PROFESSIONAL LIABILITY APPLICATION FOR HOME HEALTHCARE AGENCY AND MEDICAL PERSONNEL STAFFING

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1. Applicant Name:_____

2. Mailing Address:_____

_____

3. Location Address(es):_____

_____

4. County (parish) of Each Location:_____

_____

5. Telephone Number: Office:_____ Fax:_____

6. Person to Contact for Survey: Name:_____ Title:_____

7. Date Established:_____

8. The applicant is:

[ ] Sole Practitioner [ ] Corporation

[ ] Sole Proprietorship [ ] Other; Describe:_____

[ ] Partnership _____

9. Gross Annual Receipts: Estimated Next 12 Months: $_____

Last 12 Months: $_____

10. Entity is: [ ] For Profit [ ] Non-Profit

Describe source of funds:_____

PART II. EXPOSURES

1. Type of Operations (Check all that apply):

[ ] Home health care agency

[ ] Medical personnel staffing for home health care services

[ ] Medical personnel staffing for all other

[ ] Other:_____

2. Describe the nature of insured's operation including types of services rendered and activities conducted:

_____

_____

3. Number of **Professional Staff**: (**E = Employed ; C = Contracted**)

E	C		E	C	
_____	_____	Case Managers	_____	_____	Psychiatrists*
_____	_____	Dieticians/Nutritionists	_____	_____	Psychologists/Psychotherapists
_____	_____	Marriage/Family Counselors	_____	_____	Respiratory Therapists
_____	_____	Nurse Practitioners	_____	_____	RNs/LVNs/LPNs
_____	_____	Occupational Therapists	_____	_____	School Counselors
_____	_____	Pharmacists	_____	_____	Social Workers
_____	_____	Physician Assistants	_____	_____	Speech Therapists
_____	_____	Physicians*/Dentists	_____	_____	Teachers
_____	_____	Physiotherapists/Physical Therapists	_____	_____	Other:_____

4. Is the applicant/facility and all professional employees licensed and certified as required by state and federal laws? [ ] Yes [ ] No

   If no, explain:_____

5 Is the facility:

   a. Licensed and approved by State Board of Health? [ ] Yes [ ] No

   b. Licensed by State Department on Aging? [ ] Yes [ ] No

_____

6. List memberships in professional organizations:_____

7. Is there any physical therapy provided at this facility? [ ] Yes [ ] No

8. Is any medication administered at this facility? [ ] Yes [ ] No

9. Is there a physician on staff or on call? [ ] Yes [ ] No

10. Does the applicant operate any residential facilities? [ ] Yes [ ] No

11. Does the applicant administer any methadone treatment? [ ] Yes [ ] No

    If Yes, please describe treatment and controls used and indicate number of treatments used.

12. Does the applicant perform:

    a. acupuncture or acupuncture anesthesia? [ ] Yes [ ] No

    b. angiography/arteriography/venography? [ ] Yes [ ] No

    c. catheterization (other than urinary or umbilical)? [ ] Yes [ ] No

    d. closed reduction of compound fractures and/or normal deliveries and/or dermabrasion? [ ] Yes [ ] No

    e. physchiatric shock therapy? [ ] Yes [ ] No

    f. silicone injenctions? [ ] Yes [ ] No

    g. laser treatments? [ ] Yes [ ] No

13. Are all patients fully ambulatory (including use of cane or walker)? [ ] Yes [ ] No

If not, explain:_____

14. Do you enter into any contractual agreements? [ ] Yes [ ] No

If yes, attach sample copies of all contracts (including those contracts for use with patients/clients.)

15. Do you have any other premises or operations not stated in this application? [ ] Yes [ ] No

If yes, enclose complete description/locations of operations and insurance information. _____

_____

PART III. RISK MANAGEMENT

1. Do you require staff to report all incidents (accidents)? [ ] Yes [ ] No

Are records of such reports kept on file by you? [ ] Yes [ ] No

If not, explain:_____

2. Are precautions taken to prevent patients/clients leaving premises or "wandering" without applicant's knowledge, such as exit alarms, etc.? [ ] Yes [ ] No

Please describe:_____

_____

3. Are the following security/safety measures are taken:

a. Daily attendance taken [ ] Yes [ ] No

b. Alarms on all outside doors [ ] Yes [ ] No

c. Full supervision of all activities [ ] Yes [ ] No

d. Full fencing on any outdoor/recreation areas [ ] Yes [ ] No

e. Video surveillance [ ] Yes [ ] No

f. Sprinkler systems [ ] Yes [ ] No

g. Background checks on all staff [ ] Yes [ ] No

h. All medications secured [ ] Yes [ ] No

4. Does the applicant/facility have personnel trained in emergency medical care in the facility during all hours of operation? [ ] Yes [ ] No

Please describe:_____

_____

5. Explain arrangements for medical emergencies (e.g., physician on call, transfer arrangement with hospital, etc.):_____

_____

6. Complete the following for each Physician, including Medical Director, Dentist, Chiropractor, Podiatrist, Psychiatrist, Nurse Practitioners, and Physician Assistants:

* Complete Physician Supplement when applicable.

Name	Professional Status	E, C, or I (E = Employee C = Contract I = Independent)	Maintains malpractice insurance	Limit of Liability	Certificate of Insurance Obtained

7. Has the applicant or have any of the above employees:

a. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? [ ] Yes [ ] No

b. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [ ] Yes [ ] No

c. ever been treated for alcoholism or drug addiction? [ ] Yes [ ] No

d. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? [ ] Yes [ ] No

If Yes to any of the above, please explain.

8. Name, qualification, and number of years of experience of the Medical Director, all managers, and supervisors:

Name Title Experience/Training Association Membership

_____

_____

_____

PART IV. HISTORY

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

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

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

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

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? [ ] No [ ] Yes

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

_____

_____

_____

_____

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? [ ] No [ ] Yes

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 MarketScout, 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 applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

_____

Applicant Signature

_____

Title

_____

Date