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Allied Health Care Providers Program – Home Health Care, Hospice and Medical Staffing Firms Professional Liability & General Liability Insurance Application

Instructions:

- Please answer all questions completely. If any questions do not apply, print "N/A" in the space. Check all Yes/No answers. This form must be completed, dated and signed by a Principal or Officer of the Applicant Firm.
- Submit with current insurance company loss reports for the past five (5) years. Specify date, description and amount outstanding/current reserve for each claim.

Applicant Information:

Applicant (Entity) Name:	(If more than one entity/subsidiary, please attach description and % owned for each)		
DBA (If Applicable):			
Date Business First Established:		Employer Federal Tax ID Number (Required):	
Mailing Address:	Street: PO Box: City: State: Zip Code:		
Physical Address:	Street: City: State: Zip Code: County:		
Phone Number:		Fax Number:	
Website:		Number of Years Under Current Ownership:	
Contact Name:			
Contact E-Mail Address:			

Description of Operations: (check all that apply)

☐ Home Health Care Firm	☐ Medical Equipment Supplier	☐ Nurse Registry
☐ Personal Care/Support Services	☐ Oxygen Equipment Provider	☐ Traveling Nurse Firm
☐ Companion Care Provider Visiting Nurse	☐ Infusion Therapy Firm	☐ Medical Staffing
☐ Visiting Nurse Association(VNA)	☐ Pharmacy (Closed Shop)	☐ Non-Medical Staffing
☐ Hospice	☐ Retail Pharmacy	☐ Other (describe):

Current Accreditation (check all that apply):

☐ Accreditation Commission for Health Care (ACHC)
☐ Commission on the Accreditation of Rehabilitation Facilities (CARF)
☐ Community Health Accreditation Program (CHAP)
☐ The Joint Commission (formerly JCAHO) ☐ Other: _____ _____

Current Membership (check all that apply):

☐ Active Member – National Association for Home Care & Hospice (NAHC) *Exclusively Endorsed NAHC Affinity Partner*
☐ ActiveMember – State Home Care Association (name of assoc.): _____
☐ Active Member – Other (Association name): _____ _____

Operations:

Total Number of Employees:	Total Annual Gross Receipts: $
Permanent Employee Turnover Rate: _____ %	State(s) of Operation (list all):
Legal Entity - Choose One: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ Limited Liability Co.	Entity Type - Choose One: ☐ For Profit ☐ Non-Profit ☐ Government
Percentage of **Receipts** obtained for the following payor categories: (total must equal 100%) Medicare: _____% Medicaid: _____ Private Pay: _____ Other: _____	Medicare Provider #: _____

License/Certification Information:

1. Is the Applicant licensed in all states in which it is operating? If No, explain how non-licensed states are monitored:	☐ Yes	☐ No
Licensed Specialty:		
Licensing Agency:		
2. Has the Applicant's License or Certification ever been revoked, suspended, refused, canceled or voluntarily surrendered? Are any such charges pending against the Applicant?	☐ Yes ☐ Yes	☐ No ☐ No
3. Has any hospital or other healthcare entity ever denied, suspended, non-renewed, revoked, declined or in any way restricted the Applicant' s privileges?	☐ Yes	☐ No
4. Has a professional licensing board, certification board or professional ethics board ever taken disciplinary action against the Applicant? Are any disciplinary actions pending?	☐ Yes ☐ Yes	☐ No ☐ No
5. Has the Applicant ever been convicted of a misdemeanor or felony or is any such charge pending?	☐ Yes	☐ No
6. Has the Applicant ever been investigated by a State Health Department, State Licensing Board or other Governmental Body (i.e. FBI, Dept. of Justice)?	☐ Yes	☐ No

Location(s) Where Services are Provided: (total must equal 100%)

Location	Percentage of total revenue	Location	Percentage of total revenue
☐ Private Homes	%	☐ Doctors' Offices	%
☐ Nursing Homes/ Assisted or Independent Living Facilities		☐ Adult Day Care Facilities/Centers	
☐ Hospitals		☐ Prison Facilities	
☐ Clinics		☐ Schools	
☐ Laboratories		☐ Other Locations (describe):	
☐ Hospices			

