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 www.hccis.com

## HOME HEALTH CARE AGENCY APPLICATION

This application includes questions pertaining to your home health care agency organization. As a response is required for all questions, please indicate "NA" if any question does not apply to your organization. Supplemental Applications are also included which may apply to your agency.

### I. GENERAL INFORMATION

Policy Effective Date: \_\_\_/\_\_\_/\_\_\_ Current Professional Liability Retro Date: \_\_\_/\_\_\_/\_\_\_ OR  N/A (Occurrence)  
 Current General Liability Retro Date: \_\_\_/\_\_\_/\_\_\_ OR  N/A (Occurrence)

**(Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.)**

Name of applicant (legal name): \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code) (County)

Mailing address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code) (County)

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ FEIN (Federal Tax ID) #: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Web site address: \_\_\_\_\_

Insurance contact and title: \_\_\_\_\_

How many years have you been in operation? \_\_\_\_\_

Is your organization?  Non-profit  For-profit  Governmental

What is your organizational structure? (Choose one):  Corporation  Partnership  Privately/Individually-owned  
 Joint Venture  Limited Liability Company  Other (describe): \_\_\_\_\_

Are there additional entities that are to be included as Additional Named Insureds?  Yes  No

If "yes," please list the name of each entity and a brief description of their operations. Please include a copy of your organizational chart.

\_\_\_\_\_  
 \_\_\_\_\_

Do you engage in any business other than home health care services? If so, please explain: \_\_\_\_\_  
 \_\_\_\_\_

### II. PROFESSIONAL SERVICES

1. Do you provide **skilled** home healthcare services?  Yes  No If "yes," how many total patient visits during the past 12 months? \_\_\_\_\_ Next 12 months? \_\_\_\_\_

2. Number of skilled home health care patients during the past 12 months? \_\_\_\_\_

3. Please indicate which of the following skilled home health services are provided by your organization:

- |  |  |
|--|--|
| <input type="checkbox"/> Adult Day Care <b>(Contact us for a Supplement)</b>           | <input type="checkbox"/> Pharmacy <b>(Contact us for a Supplement)</b>             |
| <input type="checkbox"/> Cardiac Care  | <input type="checkbox"/> Rehab Services (PT,OT, Speech Therapy)                    |
| <input type="checkbox"/> Case Management   | <input type="checkbox"/> Respiratory Therapy                                       |
| <input type="checkbox"/> Child Day Care <b>(Contact us for a Supplement)</b>           | <input type="checkbox"/> Trach/ventilator  |
| <input type="checkbox"/> Gastrostomy Tube (GT) Care                                    | <input type="checkbox"/> Respite Care  |
| <input type="checkbox"/> Infusion Therapy  | <input type="checkbox"/> Special Care (Alzheimer's/Dementia, etc.)                 |
| <input type="checkbox"/> Medical Equipment Supplier <b>(Complete Supplement No. 4)</b> | <input type="checkbox"/> Supplemental Staffing <b>(Complete Supplement No. 10)</b> |
| <input type="checkbox"/> Medical Social Services                                       | <input type="checkbox"/> Telehealth  |
| <input type="checkbox"/> Obstetrical Services  | <input type="checkbox"/> Thrift Shops: Annual Gross Sales \$ _____                 |
| <input type="checkbox"/> Palliative Care. Number of annual visits: _____               | <input type="checkbox"/> Other: _____  |

4. Please indicate the location where services are provided:  Private Homes  Hospitals  Clinics  
 Nursing Homes/ALF's  Schools  Outpatient Facilities  Other \_\_\_\_\_
5. Do you participate in community wellness programs, including immunizations or vaccination programs?  
 Yes  No If "yes," please provide the number of immunizations: \_\_\_\_\_
6. Do you provide **non-skilled personal care or ADL** ("Assistance with Daily Living") services?  Yes  No  
 If "yes," what is the number of annual clients? \_\_\_\_\_ How many of these clients are provided 24-hour "live-in" services? \_\_\_\_\_
7. Do you provide any services for children?  Yes  No If "yes," what percentage of your total services includes pediatric care? \_\_\_\_\_%

