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ALLIED HEALTH CARE PROFESSIONAL LIABILITY
HOME HEALTH CARE APPLICATION

THE COVERAGE IS ON A CLAIMS MADE AND REPORTED BASIS.
PLEASE READ THE COVERAGE CAREFULLY.

1. Complete name of facility (applicant) (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary):** _____

   _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Contact name: _____ Title: _____

   Phone: _____ Web site Address: _____ Fax: _____

   List all other locations **(use an additional sheet of paper if necessary):** _____

   _____

   _____

2. In what state is the facility domiciled? _____

3. Applicant is: a. ❑ Individual ❑ Partnership ❑ Corporation
   ❑ Professional Association ❑ Other: _____
   b. ❑ Not-for-profit ❑ For-profit ❑ Both

4. Current accreditations or associations: ❑ NAHC ❑ TAHC ❑ JCAHO
   ❑ CHAP ❑ NHPCO ❑ Other: _____

5. Is the firm engaged in, owned by or associated with or controlled by any other business? ..... ❑ Yes ❑ No
   If yes, give details (use an additional sheet of paper if necessary): _____

6. Date established: _____/_____

7. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered?..... ❑ Yes ❑ No
   If yes, give details: _____

   _____

8. Limits of Liability desired for Professional Liability:
   ❑ $100,000/$300,000 ❑ $250,000/$250,000 ❑ $500,000/$500,000
   ❑ $1,000,000/$1,000,000 ❑ $1,000,000/$2,000,000 ❑ $1,000,000/$3,000,000
   ❑ Other: $_____/$_____

   Deductible desired:
   ❑ $2,500 ❑ $5,000 ❑ $10,000 ❑ $25,000 ❑ $50,000 ❑ Other: _____

   MAXIMUM AND MINIMUM DEDUCTIBLES WILL BE SUBJECT TO UNDERWRITING APPROVAL.

9. Effective date desired: _____

10. Please list the individual shareholders or partners of the facility:

    _____ _____ _____

    _____ _____ _____

11. List states in which applicant is licensed to do business: _____

12. List gross revenues as follows:

Professional Activities	Gross Revenues Prior Year	Gross Revenues Estimate for Current Year
Home Health Care Services		
Sale of Medical Supplies/Equipment		
Other (specify):		

13. Does applicant have positive net worth? ..... ❑ Yes ❑ No

14. Does applicant have sufficient working capital? ..... ❑ Yes ❑ No

15. State percentage of revenues derived from:

Source	Percentage for Last Policy Year	Estimated Percentage for Current Year
a. Charitable Contributions	%	%
b. Government Funding	%	%
c. Fee for Service	%	%
d. Other (specify):	%	%

16. Funding Source: ❑ Medicare ❑ Medicaid ❑ Private Pay ❑ Grants ❑ Other: _____

17. Do you have any contracts with any of the following:

    a. Hospitals?..... ❑ Yes ❑ No

    If yes, what is the percentage of total revenues from this contract? ..... _____ %

    b. Nursing Homes? ..... ❑ Yes ❑ No

    If yes, what is the percentage of total revenues from this contract? ..... _____ %

    c. Other Entities?..... ❑ Yes ❑ No

    If yes, what is the percentage of total revenues from this contract? ..... _____ %

    Describe: _____

18. Location and percentage where services are provided (total must equal 100%):

LOCATION	PERCENTAGE
Private Home	%
Assisted Living	%
Hospital	%
Clinic	%
Nursing Home	%
Other (specify):	%

19. State the number of patient encounters as follows (patient encounters refer to number of visits—not number of patients):

    _____ Number for last 12 months _____ Estimated number for next 12 months

20. Type of services provided along with the percentage (total must equal 100%):

SERVICES	PERCENTAGE
Skilled Nursing Care	%
Personal Care Chore or Companion	%
Physical/Occupational/Speech Therapy	%
Infusion Therapy	%
Pediatric Care	%

21. Please schedule all of your employees and independent contractors:

DISCIPLINE	EMPLOYEES				INDEPENDENT CONTRACTORS	
	No. of Full-Time	No. of Part-Time	Annual Hours Worked	Annual Payroll	No. of Contractors	Annual Hours Worked
Administrator						
Physician						
Psychiatrist						
Psychologist—Doctorate						
Psychologist—Bachelors/Masters						
Counselor—Other						
Social and Case Workers						
Occupational Therapist						
Respiratory Therapist						
Physical Therapist						
Speech Therapist						
Therapist Aide						
Nurse—RN						
Nurse—LPN/LVN						
Nurse Practitioner						
Nurse Aide						
Home Health Aide						
Pharmacist						
Pharmacy Assistant						
General Clerical or Maintenance						
Medical Technician						
Homemaker/Provider/Caregiver						

a. Do Aides and/or Homemakers have CPR or First Aid Training? ..... ❑ Yes ❑ No

b. Are all the above individuals licensed in accordance with applicable state and federal regulations? ..... ❑ Yes ❑ No
If no, attach an explanation.

