JM WILSON

800-666-5692

Agency:
Agency Code:
Contact:
Phone:
Email:
New ☐ **Renewal** ☐ **Policy #:**

Professional Liability Application for Home Health Care Agencies

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED. If the answer is NONE, state NONE; If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A). If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____

Tax ID: _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (_____ Fax (_____)_____

Email: _____

Website: _____

1.6 Person to contact for Survey: Name: _____Title: _____

Email: _____Telephone Number: (_____

1.7 Year entity established: _____

1.8 The Applicant is (Please check and complete A) or B) below:

☐ A. The **APPLICANT** is an: ☐ INDIVIDUAL ☐ Employee ☐ Student ☐ Sole Practitioner

☐ B. The **APPLICANT** is a: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability

☐ Other –Please Describe _____

1.9 Entity is: ☐ For Profit ☐ Non-Profit

Please describe source of funds: _____

_____

1.10 **Proposed Effective Date:** _____

1.11 Requested Limits of Liability (if available): $ _____/$ _____

1.12 Annual Gross Receipts: Estimated next twelve months - $_____

Last twelve months - $_____

1.13 Annual Remuneration: Estimated next twelve months - $_____

Last twelve months - $_____

1.14 Total Premises Square Footage Occupied By Applicant:_____

1.15 List all memberships in professional organizations: _____

_____

PART II. EXPOSURES

2.1 Healthcare Staff: Please indicate the next twelve months estimated figures for each of the following categories of staff, hours worked and compensation.

2.1.1 Employed Staff (W-2):

Type	Maximum No.	Annual Hours of Service	Annual Remuneration
Registered Nurse	_____	_____	$_____
Licensed Practical Nurse	_____	_____	$_____
Physical Therapist	_____	_____	$_____
Occupational Therapist	_____	_____	$_____
Respiratory Therapist	_____	_____	$_____
Psychotherapist	_____	_____	$_____
Speech Therapist	_____	_____	$_____
Social Workers	_____	_____	$_____
Aides, Homemakers	_____	_____	$_____
Physicians*	_____	_____	$_____
Other: _____	_____	_____	$_____
Employed Subtotal	_____	_____	$_____

2.1.2 Contracted Staff (1099):

Type	Maximum No.	Annual Hours of Service	Annual Remuneration
Registered Nurse	_____	_____	$_____
Licensed Practical Nurse	_____	_____	$_____
Physical Therapist	_____	_____	$_____
Occupational Therapist	_____	_____	$_____
Respiratory Therapist	_____	_____	$_____
Psychotherapist	_____	_____	$_____
Speech Therapist	_____	_____	$_____
Social Workers	_____	_____	$_____

Aides, Homemaker	_____	_____	$_____
Physicians*	_____	_____	$_____
Other:_____	_____	_____	$_____
Contracted Subtotal	_____	_____	$_____
Total	_____	_____	**$**_____

*Other than Medical Director, show no. of patient visits in lieu of hours of service, and complete Physician Exposure Supplement.

2.1.3 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf)? ☐ Yes ☐ No

2.1.4 Enter percentage of services provided by category of staff including contracted staff:

RN's & LPN's	**AIDES/ORDERLIES**
___% Hospitals	___% Hospitals
___% Nursing Homes / Assisted Living	___% Nursing Homes / Assisted Living
___% Private Doctors	___% Private Doctors
___% Private Home Care	___% Private Home Care
___% Other (Describe):_____	___% Other (Describe):_____
OTHER: _____	OTHER: _____
___% Hospitals	___% Hospitals
___% Nursing Homes / Assisted Living	___% Nursing Homes / Assisted Living
___% Private Doctors	___% Private Doctors
___% Private Home Care	___% Private Home Care
___% Other (Describe):_____	___% Other (Describe):_____

2.2 Of the total payroll for home all health care staff, indicate the percentage of payroll attributable to each of the following: ***if any, please also complete supplement for IV Therapy**

_____% IV Therapy*
_____% AIDS Therapy*
_____% Chemotherapy*
_____% Infant Monitoring (SIDS, etc.)
_____% Pediatric/infant childcare including "babysitting"

2.3 Number of estimated patients next twelve months:_____

2.4 Number of patients last twelve months: _____

2.5 Is applicant's facility owned by an M.D.? ☐ Yes ☐ No
If **YES**, owner name(s):_____
_____

2.6 Does applicant sell, rent or otherwise provide any equipment or products to patients? ☐ Yes ☐ No
To others? ☐ Yes ☐ No
If **YES**, to either question, please complete Product Sales/Rental Supplement.