### III. OPERATIONS

1. What is your total annual operating budget? \_\_\_\_\_ (If budget exceeds \$5,000,000 please attach a copy of your latest audited financial statement)
2. Are you accredited by?  JCAHO  CHAP  ACHC  NCQA  COA
3. Are you Medicare-certified?  Yes  No
4. Licensure:  
 Are you required to be licensed in any states in which you are operating?  Yes  No  
 If "yes," in what states are you currently licensed? \_\_\_\_\_  
 Are any license applications currently pending?  Yes  No If "yes," what state(s)? \_\_\_\_\_  
**Please attach a copy of your most recent state agency's inspection report, together with corrective actions completed, if any.**
5. Does your organization participate in the State Patient Compensation Fund?  Yes  No  Not Applicable
6. Has your organization merged, acquired, or consolidated with any other organization within the last ten years?  
 Yes  No If "yes," please provide the name(s) of the organization(s) and the date of acquisition.  
 \_\_\_\_\_  
 \_\_\_\_\_
7. Describe any changes in services or operations planned within the next year, including new or discontinued services, locations, or acquisitions.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
8. Within the last three years has your organization or any of its senior managers, officers or other "insureds" been a part of any civil or criminal litigation or arbitration proceedings related to the applicant's activities?  
 Yes  No If "yes," **please provide details on a separate attachment.**

### IV. EMPLOYEE INFORMATION

1. Total number of employees: \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time/Per Diem \_\_\_\_\_ Volunteers
2. Is Employer's Stop Gap Liability desired? (Only applicable in ND, OH, WA, WY)  Yes  No  
 If "yes," provide current annual payroll \$ \_\_\_\_\_
3. Do you engage the use of Independent Contractors to provide any services?  Yes  No  
 If "yes," what percentage of services is provided by Independent Contractors? \_\_\_\_\_%  
 What services do they provide?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Do you require that all Independent Contractors maintain liability insurance and provide you with a copy of their Certificate of Insurance each year?  Yes  No
4. What percentage of your staff is composed of temporarily assigned personnel acquired through staffing agencies? \_\_\_\_\_%

- |  |  |  |
|--|--|--|
| 5. Which of the following background check methods do you use? | <u>Employees</u>   | <u>Volunteers (if any)</u>                               |
| Social Security number verification and search                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Home telephone/residency verification                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Present employment and two previous employers' verification    | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Education and professional licensing verification              | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Driver's license information (MVR)                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| County, state (if available) and federal criminal checks       | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug screening   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
6. Who is responsible for human resources in your organization?  
Name and title: \_\_\_\_\_
7. Is annual training provided and attendance documented for all employees and volunteers?  
 Yes  No If "yes," briefly describe your in-service training program:  
\_\_\_\_\_  
\_\_\_\_\_

## V. RISK MANAGEMENT AND LOSS CONTROL

*Please attach a copy of your currently valued three-year loss experience from your insurance carrier.*

- Within the last three years has your organization been a part of any civil or criminal litigation or arbitration proceeding?  
 Yes  No If "yes," please provide details on a separate attachment.
- Does your organization have knowledge of any incidents which have not been reported to your current insurance carrier that may result in a claim or suit?  Yes  No If "yes," please provide details on a separate attachment.
- Does your organization have a formal Quality Assurance or Risk Management program?  Yes  No  
If "yes," name and title of who is responsible for the program: \_\_\_\_\_
- Do you have an active Safety Committee?  Yes  No
- Do all contracts with pharmacies, DME suppliers, hospitals, nursing homes and assisted living facilities include mutual hold harmless agreements?  Yes  No
- Has any insurer ever refused to renew or cancelled any insurance coverage during the past five years?  
 Yes  No If "yes," please provide the reason for cancellation: \_\_\_\_\_

## VI. HEALTH CARE PROFESSIONALS

- Do you have any employed, volunteer or contracted physicians?  Yes Number: \_\_\_\_\_  No
- Do you have any employed, volunteer or contracted nurse practitioners?  Yes Number: \_\_\_\_\_  No  
**Complete Supplement No. 7 for each employed, volunteer, or contracted Physician or Nurse Practitioners serving your agency. Note: Physicians and Nurse Practitioners must be specifically endorsed onto your policy as Additional Insureds for coverage to apply.**
- Do you engage in a credentialing process for your physicians and all health care professionals prior to hire or at inception of their contract?  Yes  No  
How often do you re-credential?  Annually  Every three years  No re-credentialing process in place
- Indicate the number of each of the following types of medical professionals, whether volunteer or employed, if insurance is to be provided on our policy.  
**Each of the following medical professionals must be specifically endorsed onto your policy as an Additional Insureds for coverage to apply.**

