Professional Liability Application for Home Health Care Agencies & Medical Personnel Staffing

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 DBAs): _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of Each Location: _____

1.5 Telephone Number: Office: _____ Fax: _____

1.6 Person to Contact for Survey: Name: _____ Title: _____

1.7 Year Entity Established: _____

1.8 Entity is: ☐Individual ☐Corporation ☐Partnership ☐Professional Association/Corporation
☐Other; Describe: _____

1.9 Entity is: ☐For Profit ☐Non-Profit
Describe Source of Funds: _____

1.10 Entity is: ☐Home Health Care Agency
☐Medical Personnel Staffing (Home Health Care Services Only)
☐Medical Personnel Staffing (All Other)
☐Other; Describe: _____

1.11 Accreditation Information (check whichever applies):
Type: ☐SAS Distinguished or Gold Standards ☐SAS Full Accreditation
☐Other; Describe: _____

1.12 Proposed Effective Date: _____

1.13 Requested Limits of Liability (if available):
Professional Liability $_____/$_____
General Liability $_____Each Occurrence
$_____General Aggregate

1.14 Annual Gross Receipts: Estimated next 12 Months: $_____
Last 12 Months: $_____

1.15 Total premises square footage occupied by applicant: _____

1.16 List all memberships in professional organizations: _____

_____

_____

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Part II. Exposures

2.1 Health care Staff: Indicate the next 12 months estimated figures for each of the following categories of staff, hours worked, and compensation.

2.1.1 **Employed Staff (W-2):**

	Maximum No.	Annual Hours of Service	Annual Payroll
Registered Nurse			$
Licensed Practical Nurse			$
Physical Therapist			$
Occupational Therapist			$
Respiratory Therapist			$
Psychotherapist			$
Speech Therapist			$
Social Worker			$
Aide, Homemaker			$
Physician*			$
Other:			$
Employed Subtotal:			$

2.1.2 **Contracted Staff (1099):**

	Maximum No.	Annual Hours of Service	Annual Payroll
Registered Nurse			$
Licensed Practical Nurse			$
Physical Therapist			$
Occupational Therapist			$
Respiratory Therapist			$
Psychotherapist			$
Speech Therapist			$
Social Workers			$
Aide, Homemaker			$
Physician*			$
Other:			$
Contracted Subtotal:			$
Total:			$

*Other than Medical Director, show number of patient visits in lieu of hours of service, and complete the Physician's 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:

RNs & LPNs	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:

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_____% 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 all home health care staff, indicate the percentage of payroll attributable to each of the following:

_____% IV Therapy*

_____% AIDS Therapy*

_____% Chemotherapy*

_____% Infant Monitoring (SIDS, etc.)

_____% Pediatric/infant childcare including "babysitting"

*If any, also complete supplement for IV Therapy.

2.3 Number of patients next 12 months: _____

2.4 Number of patients last 12 months: _____

2.5 Is your facility owned by an M.D.? ☐Yes ☐No

If yes, owner name(s): _____

2.6 Do you sell, rent, or otherwise provide any equipment or products to patients? ☐Yes ☐No
To others? ☐Yes ☐No
If yes, to either question, 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

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 credentializing policy and procedure for all individuals associated with or practicing within the agency? ☐Yes ☐No

3.3 Do you 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 Do you 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 your 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 Are you equipped with an emergency 24-hour telephone call line for all staff and patients? ☐Yes ☐No

3.10 Do you 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 contacts. ☐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 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? ☐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

Explain any exceptions: _____

_____

_____

_____

3.14 Does your 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, 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, or joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations. ☐None ☐Description Attached

Part IV. Medical Staffing Services Only

If you do not provide staffing services, please initial here and proceed to Part V: _____

4.1 Is any staff provided to hospitals specifically to serve a particular specialty (e.g., OR, ICU, CCU, ER, etc)? ☐Yes ☐No

If yes, enter percentage of services provided, by category, of staff including contracted staff:

_____ % OR

_____ % Labor/delivery

_____ % ICU/CCU

_____ % ER

_____ % Other; Describe: _____

4.2 Do you prepare job descriptions and instructional manuals for your staff? ☐Yes ☐No

If yes, enclose a copy of each.

4.3 Do you maintain records of specific areas of experience of each staff member? ☐Yes ☐No

4.4 Do you require staff to report all incidents (accidents) that might result in a liability claim AND are records of such reports kept on file by you? ☐Yes ☐No

Part V. History

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

	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? _____

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

	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? _____

5.3 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): _____

5.4 Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 5.3 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, 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 Underwriters, 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 does NOT bind the company to complete the insurance.

Date	Applicant Signature / Title

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