TPM Total Program Management
4175 Veterans Memorial Hgwy., Suite 306 Ronkonkoma, NY 11719 • (P): (631) 319-6210 • (F): (631) 319-6208

HOME HEALTH CARE SUPPLEMENTAL APPLICATION

Insured: _____ Eff Date: _____ FEIN NO. _____
Contact Name & Title: _____ Tel. No.: _____ Fax No.: _____

INSURED HISTORY:

Years in business:_____ if less than 5 number of years in trade_____ No. of locations _____
Detailed Description of Operations: _____
Total # of employees:_____

Business Entity Information:
Not for profit: ___ For profit: ___ Medicare Certified: ___ Medicaid certified: ___ Other: (indicate): _____
Out of state exposure: ☐ Yes ☐ No If yes, name of states: _____ Foreign Travel: ☐ Yes ☐ No

Licenses for your business:
State: _____ Type: _____ License#: _____ License period: _____
Other: _____ Type: _____ License#: _____ License period: _____

Are any licenses conditional or restricted?: ☐ Yes ☐ No If 'yes', explain: _____
Have any of your licenses been suspended; revoked or placed under probation in the past 5 years?: ☐ Yes ☐ No
If 'yes' to the above; explain: _____

Does this facility use outside labor &/ or vendors for their healthcare business operations?: Yes__ No__
If "Yes" are Certificates of Insurance obtained for any subcontracted outside vendors?: Yes__ No__
If "No" explain:_____
Please indicate the person(s) responsible for maintaining these records:_____Title:_____

Is the applicant engaged in any of the following:
-Employee Leasing?: ☐ Yes ☐ No If 'yes', explain: _____
-Temporary Agency Staffing?: ☐ Yes ☐ No If 'yes'; explain: _____
-Preferred Employer Organizations: ☐ Yes ☐ No If 'yes'; explain: _____

What is the criteria for accepting home care patients?: (Explain): _____
_____

Are all home health care workers who visit patient/clients in their homes licensed?: ☐ Yes ☐ No Bonded?: ☐ Yes ☐ No
Are Oxygen/Respiratory services performed by the home health care workers in the home?: ☐ Yes ☐ No
Are all visits to patient/clients homes documented? ☐ Yes ☐ No If 'yes'; who maintains logs?:_____
Do home health care workers use their own vehicles to transport patient/clients?: ☐ Yes ☐ No
If 'yes' to the above question, purpose of transporting: List: _____
Are meal delivery services provided by the applicant?: ☐ Yes ☐ No If 'yes'; # of assigned daily visits: _____
Describe the general duties of the home health care employee: List: _____

Has the applicant made any written provisions for emergency services?: ☐ Yes ☐ No If 'yes': (indicate): _____
_____

List any specialized equipment that employees are required to use in connection with home health care operations:

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Employment Information:

Present number of employees: Full-time employees _____ Part-time _____ Seasonal _____ Volunteers_____
Percent of employee turnover in the last 12 months Full-time _____ Part-time _____
Employee staffing expectation over the next 12 months Full-time _____ Part-time _____
Benefits provided – are ALL employees eligible ☐ Yes ☐ No If not then who is eligible? _____

			% paid by employer	**% of participation**
Group Health	☐ Yes	☐ No	_____	_____
Paid sick leave	☐ Yes	☐ No		

Name of Healthcare provider: _____

Indicate the safety activities currently established and practiced regularly:

Employee handbook provided ☐ Yes ☐ No
Return to light duty plan ☐ Yes ☐ No Includes full wages ☐ Yes ☐ No
Return to Full-time modified work plan ☐ Yes ☐ No
Safety meetings held for all employees ☐ Yes ☐ No Frequency of meetings _____
Safety training held for all employees ☐ Yes ☐ No Incentive program for employees ☐ Yes ☐ No
Hazardous Materials Communication program in place ☐ Yes ☐ No
Personal Protective safety equipment provided for all employees ☐ Yes ☐ No If yes, what type:_____
Have all employees been taught safe lifting procedures?: ☐ Yes ☐ No
Are safety syringes &/or "needle-less" devices being used?: ☐ Yes ☐ No Other: specify: _____
Are latex gloves provided and utilized in the daily operations?: ☐ Yes ☐ No ___ If 'no'; explain: _____
Are you compliant with all mandated OSHA reporting?: ☐ Yes ☐ No If "no"; explain: _____
Does the employer check the general housekeeping conditions of the prospective patient/client prior to dispatching the home heath care worker to a job site?: ☐ Yes ☐ No

HIRING PRACTICES:

Employment application	☐ Yes	☐ No	Drug/substance abuse	☐ Yes	☐ No
Reference checks	☐ Yes	☐ No	Written disciplinary procedure	☐ Yes	☐ No
Motor Vehicle Record check	☐ Yes	☐ No	Pre/Post employment physical	☐ Yes	☐ No
Volunteer labor used	☐ Yes	☐ No	Certificates of insurance obtained	☐ Yes	☐ No
Temporary labor used	☐ Yes	☐ No	Orthopedic back test	☐ Yes	☐ No

Does this facility use outside labor &/ or vendors for their healthcare business operations?: Yes__ No__
If "Yes" are Certificates of Insurance obtained for any subcontracted outside vendors?: Yes__ No__
If "No" explain:_____
Please indicate the person(s) responsible for maintaining these records:_____Title:_____

PAYROLL AND PREMIUM HISTORY:

Payroll	Premium	Mod
Current Yr. _____	Current Yr. _____	Current:_____
1st Prior Yr. _____	1st Prior Yr. _____	1st PriorYr._____
2nd Prior Yr._____	2nd Prior Yr._____	2nd Prior Yr._____
3rd Prior Yr._____	3rd Prior Yr._____	3rd Prior Yr._____

Signature:_____ Title:_____ Date:_____