Physician's Assistant _____	Dentist _____	Psychiatrist _____
Resident Intern _____	Extern _____	Chiropractor _____
Acupuncturist _____	Nurse-Midwife _____	Certified Nurse Anesthetist _____

5. Please identify the respective individuals below, along with their title or position:

Name

Title or Position

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## VII. OPTIONAL COVERAGES

**HIRED AND NON-OWNED AUTOMOBILE LIABILITY** - Please indicate if this coverage is desired:  Yes  No

If "yes", please answer the following questions:

**Note: If you have owned or leased vehicles titled or contracted under your organization's name please contact us for an automobile application. If company-owned or leased vehicles are insured by another carrier, Non-owned Auto Liability coverage will be excluded from this policy and must be secured under your owned automobile policy.**

1. Do your employees and volunteers utilize their personal vehicles to provide services on behalf of your organization?  
 Yes  No

2. Do you annually order MVR's on each employee and volunteer with driving responsibilities?  Yes  No

3. Do you agree to extend driving privileges only to employees and volunteers with acceptable driving records?  
 Yes  No

*Note: Acceptable driving records are:*

a) *No more than three moving violations or more than one chargeable accident during the past 36 months, AND*

b) *No major convictions (driving under the influence of alcohol or drugs, reckless driving, etc.) within the past seven years, AND*

c) *No license suspensions or revocations within the past seven years.*

4. Do you require that all employees and volunteers who operate their personal autos on behalf of your organization maintain minimum state financial responsibility limits?  Yes  No

5. Do your employees and volunteers transport patients or clients in their personal autos?  Yes  No

If "yes," does your employee or volunteer maintain auto liability limits of at least \$100,000 Combined Single Limit?

Yes  No

6. Do you allow your employees and volunteers to operate a patient's or client's vehicle?  Yes  No

If "yes," do you:

Restrict use to business use?  Yes  No

Secure prior written permission from each client regarding use of their vehicle and maintain a copy for your records?  Yes  No

Secure written verification that each client maintains current in-force limits of at least \$100,000 Combined Single Limit?  Yes  No

Include driver safety education to your staff?  Yes  No

**SEXUAL ABUSE LIABILITY** - Please indicate if this coverage is desired:  Yes  No If "yes", please answer the following questions:

Does your organization have a written "zero tolerance" sexual abuse and molestation policy?  Yes  No

Does your written policy include?

Definition of sexual abuse/molestation  Yes  No

Reporting procedures at least two persons to report to internally  Yes  No

Investigation procedures  Yes  No

Disciplinary procedures  Yes  No

Retaliation warning  Yes  No

Is the policy consistently enforced, requiring annual review by each employee and/or volunteer, mandating individual signoff that he or she has read the policy, has received appropriate training and agrees to adhere to the policy?

Yes  No

Have procedures been established to monitor the implementation of the program?  Yes  No

Is sexual abuse training conducted for all employees and volunteers in the program and is documentation maintained on attendees?  Yes  No

Have you ever had any prior incidents, allegations or claims involving sexual abuse?  Yes  No

If "yes", please provide details.

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**Please attach a copy of your current sexual abuse and molestation prevention policy.** (If you would like to view a copy of a standardized version of an acceptable sexual abuse and molestation prevention policy for reference in developing your own, contact our web site, [www.hccis.com](http://www.hccis.com).)

**EMPLOYEE BENEFITS LIABILITY**

\$25,000 each employee/\$50,000 aggregate is automatically provided, but additional limits may be available. Please indicate desired coverage limit if different from automatic coverage:

- \$50,000/\$50,000     \$100,000/\$100,000     \$250,000/\$250,000     \$500,000/\$500,000  
 \$750,000/\$750,000     \$1,000,000/\$1,000,000

**EXCESS LIABILITY**

Please indicate if coverage is desired:  Yes  No If "yes," please indicate the limit of liability desired.

- \$1,000,000     \$2,000,000     \$3,000,000     \$4,000,000     \$5,000,000

**COMMERCIAL PROPERTY**

If you have any owned or leased property and desire a quote, please indicate  Yes  No **If "yes," please complete Supplement No. 9.**

**DIRECTORS AND OFFICERS LIABILITY COVERAGE**

If your organization is a nonprofit organization and you desire a proposal, please contact us for an application.