Types of Services Provided: (total must equal 100%)

Service	Percentage of total revenue	Service	Percentage of total revenue
☐ Home Health Nursing	%	☐ Medical Supplemental Staffing	%
☐ Personal Care/Companion/Sitter		☐ Non-Medical Supplemental Staffing	
☐ Infant Care/Pediatric Care		☐ Rehabilitation	
☐ Surg. Nursing/Operating Techs		☐ Medical Equipment Supplier	
☐ Obstetrical Services		☐ Retail Pharmacy	
☐ Post Partum Caregivers		☐ Closed Shop Pharmacy	
☐ Hospice		☐ Mail Order Pharmacy	
☐ Respite Care		☐ Mental Health/Counseling	
☐ Meals on Wheels		☐ Psychiatric Care	
☐ Respiratory Care		☐ Adult Day Care	
☐ Trach/Ventilator Care		☐ Child Day Care	
☐ Infusion Therapy		☐ Laboratory Services	
☐ Palliative Care/Pain Mgmt.		☐ Clinics Owned/Operated	
☐ Blood Transfusion		☐ Dialysis	
☐ Chemo Therapy		☐ Bereavement Camps	
☐ Radiation Therapy		☐ Other (describe):	

Risk Management:

1. Does the Applicant utilize a formal written Quality Improvement and Risk Management Program?	☐ Yes	☐ No
2. Is the overall responsibility for risk management assigned to one individual in your firm? If Yes, Name/Title: _____ _____ If No, please describe how risk management is monitored:	☐ Yes	☐ No
3. Does the Applicant have an informed consent process in place?	☐ Yes	☐ No
4. Does the Applicant have a formal incident reporting procedure?	☐ Yes	☐ No
5. Does the Applicant have a formalized training and education program with staff attendance required at mandatory in servicing?	☐ Yes	☐ No
6. Are complete records kept on all patients? If so, are they stored in locked cabinets or password protected if electronic records? Are patient records protected in compliance and accordance with HIPAA? Does the Applicant require signed release forms for the release of records? Does the Applicant conduct semi-annual audits of all required paperwork?	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No ☐ No

Hiring/Screening and Credentialing Procedures:

1. Does the Applicant perform criminal background checks on prospective employees, independent contractors and volunteers? If Yes, at what level is the criminal searched conducted? (check all those applicable) ☐ County ☐ State ☐ Federal ☐ Felony ☐ Misdemeanor Convictions	☐ Yes	☐ No
2. Does the Applicant verify employment related references prior to an employee or independent contractor being hired/placed?	☐ Yes	☐ No
3. Does the Applicant verify certification and/or professional licensure status of all employees and independent contractors at hire date and on an ongoing basis?	☐ Yes	☐ No

Hiring/Screening and Credentialing Procedures (continued):		
4. Does the Applicant confirm in writing any of the following relative to prospective employees: - Whether their medical professional liability insurance has ever been denied or canceled? - Whether they have ever been involved in any professional liability claims or litigation? - Whether any action has ever been taken on their clinical privileges? - Whether the individual has ever been convicted of any crime, including sexual abuse or molestation and/or assault & battery?	☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No
5. Does the Applicant conduct a personal interview for each prospective employee?	☐ Yes	☐ No
6. Has the Applicant formalized a drug and alcohol screening program requiring all employees and independent contractors to satisfy drug and alcohol testing prior to hire/placement?	☐ Yes	☐ No
7. Is there a procedure for screening suspect employees/independent contractors when drug or alcohol abuse is alleged?	☐ Yes	☐ No
8. Are all employees/independent contractors required to sign a formal confidentiality statement?	☐ Yes	☐ No
9. Are written job descriptions provided to all employees?	☐ Yes	☐ No
10. Does your organization require that all contracted professionals (including physicians and physicians' assistants) maintain primary professional liability insurance? If so, please specify limits of liability required: _____ _____ Are certificates of insurance obtained on an annual basis?	☐ Yes ☐ Yes	☐ No ☐ No
11. Is there a formalized professional staff credentialing process in place, including verification of license, certification, education and training?	☐ Yes	☐ No

Professional Staff – License and Insurance Coverage Information:

Please provide the following information for each Physician, Physician Assistant and/or Nurse Practitioner:

Full Name of Professional	State of Licensure	Employee, Volunteer or Independent Contractor?	Average Hours per Month	Primary Insurance Coverage? (Yes/No)	Name of Primary Insurance Carrier

Services Provided – Additional Details:

1. Does the Applicant provide **Pediatric Care**? If Yes, describe types of pediatric services:	☐ Yes	☐ No
2. Do you take on **tracheotomy/ventilator** dependent patients? If Yes, what is the percentage of total patients? %	☐ Yes	☐No
3. Are **Apnea Monitors** used in the delivery of care? If Yes, does the Applicant rent this equipment to others? If Yes, number of Monitors owned by Applicant:	☐ Yes ☐ Yes	☐No ☐No
4. Does the Applicant provide **Psychiatric Care or Mental Health Services**? If Yes, please describe services:	☐ Yes	☐ No

Services Provided – Additional Details (continued):

5. Does the Applicant provide any **"live-in" home health care services**? ☐ Yes ☐ No
   If Yes, please provide the percentage of patients that use this service: _____ %

6. Does the Applicant provide any services to **Alzheimer's, quadriplegic, or mentally incapacitated** patients? ☐ Yes ☐ No

7. Does the Applicant own or operate any **bed/board facilities** (i.e. hospice, skilled nursing, etc.)? If yes, number of beds: _____ ☐ Yes ☐ No
   If yes, are all **medications** stored in a locked cabinet? ☐ Yes ☐ No

8. **Home Health Care** – total number of patients treated in their homes (annually): _____
   Percentage under 18 years of age: _____%
   Percentage Adult (19-65): _____%
   Percentage Senior (over 65): _____%

9. Does the Applicant perform **home-site surveys** prior to the commencement of care? ☐ Yes ☐ No

10. Are employees required to complete **daily work reports**? ☐ Yes ☐ No

11. Do all patients receiving any level of skilled care have a current and regularly updated **physician treatment plan** on file? ☐ Yes ☐ No

12. Is the Applicant a **Durable Medical Equipment Supplier*** (sales, lease and/or rental)? ☐ Yes ☐ No
    If Yes, please complete DME supplemental application.

13. Does the Applicant provide any **Supplemental Staffing** services? ☐ Yes ☐ No

14. **Total Revenue** derived from Supplemental Staffing services: $_____

    Percentage of total revenues by **location of staffing services** (total must equal 100%):

    ☐ Nursing Homes/Assisted or Independent Living Facilities: _____%
    ☐ Hospitals (see Q15.) _____
    ☐ Clinics/Laboratories: _____
    ☐ Hospices: _____
    ☐ Doctor's Offices: _____
    ☐ Schools: Adult Day Care _____
    ☐ Facilities: _____
    ☐ Prison Facilities: _____
    ☐ Other (please specify): _____

15. If Supplemental Staffing is provided to **Hospitals,** please specify percentage of total revenues by specialized service (total must equal 100%):

    ☐ Obstetrical: _____%
    ☐ Psychiatric: _____
    ☐ Intensive Care Unit: _____
    ☐ Neonatal: _____
    ☐ Emergency Department: _____
    ☐ Medical/Surgical Unit: _____
    ☐ Pediatric: _____
    ☐ Coronary Care Unit: _____
    ☐ All other units: _____

16. Do you require that **Contractual Agreements** you enter into to provide temporary or supplemental staffing to client facilities include the following provisions:
    Mutual indemnification and hold harmless agreement? ☐ Yes ☐ No
    Require third parties to carry liability insurance with limits of at least $1M/$3M? ☐ Yes ☐ No
    Require the third party to provide the Applicant with a certificate of insurance? ☐ Yes ☐ No

    Please provide a copy of your standard contract.

EMPLOYEES/STAFF GRID:

Does Applicant provide services in more than one state? Yes** ☐ No ☐ STATE: _____

If Yes, please make a copy of this page and complete this employees/staff grid for each state.