2.7 Is the applicant eligible for certification or accreditation? ☐ Yes ☐ No

If **YES**, is applicant certified and/or accredited? ☐ Yes ☐ No

If **NO**, explain the reason. _____

_____

2.8 Is applicant approved to receive Medicare and Medicaid payments? ☐ Yes ☐ No

2.9 Does the applicant desire Hired and Non-Owned Auto coverage? ☐ Yes ☐ No

If **YES**, please specify the number of drivers: _____

PART III. RISK MANAGEMENT

3.1 Name, qualifications and number or years of experience of the Medical Director:

Name	Title	Experience/Training	Association Membership

3.2 Does your Agency have a written credentialing policy and procedure for all individual's associated with or practicing within the Agency? ☐ Yes ☐ No

3.3 Does the applicant conduct pre-employment screening and investigation? ☐ Yes ☐ No

3.4 Does the staff supervisor make regular audit visits of staff in the field? ☐ Yes ☐ No

3.5 Does the applicant require contracted staff (if any) to carry their own Professional Liability Insurance? ☐ Yes ☐ No

Do you secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No

3.6 Describe applicant's procedures for matching staff to patients. Who does the matching/assigning of staff to client, and what is his/her experience? _____

_____

3.7 Who does the supervising of staff, and what is his/her experience? _____

_____

3.8 Describe the referral source(s) by which patients are directed to the entity. _____

_____

3.9 Is the applicant equipped with an emergency 24 hour telephone call line for all of staff and patients? ☐ Yes ☐ No

3.10 Does the applicant enter into any contractual agreements (other than lease of premises agreements) in which you hold others harmless? If **YES**, please attach copies of all such contracts. ☐ Yes ☐ No

3.11 Does the home health agency advertise its services other than an ordinary local telephone directory listing? If **YES**, please attach a copy of each advertisement. ☐ Yes ☐ No

3.12 Does the applicant maintain a written clinical record showing the total number of visits by each category of staff for each patient? ☐ Yes ☐ No

3.13 Are patients' accepted for health care services only upon a written plan of treatment established by an attending physician? ☐ Yes ☐ No

Please explain any exceptions: _____

_____

_____

3.14 Does applicant's agency have a written incident/occurrence reporting policy and procedures? ☐ Yes ☐ No

3.15 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? If **NO**, please attach explanation of any exception. ☐ Yes ☐ No

3.16 Has the applicant or any of its employees:

a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ☐ Yes ☐ No

b) Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ☐ Yes ☐ No

c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

IF THE ANSWER TO ANY OF 3.16 IS YES, PLEASE ATTACH A DETAILED EXPLANATION.

3.17 Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is Currently engaged which would fall outside the scope of typical home healthcare operations.

☐ None ☐ Description Attached

PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.						☐	☐
2.						☐	☐
3.						☐	☐
4.						☐	☐
5.						☐	☐

If claims-made, what is the most recent retroactive date?_____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.						☐	☐
2.						☐	☐
3.						☐	☐
4.						☐	☐
5.						☐	☐

If claims-made, what is the most recent retroactive date?_____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐ Yes ☐ No

If **YES**, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary)._____

_____

_____

_____

_____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? ☐ Yes ☐ No

If **YES**, please describe the event and indicate the reason for anticipation of a claim.

_____

_____

_____

_____

_____

_____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Greenhill Insurance Services, LLC. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

_____ _____

Date Applicant Title

IV Therapy in the Home Health Setting Supplement

HOME HEALTH AGENCY:

PLEASE COMPLETE THIS SUPPLEMENT IF ANY IV THERAPY IS/WILL BE DONE BY YOUR AGENCY'S PERSONNEL.