**EMPLOYEE RETIREMENT INCOME SECURITY ACT INSURANCE (ERISA)**

We can offer you a proposal for a bond to insure your organization's liability in the proper administration of employer-administered employee benefit plans. The act is designed to protect the rights of employees and beneficiaries covered under the benefit plans your organization administers.

If a quote is desired, please indicate  Yes  No **If "yes," please request a Supplement.**

**ANY SIGNIFICANT CHANGES TO YOUR ORGANIZATION DURING THE POLICY YEAR MUST BE REPORTED TO GLATFELTER UNDERWRITING SERVICES, INC. TO ENSURE COVERAGE.**

## PLEASE READ CAREFULLY --- GENERAL FRAUD WARNING NOTICE

Any person who knowingly and with intent to defraud any insurance company or another 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 fact material thereto, commits a fraudulent act, which is a crime and may subject the person to criminal and civil penalties.

### STATE-SPECIFIC FRAUD WARNING NOTICES

#### Arkansas Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

#### Colorado Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of Insurance within the department of regulatory agencies.

#### District of Columbia Fraud Warning

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by an applicant.

#### Florida Fraud Warning

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

#### Hawaii Fraud Warning

Intentionally or knowingly misrepresenting or concealing a material fact, opinion or intention to obtain coverage, benefits, recovery or compensation when presenting an application for the issuance or renewal of an insurance policy or when presenting a claim for the payment of a loss is a criminal offense punishable by fines or imprisonment, or both.

#### Kentucky Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

#### Louisiana Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

#### Maine Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

#### Maryland Fraud Warning

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

#### New Hampshire Statement of Residency

To procure automobile insurance, I hereby attest that I am, and each named insured is, a resident of the State of New Hampshire. I understand that if I falsely claim for myself or any named insured to be a resident of the State of New Hampshire, I am subject to prosecution, imprisonment of up to one year, a fine of \$2,000 and the denial of coverage for any loss, not occurring in New Hampshire, under the automobile insurance policy for which I am applying. I also understand that this statement will be relied upon in connection with future renewals of the automobile insurance policy for which I am applying, and that it is my responsibility to inform my insurance company before my next renewal after I or any named insured ceases to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.

HOME HEALTH CARE AGENCY APPLICATION 07/10

#### New Jersey Fraud Warning

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

#### New Mexico Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

#### New York Fraud Warning

Automobile Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the value of the subject motor vehicle or stated claim for each violation.

Other Types of Insurance: 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

#### Ohio Fraud Warning

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

#### Oklahoma Fraud Warning

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

#### Oregon Fraud Warning

Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

#### Pennsylvania Fraud Warning

All Types of Insurance: 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Motor Vehicle Insurance: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.

#### Tennessee Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

#### Virginia Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

#### Washington Fraud Warning

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Your signature below acknowledges that you have read the General Fraud Warning Notice and the State Specific Fraud Warning Notice that applies to your state of domicile.

**The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.**

**Authorized Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name and Title:** \_\_\_\_\_

**THIS APPLICATION MUST BE SIGNED BEFORE WE CAN PROCESS.**

**INSURANCE AGENT INFORMATION:**

Agency name: \_\_\_\_\_

Contact person: \_\_\_\_\_

Agency address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

E-mail address: \_\_\_\_\_



## DURABLE MEDICAL EQUIPMENT SUPPLEMENT (No. 4)

**If this service is subcontracted, please confirm that Certificates of Insurance are required of the DME provider, and leave the remainder of the form blank:**

Certificates Required     Certificates Not Required

1. Name of Applicant: \_\_\_\_\_

2. Do you supply medical equipment to only your patients?  Yes  No If "no," what percentage of annual revenue is derived from the general public? \_\_\_\_%

3. What services do you provide for this equipment?  Sell  Lease  Repair medical equipment

4. Annual revenue from sales/leases/repairs: \$ \_\_\_\_\_

5. Types of Durable Medical Equipment

Category III – Diagnostic or Treatment Devices – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines or sending devices.

**Number of inventory items in this category** \_\_\_\_\_

Category IV – Life Sustaining or Critical Life Monitoring Equipment or Devices – This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/fail or improperly function which could result in death or serious deterioration in health condition.

