HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

NEW ENGLAND EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641
800-548-4301 • www.neee.com

MISCELLANEOUS HEALTH CARE – HOME HEALTH PROFESSIONAL AND GENERAL LIABILITY APPLICATION

CLAIMS MADE AND REPORTED BASIS.
PLEASE TYPE OR PRINT IN INK

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 advise 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 indemnity (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 (percentage of persons under age 18) **Must be complete**	%

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 any of your employees or independent contractors provide services as directed by you to members of their own family? _____ ❑ Yes ❑ No
23. Do you provide imaging services? _____ ❑ Yes ❑ No
    If yes, complete the supplemental application.
24. Describe the type of procedures performed at or by this facility: _____
    _____
25. Are all personnel performing these procedures certified and properly trained to perform these procedures? _____ ❑ Yes ❑ No
26. Please schedule all of your employees and independent contractors:

DISCIPLINE	**EMPLOYEES**				**Independent CONTRACTORS**	
	#- Full-Time	**#- Part-Time**	**Annual Hrs. Worked**	**Annual Payroll**	**No. of Contractors**	**Annual Hrs. 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						

27. 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

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

RISK MANAGEMENT/LOSS CONTROL

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

GENERAL LIABILITY

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

LOCATION ADDRESS	OCCUPANCY	SQUARE FOOTAGE
	❑ Owned ❑ Leased	
	❑ Owned ❑ Leased	
	❑ Owned ❑ Leased	

51. 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

52. Do you supply or sell any medical supplies or equipment to patients or clients? _____ ❑ Yes ❑ No
53. 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 Devises—including dialysis or heart/lung machines, all monitors	Annual Sales:	$

54. Do you install, service or demonstrate products or equipment? ❑ Yes ❑ No

INSURANCE AND CLAIM INFORMATION

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

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? _____

56**. CLAIMS HISTORY:**

a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ❑ Yes ❑ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS

IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? _____❑Yes ❑ No
If yes, provide full details. _____

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? ❑ Yes ❑ No
If yes, fully describe the circumstances and follow up action taken: _____
_____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

*Notice applicable in most states:
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

_____/_____ _____

Applicant's Signature **Title** **Date**

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.