MarketScout
A DIVISION OF NOVATAE

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. Date Established:_____

5. The applicant is:

[ ] Sole Practitioner
[ ] Corporation
[ ] Sole Proprietorship
[ ] Partnership
[ ] Other; Describe:_____

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

If yes, provide description/locations of operations._____

_____

_____

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

Last 12 Months: $_____

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:_____

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

_____

_____

_____

_____

_____

3. Please confirm as follows:

a) Do you prepare a care plan? [ ] Yes [ ] No

If yes:

i. Is each care plan this signed off by a physician or guardian? [ ] Yes [ ] No

ii. How often is each care plan reviewed? [ ] Yes [ ] No

b) Have you received training on how to refuse a client who is asking for support to do something outside the scope of the care plan? [ ] Yes [ ] No

c) Does the applicant have a disciplinary policy if an aide is found to be doing something outside the scope of the care plan? [ ] Yes [ ] No

d) Please confirm whether you refuse intake for clients who have a history of wander/elopement; severe mental and physiological impairment; susceptibility to pressure sores/wounds? [ ] Yes [ ] No

e) Do you have written guidelines in place for an emergency situation? [ ] Yes [ ] No

4. Enter percentage of services provided in each location type:

_____% Hospitals

_____% Nursing Homes/Assisted Living

_____% Private Doctors

_____% Private Home Care, what percentage of this is overnight care? _____%

_____% Other; Describe:_____

5. For all home health care, indicate the percentage attributable to each of the following:

_____% IV Therapy (If any, please complete supplement for IV Therapy)

_____% AIDS Therapy*

_____% Chemotherapy*

_____% Infant Monitoring (SIDS, etc.)

_____% Pediatric/infant childcare including "babysitting"

6. Is any staff provided to hospitals specifically to serve a particular specialty (e.g., 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:_____

7. Do you provide professional services to minors? [ ] Yes [ ] No

If Yes, what percentage of your business is provided to minors? _____%

8. Do you prepare job descriptions and instructional manuals for your staff? If yes, enclose a copy [ ] Yes [ ] No

9. Do you maintain records of specific areas of experience of each staff member? [ ] Yes [ ] No

10. Are all employees caring for bedbound patients are trained in the use of Hoyer lifts? [ ] Yes [ ] No

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

E	**C**		**E**	**C**	
_____	_____	Aide/Homemaker	_____	_____	Registered Nurse
_____	_____	Licensed Practical Nurse	_____	_____	Respiratory Therapist
_____	_____	Occupational Therapist	_____	_____	Speech Therapist
_____	_____	Physical Therapist	_____	_____	Social Worker
_____	_____	Physician	_____		Other: _____
_____	_____	Psychotherapist			_____

12. Do you sell, rent, or otherwise provide any equipment or products? [ ] Yes [ ] No

If yes, complete Product Sales/Rental Supplement

13. List memberships in professional organizations:_____

14. 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. psychiatric shock therapy? [ ] Yes [ ] No

f. silicone injections? [ ] Yes [ ] No

g. laser treatments? [ ] Yes [ ] No

15. Is any medication administered as part of services provided? [ ] Yes [ ] No

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

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

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

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

If not, explain: _____

_____

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

If yes, please confirm it includes a hold harmless clause running in favor of the applicant for all services performed in residential facilities.

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

_____

_____

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

If no, explain: _____

_____

PART VI. HISTORY

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

Insurer	Limit of liability	Premium	Effective Dates	Claims-made or Occurrence?

What is the most recent retroactive date? _____

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

Insurer	Limit of liability	Premium	Effective Dates	Claims-made or Occurrence?

What is the most recent retroactive date?_____

3. 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.

_____

_____

_____

_____

_____

4. Have any claims been made or accidents 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):

_____

_____

_____

_____

_____

Does any proposed insured have any knowledge of an event, circumstance, occurrence (other than any listed in 4.4 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? 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, a division of Novatae, 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