

**MISCELLANEOUS HEALTH CARE – HOME HEALTH
PROFESSIONAL AND GENERAL LIABILITY APPLICATION
(CLAIMS MADE AND REPORTED BASIS)**

Please email this application back to the underwriter with whom you are working.
For contact information please visit www.usrisk.com/healthcare.html

Effective date desired: _____

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

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Contact name: _____ Title: _____ Email address: _____

Phone: _____ Web site Address: _____ Fax: _____

List all other locations **(use an additional sheet of paper if necessary)**: _____

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, give details (use an additional sheet of paper if necessary): _____

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, please explain, including what 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, please attach an 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, please 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, give details: _____

12. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)? _____ Yes No

If yes, please attach a copy of ALL of the advertisements.

13. Does the applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby 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 indemnify (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,

(i) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? _____ Yes No

(ii) 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	%
Pediatric Care	%

20. State the number of patient encounters and/or patient tests carried out as follows (patient encounters refer to number of visits—not 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 you provide imaging services? _____ Yes No

If yes, complete the supplemental application.

23. Describe the type of procedures performed at or by this facility: _____

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

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

DISCIPLINE	EMPLOYEES				INDEPENDENT CONTRACTORS	
	No. of Full-Time	No. of Part-Time	Annual Hours Worked	Annual Payroll	No. 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						

26. 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 health care staff with other businesses? _____ Yes No
 If yes, what percentage of your revenues is derived from the placement of:
 Nurse Practitioners? _____ %
 Other health care 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, attach an explanation.
 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: _____
 (i) Is coverage provided for the medical director under any other insurance policy? _____ Yes No
 (ii) If yes, please provide type of policy and name of carrier: _____

HIRING PRACTICES

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

RISK MANAGEMENT/LOSS CONTROL

37. Is there a written, formalized Risk Management Program? _____ Yes No
 38. Is there a written, formalized Quality Assurance Program? _____ Yes No
 39. Do you have a standard system to handle a patient's complaints or suggestions? _____ Yes No
 40. Do you practice universal precautions? _____ Yes No
 41. Do you have a Quality Assurance Department? _____ Yes No
 42. In case of an emergency is management available 7 days a week, 24 hours a day? _____ Yes No
 43. Do you have policies and procedures in place regarding medications? _____ Yes No
 44. Are nursing charts maintained regularly? _____ Yes No
 45. Do you regularly check employees' licenses and certifications? _____ Yes No
 46. 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
 47. Do you discuss at staff orientation elder and/or child abuse or sexual abuse? _____ Yes No
 48. Do you have a supervision plan in place that monitors staff in the daily relationships with clients? _____ Yes No

GENERAL LIABILITY

49. Complete the following for any owned or leased premises (use a separate sheet of paper if needed):

LOCATION ADDRESS	OCCUPANCY	SQUARE FOOTAGE
	<input type="checkbox"/> Owned <input type="checkbox"/> Leased	
	<input type="checkbox"/> Owned <input type="checkbox"/> Leased	
	<input type="checkbox"/> Owned <input type="checkbox"/> Leased	

50. 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. Use separate sheet if required.)

NAME	ADDRESS	INTEREST

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

52. 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	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:	\$

53. Do you install, service or demonstrate products or equipment? _____ Yes No

INSURANCE AND CLAIM INFORMATION

54. Do you currently carry the following:

a. Professional Liability Insurance? _____ Yes No

List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

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

b. 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? _____

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

1. COPY OF 5 YEAR CURRENTLY VALUED HARD COPY COMPANY LOSS RUNS
2. COPY OF THE DECLARATION PAGE OF YOUR MOST RECENT PROFESSIONAL LIABILITY POLICY
3. IF A START UP FIRM, COPY OF THE PROFORMA BUSINESS PLAN
4. COPY OF ANY ADVERTISING BROCHURES OR ADVERTISEMENTS
5. COPY OF A SAMPLE CLIENT CONTRACT
6. RESUMES/CV'S 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.