**Number of inventory items in this category** \_\_\_\_\_

6. Do you accept donated equipment?  Yes  No If "yes," is there an equipment maintenance policy in place for repairs and general maintenance?  Yes  No

7. Who trains your clients/families regarding proper operation of the equipment? \_\_\_\_\_

8. Do you provide written instructions to your customers?  Yes  No \_\_\_\_\_

9. Do your employees deliver equipment?  Yes  No  
If "yes," do you provide driver safety training to drivers?  Yes  No

10. Do you repackage, re-label, modify or manufacture any medical equipment or products?  Yes  No

11. Is all equipment checked and its condition documented prior to release?  Yes  No

12. Do you distribute oxygen cylinders?  Yes  No If "yes," are the cylinders pre-filled?  Yes  No

13. Do you subcontract labor for any maintenance, installation services or repair of medical equipment or supplies?  
 Yes  No If "yes," do you require Certificates of Insurance?  Yes  No

**Note: If Property insurance is desired for durable medical equipment, please include these items under Business Personal Property on the Property Supplement No. 9.**



**STAFF PHYSICIAN / NURSE PRACTITIONER SUPPLEMENT (No. 7)**

**PAGE 1 OF 2**

*(Applicable to Physicians and Nurse Practitioners who are not currently endorsed as Additional Named Insureds)*

A printed or typed response is required for all questions. This application must be signed by the licensed physician or nurse practitioner. Please attach curriculum vitae.

1. Name of Applicant Organization: \_\_\_\_\_

2. Physician/Nurse Practitioner Name: \_\_\_\_\_  
(First) (Middle Initial) (Last)

3. Date of birth: \_\_\_\_\_

4. Home address: \_\_\_\_\_  
 \_\_\_\_\_

5. Indicate the number of hours worked per month for this organization: \_\_\_\_\_

6. Do you serve as:  paid employee  volunteer  independent contractor

7. Do you maintain separate personal medical malpractice insurance coverage?  Yes  No **If "yes," please includes a Certificate of Insurance.**

Insurance Company Name: \_\_\_\_\_ Limits of Liability: \_\_\_\_\_

8. Does your policy cover you while performing work for this hospice/home health care agency?  Yes  No

9. Does the insurance include coverage for this hospice/home health care agency?  Yes  No

10. List all the states in which you are currently licensed:

State	License Number	Percentage of Practice

11. Has your license or medical staff privileges or appointment to a hospital ever been suspended, voluntarily withdrawn, reduced, withheld, denied, revoked or subjected to any disciplinary action?  Yes  No **If "yes," describe circumstances.** \_\_\_\_\_  
 \_\_\_\_\_

12. Has any professional liability insurer ever canceled, declined or refused renewal of your professional liability insurance?  Yes  No

13. In the past ten years, has a professional liability claim or suit against you been filed or closed, or are you aware of any pending or potential claim or suit?  Yes  No

**IF "YES," PLEASE PROVIDE NARRATIVE DESCRIPTION OF MEDICAL FACTS AND COMPLETE THE FOLLOWING CHART FOR EACH INCIDENT. INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF THIS APPLICATION. (PLEASE NOTE THAT A HARD COPY LOSS RUN FROM YOUR PREVIOUS CARRIER(S) MAY BE REQUIRED.)**

Plaintiff	Incident Date	Report Date	Status (Open or Closed)	Settlement Amount	Date Paid	Insurance Company

14. Have all known potential claims or suits, if any, been reported to your current insurance carrier?  Yes  No

15. Are you board certified?  Yes  No

16. Name of certifying board: \_\_\_\_\_

**STAFF PHYSICIAN / NURSE PRACTITIONER PROFILE SUPPLEMENT (No. 7)**

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**Please continue with the following questions if you are a Physician.**