Professional Classification	Total Number of Annual Hours Worked	Number of Employees		Number of Indep Contractors		Annual Payroll (or 1099 amount)
		FULL	PART	FULL	PART	
Administrative/Clerical						$
Audiologist						
Cardiology Technician						
Companion/Sitter						
Clergy						
Dental Hygienist/Dental Assistant						
Dialysis Technician						
Dietician/Nutritionist						
EKG/EEG Technician						
Enterostomal Therapist						
Home Health Aide/CNA						
Homemaker						
Lab Technician						
LPN/LVN						
Medical Director						
Medical Technologist						
Mental Health Counselor						
MRI Technician						
Nuclear Medicine Technician						
Nurse Aide						
Nurse Practitioner						
Nurse/RN						
Occupational Therapist						
Pharmacist						
Pharmacy Assistant/Tech						
Phlebotomist						
Physical Therapist						
Physician						
Physicians' Assistant						
Psychologist						
Radiological Technologist						
Rehabilitation Counselor/Therapist						
Respiratory Therapist						
Social Worker						
Speech Therapist						
Ultrasound Technician						
Volunteer						
Wellness Counselor						
X-Ray Technician						
Other:						

Operations/Exposure Information:

1. Will any new services be provided in the next 12 months? If yes, please describe:	☐ Yes	☐ No
2. Will any services be discontinued in the next 12 months?	☐ Yes	☐ No
3. Have any services been discontinued in the last 24 months?	☐ Yes	☐ No
4. Within the next 12 month period, does the Applicant plan to: Obtain another operation or entity? If yes, please describe: _____ Add to the number of employees? Expand the number of locations?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
5. Are any residential facilities owned or operated by the Applicant?	☐ Yes	☐ No
6. Does the Applicant's staff prescribe medication(s) to patients?	☐ Yes	☐ No
7. Does the Applicant utilize recreational activities in the treatment of patients?	☐ Yes	☐ No
8. Does the Applicant handle all billings in-house?	☐ Yes	☐ No
9. Does the Applicant have a compliance program in place for both HIPAA and billing errors?	☐ Yes	☐ No
10. Is there a Medical Billings Compliance Officer on staff?	☐ Yes	☐ No
11. Are there any fundraising events planned for the upcoming year? If yes, please describe:	☐ Yes	☐ No

Abuse & Molestation Coverage Section: (if not requesting this coverage, please cross through this section)

1. Does the Applicant have written procedures that monitor the staff in day to day relationships with clients, both on (if applicable) and off the premises?	☐ Yes	☐ No
2. Does the Applicant have formal staff training on sexual abuse and molestation, including how to recognize the signs?	☐ Yes	☐ No
3. Does the Applicant have more than one person responsible for the welfare of any single patient?	☐ Yes	☐ No
4. Does the Applicant have a formal complaint reporting and documentation procedure for clients and employees?	☐ Yes	☐ No
5. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities and the media if there is an incident of abuse?	☐ Yes	☐ No
6. Does the Applicant's employment application include questions (if permissible) about whether the individual has ever been accused or convicted of any crime, including any sexual or molestation related offense?	☐ Yes	☐ No
7. Has the Applicant ever had an incident that resulted in an allegation of sexual abuse or molestation? If Yes, please describe: _____ _____ _____ Was the case settled? Was the case taken to trial?	☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No
8. Has the Applicant (or their insurance carrier) ever paid any damages as a result of an allegation of sexual abuse or molestation? If Yes, amount paid?: $	☐ Yes	☐ No
9. Is the Applicant aware of any fact, circumstance or situation which may lead to any future sexual abuse or molestation claim?	☐ Yes	☐ No

Non-Owned & Hired Auto Coverage Section: (If not requesting this coverage, please cross through this section)

1. Does the Applicant own any vehicles use for business purposes?	☐ Yes	☐ No
2. Does the Applicant purchase a business owned auto liability insurance policy?	☐ Yes	☐ No
3. How many employees, independent contractors (ICs) or volunteers use their own vehicle for company business? Employees _____ ICs ____ Volunteers ____	Yes	No
4. Does the Applicant obtain a copy of driver's licenses for all employees, ICs and volunteers and confirm they are valid?	☐ Yes	☐ No
5. Does Applicant require each employee, IC and volunteer to provide evidence of Insurance with personal auto limits of at least the state required minimum?	☐ Yes	☐ No
6. Does the Applicant make a visual check of all employee, IC and volunteer personal vehicles to be sure the unit is safe and operational?	☐ Yes	☐ No
7. Does Applicant check the Motor Vehicle Reports/MVRs on an annual basis of all employees/ICs/volunteers under age 25 & for all those that transport patients?	☐ Yes	☐ No
8. Do any of the Applicant's employees, ICs or volunteers drive **patient/client owned** vehicles during the course of your business?	☐ Yes	☐ No
9. Is the Applicant aware of any auto accident or loss which may result in a claim?	☐ Yes	☐ No