c. Is continuing education or staff development required for your employees? ..... ❑ Yes ❑ No

d. Do you place health care staff with other businesses? ..... ❑ Yes ❑ No
If yes, what percentage of your revenues is derived from the placement of:
Nurse Practitioners? ..... _____ %

Other health care providers? ..... _____ %

e. If you use subcontractors, do subcontractors carry their own coverage? ..... ❑ Yes ❑ No

If yes, are limits of coverage equal to or greater than your limits? ..... ❑ Yes ❑ No

22. Please list the licenses/certifications held by the facility:

Agency: _____ Agency: _____

Issue date: _____ Issue date: _____

Expire date: _____ Expire date: _____

HIRING PRACTICES

23. Do you require signed applications on all prospective employees? ..... ❑ Yes ❑ No
24. Do you verify all professional qualifications, licenses and certifications? ..... ❑ Yes ❑ No
25. Do you conduct a personal interview with prospective employees and non-employees? ..... ❑ Yes ❑ No
26. Do you require professional and personal references on each employee? ..... ❑ Yes ❑ No
27. Do you conduct a criminal background check? ..... ❑ Yes ❑ No
28. Do you provide training and orientation for new employees? ..... ❑ Yes ❑ No
29. Do you follow up on any pending license suspensions or revocations or any pending disciplinary actions? ❑ Yes ❑ No
30. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past? ..... ❑ Yes ❑ No
31. Do you have written job descriptions? ..... ❑ Yes ❑ No
32. Do you require drug/alcohol screening? ..... ❑ Yes ❑ No

RISK MANAGEMENT/LOSS CONTROL

33. Is there a written, formalized Risk Management Program? ..... ❑ Yes ❑ No
34. Is there a written, formalized Quality Assurance Program? ..... ❑ Yes ❑ No
35. Do you have a standard system to handle a patient's complaints or suggestions? ..... ❑ Yes ❑ No
36. Do you practice universal precautions? ..... ❑ Yes ❑ No
37. Do you have a Quality Assurance Department? ..... ❑ Yes ❑ No
38. In case of an emergency is management available 7 days a week, 24 hours a day? ..... ❑ Yes ❑ No
39. Do you have policies and procedures in place regarding medications? ..... ❑ Yes ❑ No
40. Are nursing charts maintained regularly? ..... ❑ Yes ❑ No
41. Do you regularly check employees' licenses and certifications? ..... ❑ Yes ❑ No

GENERAL LIABILITY

42. Complete the following for any owned or leased premises (use a separate sheet of paper if needed):

LOCATION ADDRESS	OCCUPANCY	SQUARE FOOTAGE
	❑ Owned ❑ Leased	
	❑ Owned ❑ Leased	
	❑ Owned ❑ Leased	

43. Are you required to name your landlord or any other business as an additional insured? ..... ❑ Yes ❑ No

(If yes, please list name and address of each and state interest. Use separate sheet if required.)

NAME	ADDRESS	INTEREST

44. Do you supply or sell any medical supplies or equipment to patients or clients? ..... ❑ Yes ❑ No

45. Do you rent or lease or supply any medical or therapeutic equipment to patients or clients? ..... ❑ Yes ❑ No

If the answer to Question 44. or 45. above is yes, please complete the following:

Category I	Expendable Items—intended for one time use and then disposed	Annual Sales:	$
Category II	Non-Expendable Items—including hospital beds, bath-room safety bars, portable toilets, lifts or hoists, ambula-tory aids (excludes diagnostic treatment equipment devices)	Annual Sales:	$
		Annual Rental Receipts:	$
Category III	Diagnostic or Treatment Devices—including oxygen and other medical gasses used in conjunction with res-piratory therapy (excluding ventilators)	Annual Sales:	$
		Annual Rental Receipts:	$
Category IV	Life Sustaining or Critical Monitoring Equipment or Devices—including dialysis or heart/lung machines, all monitors	Annual Sales:	$

46. Do you install, service or demonstrate products or equipment? ..... ❑ Yes ❑ No

INSURANCE AND CLAIM INFORMATION

47. **Do you currently carry the following:**

a. **Professional Liability Insurance?** ..... ❑ Yes ❑ No

List the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage.