17. Licensed Specialty: \_\_\_\_\_
18. Do you participate in the State Patient Compensation Fund (PCF)?  Yes  No  Not Applicable  
**If "yes," please include the PCF Certificate of Insurance.**
19. Medical school: \_\_\_\_\_
20. If foreign-trained, are you ECFMG-certified?  Yes  No
21. Degree: \_\_\_\_\_ Date completed: \_\_\_\_\_
22. Residency: \_\_\_\_\_ Date completed: \_\_\_\_\_
23. Fellowship: \_\_\_\_\_ Date completed: \_\_\_\_\_
24. First practice date (post residency, fellowship or military service): (Mo/Yr.) \_\_\_\_\_
25. Have you participated in any continuing medical education within the last three years?  Yes  No
26. List all hospitals or facilities where you have admitting privileges: \_\_\_\_\_  
\_\_\_\_\_
27. Has your license to prescribe or dispense narcotics ever been refused, suspended or revoked?  Yes  No  
**If "yes," attach a copy of the Medical Board Order.**
28. Are you employed solely as a Medical Director of this organization?  Yes  No
29. Do your assigned duties entail clinical care while serving as Medical Director?  Yes  No

**Note: A signature is required below for both Physicians and Nurse Practitioners.**

\_\_\_\_\_  
Signature of Physician/Nurse Practitioner

\_\_\_\_\_  
Date



**PROPERTY SCHEDULE SUPPLEMENT (No. 9)**  
**PAGE 1 OF 3**

*(If more than two locations exist, please make copies of the supplements, as required, complete and attach.)*

**Name of Applicant:** \_\_\_\_\_

**General Property Information:**

	Location #1	Location #2
1. Street address		
2. City, County, State, Zip Code		
3. Construction code of building*		
4. Your occupancy (office, residential inpatient, garage, etc.)		
5. If residential facility, number of beds		
6. List other occupants in building (office, retail, manufacturing, etc)		
7. Do you own or lease?		
8. Mortgagee name & address, if applicable		

*\*Construction Codes of Building: (select one only) (1) Frame, (2) Joisted Masonry, (3) Non-combustible, (4) Masonry Non-combustible, (5) Modified Fire Resistive, (6) Fire Resistive, (7) Heavy Timber Joisted Masonry, (8) Superior Non-Combustible, (9) Superior Masonry Non-Combustible*

9. Year building built		
10. Square footage of TOTAL building		
11. Square footage YOU occupy		
12. % of TOTAL building sprinklered		
13. # of floors in building		
14. Basement (Y/N)		
15. If building is over 25 years, provide date of updates to:		
Wiring		
Heating/Ventilation		
Roof		
16. Type of fire alarms (heat/smoke detectors, remote alarms, central station, none)		
17. Other alarms (hourly watchman, security guard, surveillance cameras, intrusion alarms, none)		

**Property Coverage:**

1. Deductible (\$250, \$500, \$1,000, \$5,000)	\$	\$
2. Building Limit (if Building owner)	\$	\$
3. Business Personal Property (includes but not limited to contents, furniture, fixtures, laptops, computer hardware and software, communication systems, durable medical equipment, phone systems, fax machines)	\$	\$

## PROPERTY SCHEDULE SUPPLEMENT (No. 9)

### PAGE 2 OF 3

	Location #1	Location #2
4. Equipment Breakdown Coverage is automatically included at a limit equal to your building and business personal property limit, not to exceed \$100,000. This applies to loss caused by or resulting from an accident to computers and electronic equipment. Please indicate here if a higher coverage limit is requested.		
5. Thrift Store merchandise (actual cash value)	\$ _____	\$ _____
6. Loss Payee's Name and Address for Business Personal Property, if applicable. Identify items.		

**Business Income/Extra Expense** - A combined Business Income and Extra Expense limit of \$50,000 is provided for any one occurrence at each described location in your policy. If an additional limit is desired for any location, please complete the worksheet below to calculate the additional coverage desired. This simplified worksheet may help you determine your potential business income/extra-expense loss that may result due to suspension of operations during the period of restoration. Please note that there must be direct physical loss or damage at a scheduled location on your policy for this coverage to apply.

- |  |          |
|--|----------|
| 1. Total estimated revenues for the 12-month period                              | \$ _____ |
| 2. Less operating expenses   | - _____  |
| 3. Net profit/loss before income tax   | = _____  |
| 4. Estimate of annual amount of noncontinuing and continuing operating expenses: |          |

Operating Expenses	Annual Amount	Non-Continuing During Loss	Continuing During Loss
Ordinary Payroll			
Executive Payroll			
Payroll Taxes			
Rent			
Telephone			
Power/Heat/Cooling			
Group Insurance			
Pension Plan			
Interest on Loans			
Advertising			
Repairs/Maintenance			
Miscellaneous			
<b>Totals</b>	(a)	(b)	(c)