PROFESSIONAL LIABILITY Insurance Coverage Information *(past three years)*:

Policy Period	Carrier	Limits	Deductible	Premium	CM/Occurrence
Current:					☐ Claims Made (CM) Retro date:_____ ☐ Occurrence
					☐ Claims Made Retro date: _____ ☐ Occurrence
					☐ Claims Made Retro date: _____ ☐ Occurrence

Has the Applicant ever had **Professional Liability** insurance canceled or non-renewed? *(Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.)* *(Nevada Applicants: If you have answered yes, please provide an explanation.)*	☐ Yes	☐ No

GENERAL LIABILITY Insurance Coverage Information *(past three years)*:

Policy Period	Carrier	Limits	Deductible	Premium	CM/Occurrence
Current:					☐ Claims Made (CM) Retro date: _____ ☐Occurrence
					☐ Claims Made Retro date: _____ ☐ Occurrence
					☐ Claims Made Retro date: _____ ☐ Occurrence

Has the Applicant ever had **General Liability** insurance canceled or non-renewed? *(Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.)* *(Nevada Applicants: If you have answered yes, please provide an explanation.)*	☐ Yes	☐ No

Claims and Incident Information:

1. Is the Applicant aware of any of the following events which may result in any claim or suit being made:		
a. Any client/patient deaths reported while they were in your care or under your supervision?	☐ Yes	☐ No
b. Any incidents including slips, trips or falls of a client or patient reported?	☐ Yes	☐ No
c. Any mistaken procedures executed or incorrect diagnoses rendered?	☐ Yes	☐ No
d. Any severe drug reaction by a client or patient?	☐ Yes	☐ No
2. Are you aware of any events where patients or their relatives have:		
a. Directly accused you or your employees of malpractice?	☐ Yes	☐ No
b. Exhibited a total disregard of advice or irrational expectations of care?	☐ Yes	☐ No
c. Abruptly discontinued care?	☐ Yes	☐ No
d. Repeated complaints about service or treatment?	☐ Yes	☐ No
3. Has any patient requested release of their records to an attorney?	☐ Yes	☐ No
4. Has any professional liability claim or suit ever been made against the Applicant or its' employees, independent contractors or volunteers?	☐ Yes	☐ No
5. Is the Applicant aware of any fact, circumstance or situation which may lead to any future claim?	☐ Yes	☐ No

Additional Insureds:

Please provide a **list of all entities to be named as an Additional Insured(s)** with complete names and insurable interest:

Name Insurable Interest

_____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____

FRAUD STATEMENTS:

GENERAL STATEMENT:
Any person who knowingly and with intent to defraud any insurance company or another 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 the person to criminal and [NY: substantial] civil penalties. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied).
APPLICABLE IN COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the isleading purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN THE DISTRICT OF COLUMBIA:
WARNING: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORIDA:
Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

APPLICABLE IN HAWAII:
For you protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT:
Any person who knowingly and with intent to defraud any insurance company or another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

APPLICABLE IN OHIO:
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA:
WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN 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.

SIGNATURE SECTION:

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

It is understood and agreed that the completion of this application does not bind the company to issue, nor the Applicant to purchase, the insurance.

Applicant Firm Name:_____ _____ _____ _____

Signed By:_____ Signature: _____ _____

(Please type or print name and title) Date: _____ _____

(Must be signed and dated by Principal or Officer of Firm)

Agent/Broker Information:

Agency Name: _____ _____ _____ _____

Contact Name: _____ __ Phone: _____ _____

Address: _____ _____ _____

Agent/Broker E-Mail: _____ Agent/Broker License# (Required):_____