866) 314-9970 FAX: (866) 883-8413

NAME OF APPLICANT: ____

MAILING ADDRESS: ____

CITY/ STATE/ ZIP: ____

GENERAL INFORMATION:

1. What is the breakdown of the types of services that are / may be provided according to the following exposures?

Hospice ________________ Home Health ________________

Thrift Shop ________________ Home Infusion ________________

Pharmacy Services ________________ Assisted Living ________________

Homemaker Services ________________ Staffing Agency ________________

Other(Specify): ____

2. What are the Insured's criteria for accepting home care patients?

____

____

3. What is the break down of employed and / or contracted personnel according to the following jobs performed?

	Number Employed	Number Contracted	Hospital Percent	Nursing Home	Client's Home
Aides	________	________	________	________	________
LPN's	________	________	________	________	________
RN's	________	________	________	________	________
Nurse Practitioner	________	________	________	________	________
Other (Specify)	________	________	________	________	________

4. Are all visits to patients' homes documented by employees accurately with report logs? If yes, how often are reports submitted to management?

____

5. What type of duties are employees required to perform?

____

6. What specific types of training do employees receive? Is updated training provided on a regular basis? If so, please advise how often.
   ____
   ____

7. What types of vehicles are used in the Insured's operation, and what is the radius of operation? Are travel logs maintained?
   ____

8. Are MVRs reviewed on a regular basis? If yes, what are the maximum allowable violations for moving and / or major incidents?
   ____

9. Are background checks performed on prospective new professional hires?; new non-professional hires?
   ____

10. Has the insured made written provision for safety procedures?
    ____

11. Are specific guidelines in place regarding lift procedures for patients and / or medical equipment?
    ____

12. What is the maximum allowable ratio between ambulatory / non-ambulatory patients?
    ____

13. Please advise of any specific accreditation(s) held by the Company and / or professional employees.
    ____
    ____

Signature of Applicant*

____
*must be completed by an owner, officer or authorized representative

Name & Title of Above ____

Date____