Specialty UNDERWRITERS

HOME HEALTHCARE APPLICATION

GENERAL INFORMATION

VGM No. _____ **Proposed Effective Date** _____

1. Insured _____

Mailing Address _____

Street City State/Zip County

Location Address _____

Street City State/Zip County

Location Address _____

Street City State/Zip County

2. Tax Identification Number _____ Telephone Number (____) _____

Contact Person _____ Email _____

3a. Years in Business _____ 3b. Applicant is ◯ Individual ◯ Partnership ◯ Corporation

4. Is applicant licensed in all in which they do business, where required? ◯ Yes ◯ No

5. Is applicant a member of?

- ☐ Accreditation Commission for Health Care (ACHC)
- ☐ Continuing Care Accreditation Commission (CCAC)
- ☐ Community Health Accreditation Program (CHAP)
- ☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- ☐ Other _____

6. **SERVICES**

Please check all that apply:

☐ Housekeeping ☐ Bathing/Grooming ☐ Cooking ☐ Client Transportation

☐ Medication Management ☐ Nursing Services ☐ Infusion Therapy ☐ Hospice Care

☐ Physical/Occupational/Respiratory/Speech Therapy ☐ Social Services/Case Management

☐ Nutritional Services ☐ Wound Care ☐ Companionship ☐ Live-in

Other: _____

7. Where are services provided?

Private Homes___% Hospitals___% Nursing Homes___% Assisted Living ___%

Medical Clinics___% Doctor's Offices___% Other (describe) _____%

8. What percentage of clients require:

Pediatric Care____% Cardiac Care ____% Respiratory Support____% Infusion Therapy ____%

9. **REVENUE AND PAYROLL HISTORY**

	Revenue	Payroll
Last 12 months		
Estimated next 12 months		

10. **LIMITS REQUESTED**

Professional Liability: $_____ Occurence ☐ Claims Made: ☐ Retro Date: _____Deductible: _____

General Liability: $_____ Occurence ☐ Claims Made: ☐ Retro Date: _____Deductible: _____

Sublimits: Physical/Sexual Abuse:_____ Hired & Non-owned Auto:_____

Employee Benefits:_____StopGap: _____

COVERAGE HISTORY

11. List Professional Liability policies covering the firm indicated in Question #1 over the past five years. If **no** insurance was in effect for a given year, state **"None"** where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							

12. List General Liability policies covering the firm indicated in Question #1 over the past five years. If **no** insurance was in effect for a given year, state **"None"** where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							

CLAIM HISTORY

13. a. Has any claim or suit been brought in the past five years against the applicant or any of their employees or contractors? ◯ Yes ◯ No

b. Are you aware of any circumstance or incident, no matter how insignificant it may seem, that could become a claim or suit that has not been reported to your current insurance carrier? ◯ Yes ◯ No

14. Has any company cancelled, declined or refused to issue similar insurance? ◯ Yes ◯ No

If Yes, please explain:

_____

15. Does the applicant have at least three years of relevant experience in the medical industry? ◯Yes ◯No

16 Does the applicant provide overnight beds or residential services? ◯Yes ◯No

17. Does the applicant provide treatment or services on their own premises? ◯Yes ◯No

HIRING/SCREENING AND EMPLOYMENT PROCEDURES

19. Check all the following that apply as part of each employee screening and hiring process:

- ☐ Applications
- ☐ Drug/HIV/Hep. Testing
- ☐ Education/Competency
- ☐ Reference verification
- ☐ Multi-state registry
- ☐ Criminal background checks
- ☐ Licenses/annual confirmation

20. Are employees required to actively participate in continuing education? ◯Yes ◯No

21. Are professional employees required to carry their own insurance? ◯Yes ◯No

If Yes, what minimum is required? $_____

22. Are certificates of insurance kept on file? ◯Yes ◯No

23. Do you subcontract work out to other agencies? ◯Yes ◯No

RISK MANAGEMENT

24. Do you have a formal written quality assurance and risk management program? ◯Yes ◯No

Person responsible: _____ Title: _____

25. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers. Please explain in an attachment any "No" answers.

a. Physician notification in the event of changes in the patient's condition ◯Yes ◯No

b. Communication to supervisors and team members ◯Yes ◯No

c. Drug administration procedures ◯Yes ◯No

d. Medical emergencies ◯Yes ◯No

e. Daily work reports (nursing reports, hospital notes, etc.) ◯Yes ◯No

f. Patient selection/physician home care treatment plan ◯Yes ◯No

g. Service discontinuation ◯Yes ◯No

h. Safe lifting, transferring and ambulating ◯Yes ◯No

i. Incident reporting (medication errors, patient injury, etc.) ◯Yes ◯No

j. Sexual/physical abuse awareness training ◯Yes ◯No

k. Advance directives (living will) ◯Yes ◯No

l. Medical equipment training ◯Yes ◯No

m. Patient's rights ◯Yes ◯No

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

Applicant's Warranty Statement: The undersigned represents to the best of his/her knowledge and belief the particulars and statements set forth are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The signing of the Application does not bind the undersigned to purchase the insurance, nor does the review of the Application bind the Company to issue a policy. It is understood the Company is relying on the Application in the event the policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued and may be attached to and become part of the policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

SIGNATURE OF APPLICANT _____ DATE _____

(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer: _____Telephone Number: (____) _____

Producer's Address: _____

Street City State/Zip

Surplus Lines Agent _____License # _____