# *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 dba's): _____

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 or enter "None" _____

_____

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 twelve months - $ _____

last twelve months - $ _____

1.15 Total Premises Square Footage Occupied by Applicant: _____

1.16 List all memberships in professional organizations: _____

_____

**PART II. EXPOSURES**

2.1 Healthcare Staff: 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 Payroll |
|---|---|---|---|
| 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 Payroll |
|---|---|---|---|
| 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

_____% Hospitals
_____% Nursing Homes / Assisted Living
_____% Private Doctors
_____% Private Home Care
_____% Other (Describe):_____

OTHER:_____

_____% Hospitals
_____% Nursing Homes / Assisted Living
_____% Private Doctors
_____% Private Home Care
_____% Other (Describe):_____

AIDES/ORDERLIES

_____% Hospitals
_____% Nursing Homes / Assisted Living
_____% Private Doctors
_____% Private Home Care
_____% Other(Describe):_____

OTHER:_____

_____% Hospitals
_____% Nursing Homes / Assisted Living
_____% Private Doctors
_____% Private Home Care
_____% 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:

___% 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 estimated patients next twelve months:_____

2.4 Number of patients last twelve 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 individual's 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 of 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? ___Yes___No
If yes, attach copies of all such contracts.

3.11 Does the home health agency advertise its services other than an ordinary local telephone directory listing? ___Yes___No
If yes, please attach a copy of each advertisement.

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? ___Yes___No
If no, attach explanation of any exception.

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. 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 (i.e. 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 so, enclose a copy of each.

4.3 Do you maintain records of specific areas of expertise of each staff member? ___Yes___No

4.4 Do you require staff to report all incidents (accidents) which 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, 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?_____

5.2 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?_____

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 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, 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 Mid-Continent General Agency, Inc. 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.**

| {PRIVATE } | 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 Signature Title

# MEDICAL PRODUCTS SALES OR EQUIPMENT RENTAL SUPPLEMENTAL APPLICATION

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

| DESCRIBE PRODUCT / EQUIPMENT LINE | ANNUAL RECEIPTS 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, 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, include them under A. and estimate the receipts in the next 12 months.

F. How are products marketed? (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, 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 indicate number... ___ Employed (W-2) ___ Contracted (1099)
Does pharmacist carry his/her own professional liability insurance? ___Yes ( Limits _____ ) ___ No

_____ _____ _____
Date Signature Title

# Non-Owned Auto Supplemental Application

If non-owned auto coverage is desired, please complete the following:

**Note**: Non-owned coverage is written only as an endorsement to the General Liability policy, does not include Hired Car, and shares the limits, deductibles and other conditions of the general liability policy. This coverage is not intended to cover livery operations by the insured, whether a fee is charged or not, and therefore excludes bodily injury to passengers of any insured non-owned autos.

1. How many employees drive their personal auto in connection with your business:_____
   How many of these are part-time employees? 15-25 hrs wk _____ Under 15 hrs wk_____

   If persons other than employees use their personal auto in connection with your business, please describe and give number : _____
   _____
   None _____

2. What are the ages of the drivers? 18 – 25 _____ 25 – 35 _____ 35 – 45 _____
   45 – 55 _____ 55 – 65 _____ Over 65 _____

3. Does applicant check all driver's MVRs? Yes___No ___

4. Does applicant require minimum limits of at least 100/300 BI - 50 PD ? Yes___No ___
   Please attach evidence of each driver's auto insurance showing the limits carried.

5. Does applicant require employees or others to provide transportation for patients / clients in their personal auto? Yes___No ___

6. Does applicant have owned, leased or hired autos used in business ? Yes___No ___
   Insurance coverage: carrier _____ limit _____eff date _____

7. Have any auto claims been made or occurrences reported during the past 5 years? Yes___No ___
   If yes, describe, indicate open/closed status, amounts paid or reserved:
   _____
   _____
   _____

_____ _____ _____
Date Applicant Title