	Yes	No
A. The client and significant others are instructed concerning the IV Therapy Treatments?	☐	☐
1. The instruction includes precautions, signs and symptoms of possible/actual problems, simple first-aid measures and when and whom to call for assistance?	☐	☐
2. A return demonstration is required before any manipulation/handling of supplies or equipment occurs?	☐	☐
3. The medical record is documented concerning instruction?	☐	☐
B. Policies and procedures concerning IV therapy are written?	☐	☐
1 They are readily available for use by the registered nurse?	☐	☐
2. They are reviewed and/or revised annually?	☐	☐
3. They include:		
a) Drug administration?	☐	☐
1) IV Fluids in general?	☐	☐
2) Specific drugs by category and method of infusion (direct push, IV Infusion)?	☐	☐
b) Site care?	☐	☐
c) Infection control?	☐	☐
d) Care of equipment, including infusion pumps?	☐	☐
e) Protocols for emergency interventions? (These should be developed with the assistance of the physician.)	☐	☐
C. The registered nurse has, at a minimum, institutional certification for IV therapy?	☐	☐
1. The certification process verifies:		
a) Performance Competency: a skills inventory/checklist is maintained which documents observed demonstration?	☐	☐
b) Knowledge Competency: a test of theoretical knowledge to include actions of various drugs administered, contradictions, complications and nursing intervention?	☐	☐
2. The registered nurse will be recertified annually?	☐	☐
D. IV therapy will be included as part of the quality assurance program?	☐	☐
1. Criteria will be established for use in monitoring the program?	☐	☐
2. The medical record, patient interview and patient assessment are included in the review process?	☐	☐

Date _____ Applicant _____ Title _____

Medical Products Sales or Equipment Rental Supplemental Application

A. LIST EACH PRODUCT OR EQUIPMENT LINE INDIVIDUALLY and provide receipts for each. Please attach COPY OF YOUR PRODUCTS / EQUIPMENT BROCHURES.

ANNUAL RECEIPTS

DESCRIBE PRODUCT / EQUIPMENT LINE From Rental From Sales

1._____

2._____

3._____

4._____

5._____

B. Describe clients applicant sells / rents to, and % each:

_____% Individuals using products in their home _____% Individuals in nursing homes*

_____% Nursing Homes or similar residential facilities* _____% Hospitals*

_____% Clinics / Labs* _____% Physicians*

_____% Other*, Describe _____

* If other than individuals in their home, is there a financial / ownership relationship between applicant and client or facility? ☐ Yes ☐ No

If **YES**, please explain _____

C. Who does the servicing and repair of the products? _____

Who does the servicing and repair of rental equipment? _____

D. Are any products manufactured by others and sold under your entity's label? ☐ Yes ☐ No

If **YES**, which products? _____

E. Are any additional products planned in the next twelve months? ☐ Yes ☐ No

If **YES**, please include them under A. and estimate the receipts in the next 12 months.

F. How are products marketed? (Please attach ad copy or brochures)_____

_____

G. Is a rental/lease agreement signed by customers prior to releasing any rental equipment? ☐ Yes ☐ No

If **YES**, please ENCLOSE A COPY OF THE RENTAL AGREEMENT.

H. Is formal written inspection program for rental equipment conducted prior to each rental? ☐ Yes ☐ No

I. Are manufacturer's labels/directions/instructions provided to customers for all rentals? ☐ Yes ☐ No

J. Do the MANUFACTURERS or distributors of any of the above listed items:

1) Name your entity as an additional insured under their products liability policies? ☐ Yes ☐ No

2) Provide Certificates of Insurance for Products Liability to you? ☐ Yes ☐ No

3) Provide maintenance/service agreements for their product(s)? ☐ Yes ☐ No

4) Hold you harmless for loss arising from their products? ☐ Yes ☐ No

If the answer is **YES** for some products, please specify which product line and which answers:

_____

K. Are all manufacturers / suppliers well known U. S. firms? ☐ Yes ☐ No

If **NO**, please give details of which are not, and any foreign products. _____

_____

L. If sales of MEDICINES OR DRUGS are made by applicant, is a licensed pharmacist employed or contracted?

☐ Yes ☐ No

If, **YES** please indicate number _____ Employed (W-2) _____Contracted (1099)

Does pharmacist carry his/her own professional liability insurance? ☐ Yes ☐ No

Limits _____

_____ _____ _____

Date Applicant Title