Policy Period From: MM/DD/YY	**To: MM/DD/YY**	**Insurance Company**	**Limit of Liability**	**Deductible**	**Claims Made or Occurrence?**	**Premium**
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If claims made, what is the retroactive date/prior acts date on your current policy? _____

b. **Commercial General Liability Insurance?** ..... ❑ Yes ❑ No

If yes, list the Commercial General Liability Insurance carried by the firm for each of the past five years including periods of no coverage.

Policy Period	**Carrier**	**Limit of Liability BI/PD**	**Deductible**	**Claims Made or Occurrence?**	**Premium**

If claims made, what is the retroactive date/prior acts date on your current policy? _____

CLAIMS HISTORY

48 a. **Have there been any professional/general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance, in the last five years?** ..... ❑ Yes ❑ No

If yes, how many? _____

If yes, please complete a Claim/Circumstance Supplement for <u>each</u> claim.

b. **Are you or anyone proposed for this insurance aware of any facts or circumstances which might give rise to a professional/general liability claim or complaint?** ..... ❑ Yes ❑ No

If yes, how many? _____

If yes, please complete a Claim/Circumstance Supplement for <u>each</u> incident.

c. **Are you or anyone proposed for this insurance aware of any charges, inquiries, investigations, grievances or other administrative hearings in the last five years or currently?** ..... ❑ Yes ❑ No

If yes, how many? _____

If yes to any, please complete a Claim/Circumstance/Administrative Hearings Supplement for <u>each</u>.

d. **Was prior professional/general liability coverage ever canceled or nonrenewed (OTHER THAN BEING NONRENEWED DUE TO THE CARRIER NO LONGER WRITING THESE COVERAGES) (NOT APPLICABLE TO MISSOURI APPLICANTS)?** ..... ❑ Yes ❑ No

IF YES, PLEASE EXPLAIN REASON FOR NONRENEWAL OR CANCELLATION: _____

_____

_____

NOTE: THE APPLICANT UNDERSTANDS AND AGREES THAT IF ANY FACTS, INCIDENTS OR CIRCUMSTANCES EXIST WHICH MAY REASONABLY GIVE RISE TO A CLAIM UNDER THIS PROPOSED POLICY, THEN ANY CLAIMS ARISING FROM SUCH FACTS, INCIDENTS OR CIRCUMSTANCES ARE EXCLUDED FROM COVERAGE.

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

1. **COPY OF ANY ADVERTISING BROCHURES OR ADVERTISEMENTS**
2. **COPY OF A SAMPLE CLIENT/PATIENT SERVICES CONTRACT**
3. **RESUMES/CVs FOR ALL KEY PERSONNEL, PRINCIPALS, EXECUTIVES, MEDICAL DIRECTORS AND/OR ADMINISTRATORS IF ESTABLISHED LESS THAN THREE YEARS**
4. **MOST CURRENT FINANCIAL STATEMENT**
5. **CURRENTLY VALUED LOSS RUNS FOR THE PAST FIVE YEARS**
6. **FULLY COMPLETED CLAIM SUPPLEMENTS FOR ALL CLAIMS**
7. **PROOF OF MEDICAL MALPRACTICE INSURANCE FOR ALL PHYSICIANS AND NURSE ANESTHETISTS**
8. **IF SEXUAL ABUSE COVERAGE IS DESIRED—COMPLETE SEXUAL ABUSE SUPPLEMENTAL APPLICATION**
9. **COPY OR DESCRIPTION OF THE STEP-BY-STEP PROCEDURE THAT IS FOLLOWED TO OBTAIN CRIMINAL BACKGROUND INFORMATION ON PROSPECTIVE EMPLOYEES**

SIGNATURE SECTION AND OTHER INFORMATION

NOTE: Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.

THE APPLICANT UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY BE ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY. THE APPLICANT ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION OR OTHERWISE.

THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THE REPRESENTATION, ON BEHALF OF THE APPLICANT OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD WARNING (Applicable in Tennessee and Washington): It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

<u>APPLICABLE IN THE STATE OF NEW YORK:</u> ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____

Name of Applicant

_____ _____

Signature and Title of Principal (must be owner, partner or officer) Date

_____

Print Name and Title of Principal Signing Above