- |   |          |
|---|----------|
| 5. Estimated maximum recovery [Line 3 + continuing expenses total 4 (c)]  | \$ _____ |
| 6. Estimated longest foreseeable shutdown% (i.e., 3 months 25%, 6 months 50%, 12 months 100%)                       | _____ %  |
| 7. Amount needed for period of restoration (Line 5 times Line 6)  | \$ _____ |
| 8. Estimated additional expenses to avoid or minimize loss (i.e., relocation expenses, temporary equipment, et al.) | \$ _____ |
| 9. Total Estimate of Required Limit of Insurance:   | \$ _____ |

## PROPERTY SCHEDULE SUPPLEMENT (No. 9)

### PAGE 3 OF 3

<b>PROPERTY PACKAGE COVERAGE OPTIONS</b>
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1. **Commercial Crime** – Crime coverage is offered if property insurance is provided. Please indicate the coverage limit requested.

\$25,000     \$50,000     \$100,000     \$250,000     \$400,000

Do checks require at least two signatures?  Yes  No

Are bank accounts reconciled by someone not authorized to deposit or withdraw?  Yes  No

Are financial records audited by outside parties?  Yes  No

2. **Accounts Receivable**

\$10,000 Accounts Receivable coverage is provided, but additional limits may be available. Please indicate if a higher limit is requested.

\$20,000     \$30,000     \$40,000     \$50,000     Other \$ \_\_\_\_\_

3. **Valuable Papers & Records**

\$10,000 Valuable Papers coverage is provided, but additional limits may be available. Please indicate if a higher limit is requested.

\$20,000     \$30,000     \$40,000     \$50,000     Other \$ \_\_\_\_\_

How often do you back up your records? \_\_\_\_\_ Are duplicate records kept off premises?  Yes  No

4. **Building Ordinance Coverage**

Coverage is available as an option. The coverage will respond to property losses that are a consequence of the enforcement of local ordinances or building code laws regulating demolition and/or restoration of buildings that have been damaged by a covered cause of loss. If this coverage is provided, it would:

a) **extend** the replacement cost coverage for damage to your building to include loss to the undamaged portion of the building and:

b) **\*\*provide an additional limit** to cover the cost to demolish and clear the site of undamaged parts of the property and,

c) **\*\*\*provide an additional limit** to pay for increased costs to repair or reconstruct damaged and undamaged portions of the building.

**Complete the following for each location where *building ordinance coverage\** is to be provided:**

Building Ordinance (b)**	\$	\$
Additional limit for demolition costs		
Building Ordinance (c)***	\$	\$
Additional limit increased cost of construction		

**Please be certain that the limits of coverage you select for insuring your buildings or business personal property are sufficient to meet your obligation to insure your property to at least 90% of the estimated replacement cost values.**



## MEDICAL STAFFING SUPPLEMENT (No. 10)

1. Name of Applicant: \_\_\_\_\_

2. Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code) (County)

### I. STAFFING OPERATIONS

**Please attach a copy of your Agency Staffing Agreement.**

1. Do you staff any non-medical positions?  Yes  No
2. What type of staffing services do you offer?  Per diem  Temporary Staffing (less than one month)  Long-term Staffing  Temporary-to-Direct Hire Placement
3. Do you employ 100% of the individuals that you place for your clients?  Yes  No
4. Please estimate which of the following are your typical staffing clients: (Total must equal 100%)
 

<input type="checkbox"/> Hospitals / Health Systems _____%	<input type="checkbox"/> Non-skilled personal care agencies _____%
<input type="checkbox"/> Nursing Homes / Assisted Living Facilities _____%	<input type="checkbox"/> Hospices _____%
<input type="checkbox"/> Private Physician Practices _____%	<input type="checkbox"/> Social Services Agencies _____%
<input type="checkbox"/> Home Healthcare Agencies _____%	<input type="checkbox"/> Surgical Centers _____%
<input type="checkbox"/> Pharmacies _____%	<input type="checkbox"/> Other _____%
5. Please indicate the location(s) where staffing services are provided:  Private Homes  Hospitals  Clinics  
 Nursing Homes/ALF's  Schools  Outpatient Facilities  Other \_\_\_\_\_
6. Do you also offer human resources consulting services on a fee-for-service basis?  Yes  No  
 If "yes," what is your estimated annual revenue from these services? \$ \_\_\_\_\_
7. What is your total estimated annual revenue from staffing for your current fiscal year? \$ \_\_\_\_\_ Last year?  
 \$ \_\_\_\_\_ **(If your revenue exceeds \$5,000,000 please attach a copy of your latest audited financial statement)**

### II. EMPLOYEE SELECTION

1. Do you perform employee background checks on staffed workers based on the requirements of the state or the healthcare facility?  Yes  No
2. Which of the following background check methods do you use?
 

