HOME HEALTHCARE PROFESSIONAL AND GENERAL LIABILITY APPLICATION—CLAIMS MADE AND REPORTED BASIS

Desired effective date: _____

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

   _____

   Address: _____

   City: _____ State: _____ County: _____ ZIP: _____

   Contact Name: _____ Title: _____

   Contact Email Address: _____ Phone: _____

   Website URL: _____

   List all other locations:

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. Date established: _____
5. List all states where you are licensed to practice:
6. Is the firm engaged in, owned by or associated with or controlled by any other business? ☐ Yes ☐ No

   If yes, provide details:
7. Please list the individual shareholders or partners of the facility:
8. Are any services provided outside of the United States? ☐ Yes ☐ No

   If yes, including countries, what type of services are provided and what percentage of your revenues are derived from these services:
9. Do you provide any internet services? ☐ Yes ☐ No

   If yes, provide explanation, including confirmation of licensing in all states in which services are provided:
10. Does the applicant anticipate any facility expansions within the next year? ☐ Yes ☐ No

    If yes, describe:

11. 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, provide details:

12. Does the applicant advertise its professional services in any manner (other than a line listing in a telephone directory)? ☐ Yes ☐ No
    If yes, please attach copies of **ALL** advertisements.
13. Does the applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., in which professional advice is offered to the public?
    ☐ Yes ☐ No
14. Hold Harmless (Indemnification) Agreements:
    a. **In favor of the applicant:** If the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained:

    b. **In favor of others:** Has the applicant agreed to indemnity (hold harmless) others under written contract? ☐ Yes ☐ No
       If yes, please submit a copy of the agreement.
15. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule? ☐ Yes ☐ No
    If yes:
    a. Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? ☐ Yes ☐ No
    b. Provide the name and title of the Applicant's Privacy Officer: _____
16. 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: _____
17. 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: _____
18. Location and percentage where services are provided (total must equal 100%):

Location	Percentage
Private Home	_____ %
Assisted Living	_____ %
Hospital	_____ %
Nursing Home	_____ %
Other (specify): _____	_____ %

19. 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	_____ %
Complete Pediatric Care (percentage of persons under age 18)	_____ %

20. State the number of patient encounters and/or patient tests carried out as follows (patient encounters refer to number of visits—not the number of patients):

Type of Encounters	Number for Last 12 Months	Estimated Number for Next 12 Months
Patient Encounters		
Patient Tests		

21. State sources and amounts of actual and projected gross revenue:

Source	Amount this Fiscal Year	Amount Next Fiscal Year
a. Charitable Contributions	$	$
b. Government Funding	$	$
c. Fee for Service	$	$

22. Do any of your employees or independent contractors provide services as directed by you to members of their own family? ☐ Yes ☐ No
23. Do you provide imaging services? ☐ Yes ☐ No
    If yes, complete the supplemental application.
24. Describe the type of procedures performed at or by this facility:

25. Are all personnel performing these procedures certified and properly trained to perform these procedures? ☐ Yes ☐ No

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

Discipline	Employees				Independent Contractors	
	Number of Full-Time	Number of Part-Time	Annual Hours Worked	Annual Payroll	Number 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				$		

27. 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 healthcare staff with other businesses? ☐ Yes ☐ No
    If yes, what percentage of your revenues is derived from the placement of:
    i. Nurse Practitioners? _____ %
    ii. Other healthcare 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
If no, explain:

f. Does the applicant have any independent contractors? ☐ Yes ☐ No
If yes, list the number and type of independent contractors who provide professional services on behalf of the applicant:

g. Name of medical director, if any: _____
Is coverage provided for the medical director under any other insurance policy? ☐ Yes ☐ No
If yes, please provide type of policy and name of carrier:

HIRING PRACTICES

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

RISK MANAGEMENT/LOSS CONTROL

38. Is there a written, formalized Risk Management Program? ☐ Yes ☐ No
39. Is there a written, formalized Quality Assurance Program? ☐ Yes ☐ No
40. Do you have a standard system to handle a patient's complaints or suggestions? ☐ Yes ☐ No
41. Do you practice universal precautions? ☐ Yes ☐ No
42. Do you have a Quality Assurance Department? ☐ Yes ☐ No
43. In case of an emergency is management available 7 days a week, 24 hours a day? ☐ Yes ☐ No
44. Do you have policies and procedures in place regarding medications? ☐ Yes ☐ No
45. Are nursing charts maintained regularly? ☐ Yes ☐ No
46. Do you regularly check employees' licenses and certifications? ☐ Yes ☐ No
47. Does your staff employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse-related offenses? ☐ Yes ☐ No
48. Do you discuss at staff orientation elder and/or child abuse or sexual abuse? ☐ Yes ☐ No
49. Do you have a supervision plan in place that monitors staff in the daily relationships with clients? ☐ Yes ☐ No

GENERAL LIABILITY

50. Complete the following for any owned or leased premises (attach an additional sheet if necessary):

Location Address	Occupancy	Square Footage
	☐ Owned ☐ Leased	
	☐ Owned ☐ Leased	
	☐ Owned ☐ Leased	

51. 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 (attach an additional sheet if necessary):

Name	Address	Interest

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

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

If the answer to Question 52 or 53 above is yes, please complete the following:

Category I	Expendable Items—intended for one time use and then disposed of	Annual Sales: $
Category II	Non-Expendable Items—including hospital beds, bathroom safety bars, portable toilets, lifts or hoists, ambulatory 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 respiratory 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: $

54. Do you install, service or demonstrate products or equipment? ☐ Yes ☐ No

INSURANCE AND CLAIM INFORMATION

55. a. Do you currently carry **Professional Liability Insurance?** ☐ Yes ☐ No

If yes, list the Professional Liability Insurance carried by the firm **for each of the past five (5) years** including periods of no coverage.

Policy Period **FROM** MM/DD/YY	Policy Period **TO** MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
			$	$		$
			$	$		$
			$	$		$
			$	$		$
			$	$		$

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

b. Do you currently carry **Commercial General Liability Insurance?** ☐ Yes ☐ No
If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
		$	$		$

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

CLAIMS HISTORY

56. a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No
If yes, provide full details;

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
☐ Yes ☐ No
If yes, fully describe the circumstances and follow up action taken:

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

1. Copy of prior five (5) years currently valued company loss runs **(if no prior coverage, complete claims supplement)**
2. Copy of the declaration page of your most recent professional liability policy
3. If a start-up firm, copy of the pro forma business plan
4. Copy of any advertising brochures or advertisements
5. Copy of a sample client contract
6. Resumes/CVs for all key personnel, principals, executives, medical directors and/or administrators

Limits of Liability desired for Professional Liability:

☐ $100,000/$100,000 ☐ $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: $ _____

MINIMUM AND MAXIMUM DEDUCTIBLES WILL BE SUBJECT TO UNDERWRITING APPROVAL.

SIGNATURE PAGE

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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.

Notice applicable in most states: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____