	<u>Staffed Workers</u>
Current Licensure, certification, and registration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Criminal background checks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present employment and two previous employers' verification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-employment verification of convictions for abuse/neglect	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security number verification and search	<input type="checkbox"/> Yes <input type="checkbox"/> No
Education	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home telephone/residency verification	<input type="checkbox"/> Yes <input type="checkbox"/> No
Driver's license information (MVR) if placement requires driving responsibilities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug screening	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do your staffing contracts stipulate that you are responsible for performing criminal background checks?  Yes  No
4. Do you conduct face-to-face interviews with all prospective staffed workers?  Yes  No

5. Do you have a process in place to assure that the staffed worker's qualifications and competencies are consistent with job placement responsibilities?  Yes  No
6. Do you require that your clients orient the staffed workers to the facility setting, the unit, and policies and procedures on each staffing assignment?  Yes  No
7. Do you seek regular feedback from your clients on employee performance on all staffed workers?  Yes  No
8. Do you have a written description of your complaint process that is supplied to each of your clients?  Yes  No
9. Do you have a process in place for temporary staffed workers to contact you if they question the appropriateness of their assignment?  Yes  No
10. Do you provide ongoing education, including in-services and other activities?  Yes  No

### III. RISK MANAGEMENT AND LOSS CONTROL

***Please attach a copy of your currently valued three-year loss experience from your insurance carrier.***

1. Do you carry Workers Compensation insurance?  Yes  No
2. Do you have processes in place for reporting and investigating allegations of hostile work environments?  Yes  No
3. Do you have a process in place to evaluate prospective clients before offering staffing services?  Yes  No  
 If "yes," does this process include an on-site visit as well as a review of the facility's orientation program for staffed workers?  Yes  No
4. Does this process include an on-site visit as well as a review of the facility's orientation program for staffed workers?  Yes  No
5. Do your staffing agreements include defined roles and responsibilities of both parties?  Yes  No
6. Do your staffing agreements include mutual hold harmless agreements?  Yes  No
7. Is the use of personal vehicles by staffed workers addressed in your agency staffing agreement?  Yes  No
8. Are staffing agreements reviewed by legal counsel?  Yes  No

#### IV. EMPLOYEE INFORMATION – ANNUAL STAFFING

1. Please provide the estimated number annual billable hours and annual payrolls for each type of staffed employee for the next twelve months. Do NOT include your own internal agency staff.

Employee Type (staffed workers)	Estimated Annual Billable Hours	Estimated Annual Payroll
Nurse (RN)		\$
LPN		
Nurse Aid / Nursing Assistant		
Home Health Aid		
Homemaker		
Social Worker		
Physical Therapist		
Speech Pathologist		
Occupational Therapist		
Pharmacy Assistant		
Lab Technician		
EKG Technician		
X-ray Technician		
Radiology Technician		
Medical Technician		
Certified Medical Assistant		
Dietician/Nutritionist		
Dialysis Technician		
Enterostomal Therapist		
Respiratory Therapist		
Phlebotomist		
Radiation Therapist		
Clerical/Administrative		
Other: _____ _____		
<b>Total</b>		\$

*Note: Staffing agencies which staff physicians, medical directors, physician assistants, surgeons, dentists, psychiatrists, residents, interns, externs, chiropractors, acupuncturists, nurse practitioners, nurse midwives, certified registered nurse anesthetists and pharmacists are not eligible for coverage*

2. What percentage of these total staff workers are assigned to Critical Care, Emergency, Obstetrics, Radiology or Pediatric Departments? \_\_\_\_\_%
3. What percentage of your business includes staffing travel nurses?  None  
 \_\_\_\_\_%
4. Do you employ international healthcare workers on work visas?  Yes  No
5. Do you place staffed workers in prisons or correctional facilities?  Yes  No