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# Professional Liability Application for Home Health Care Agencies & Medical Personnel Staffing

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

**Note:** Application must be dated and signed by owner, partner, officer, or administrator.

**Please type or print in ink.**

**Part I. General Information**

Tax ID/SSN: _____

1.1 Applicant Name (including DBAs): _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of Each Location: _____

1.5 Telephone Number: Office: _____ Fax: _____

1.6 Person to Contact for Survey: Name: _____ Title: _____

1.7 Year Entity Established: _____

1.8 Entity is: ☐Individual ☐Corporation ☐Partnership ☐Professional Association/Corporation
☐Other; Describe: _____

1.9 Entity is: ☐For Profit ☐Non-Profit
Describe Source of Funds: _____

1.10 Entity is: ☐Home Health Care Agency
☐Medical Personnel Staffing (Home Health Care Services Only)
☐Medical Personnel Staffing (All Other)
☐Other; Describe: _____

1.11 Accreditation Information (check whichever applies):
Type: ☐SAS Distinguished or Gold Standards ☐SAS Full Accreditation
☐Other; Describe: _____

1.12 Proposed Effective Date: _____

1.13 Requested Limits of Liability (if available):
Professional Liability $_____/$_____
General Liability $_____Each Occurrence
$_____General Aggregate

1.14 Annual Gross Receipts: Estimated next 12 Months: $_____
Last 12 Months: $_____

1.15 Total premises square footage occupied by applicant: _____

1.16 List all memberships in professional organizations: _____

_____

_____

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**Part II. Exposures**

2.1 Health care Staff: Indicate the next 12 months estimated figures for each of the following categories of staff, hours worked, and compensation.

2.1.1 **Employed Staff (W-2):**

| | Maximum No. | Annual Hours of Service | Annual Payroll |
|---|---|---|---|
| Registered Nurse | | | $ |
| Licensed Practical Nurse | | | $ |
| Physical Therapist | | | $ |
| Occupational Therapist | | | $ |
| Respiratory Therapist | | | $ |
| Psychotherapist | | | $ |
| Speech Therapist | | | $ |
| Social Worker | | | $ |
| Aide, Homemaker | | | $ |
| Physician* | | | $ |
| Other: | | | $ |
| Employed Subtotal: | | | $ |

2.1.2 **Contracted Staff (1099):**

| | Maximum No. | Annual Hours of Service | Annual Payroll |
|---|---|---|---|
| Registered Nurse | | | $ |
| Licensed Practical Nurse | | | $ |
| Physical Therapist | | | $ |
| Occupational Therapist | | | $ |
| Respiratory Therapist | | | $ |
| Psychotherapist | | | $ |
| Speech Therapist | | | $ |
| Social Workers | | | $ |
| Aide, Homemaker | | | $ |
| Physician* | | | $ |
| Other: | | | $ |
| Contracted Subtotal: | | | $ |
| Total: | | | $ |

*Other than Medical Director, show number of patient visits in lieu of hours of service, and complete the Physician's Exposure Supplement.

2.1.3 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf)? ☐Yes ☐No

2.1.4 Enter percentage of services provided, by category, of staff including contracted staff:

| RNs & LPNs | Aides/Orderlies |
|---|---|
| % Hospitals | % Hospitals |
| % Nursing Homes/Assisted Living | % Nursing Homes/Assisted Living |
| % Private Doctors | % Private Doctors |
| % Private Home Care | % Private Home Care |
| % Other; Describe: | % Other; Describe: |
| Other: | Other: |

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| | |
|---|---|
| _____% Hospitals | _____% Hospitals |
| _____% Nursing Homes/Assisted Living | _____% Nursing Homes/Assisted Living |
| _____% Private Doctors | _____% Private Doctors |
| _____% Private Home Care | _____% Private Home Care |
| _____% Other; Describe: _____ | _____% Other; Describe: _____ |

2.2 Of the total payroll for all home health care staff, indicate the percentage of payroll attributable to each of the following:

_____% IV Therapy*

_____% AIDS Therapy*

_____% Chemotherapy*

_____% Infant Monitoring (SIDS, etc.)

_____% Pediatric/infant childcare including "babysitting"

*If any, also complete supplement for IV Therapy.

2.3 Number of patients next 12 months: _____

2.4 Number of patients last 12 months: _____

2.5 Is your facility owned by an M.D.? ☐Yes ☐No

If yes, owner name(s): _____

2.6 Do you sell, rent, or otherwise provide any equipment or products to patients? ☐Yes ☐No
To others? ☐Yes ☐No
If yes, to either question, complete Product Sales/Rental Supplement.

2.7 Is the applicant eligible for certification or accreditation? ☐Yes ☐No
If yes, is applicant certified and/or accredited? ☐Yes ☐No

If no, explain the reason: _____

_____

2.8 Is applicant approved to receive Medicare and Medicaid payments? ☐Yes ☐No

**Part III. Risk Management**

3.1 Name, qualifications, and number or years of experience of the Medical Director:

Name Title Experience/Training Association Membership

_____

3.2 Does your agency have a written credentializing policy and procedure for all individuals associated with or practicing within the agency? ☐Yes ☐No

3.3 Do you conduct pre-employment screening and investigation? ☐Yes ☐No

3.4 Does the staff supervisor make regular audit visits of staff in the field? ☐Yes ☐No

3.5 Do you require contracted staff (if any) to carry their own Professional Liability Insurance? ☐Yes ☐No
Do you secure Certificates of Insurance as evidence of such coverage? ☐Yes ☐No

3.6 Describe your procedures for matching staff to patients. Who does the matching/assigning of staff to client, and what is his/her experience? _____

_____

3.7 Who does the supervising of staff, and what is his/her experience? _____

_____

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3.8 Describe the referral source(s) by which patients are directed to the entity: _____

_____

3.9 Are you equipped with an emergency 24-hour telephone call line for all staff and patients? ☐Yes ☐No

3.10 Do you enter into any contractual agreements (other than lease of premises agreements in which you hold others harmless? If yes, please attach copies of all such contacts. ☐Yes ☐No

3.11 Does the home health agency advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement. ☐Yes ☐No

3.12 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? ☐Yes ☐No

3.13 Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? ☐Yes ☐No

Explain any exceptions: _____

_____

_____

_____

3.14 Does your agency have a written incident/occurrence reporting policy and procedures? ☐Yes ☐No

3.15 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception. ☐Yes ☐No

3.16 Has the applicant or any of its employees:

a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital, or professional association? ☐Yes ☐No

b) Had any professional license refused, suspended, revoked, renewal refused, or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ☐Yes ☐No

c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐Yes ☐No

**If the answer to any of 3.16 is yes, please attach a detailed explanation.**

3.17 Please describe in detail any additional operations, business pursuits, or joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations. ☐None ☐Description Attached

**Part IV. Medical Staffing Services Only**

If you do not provide staffing services, please initial here and proceed to Part V: _____

4.1 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: _____

4.2 Do you prepare job descriptions and instructional manuals for your staff? ☐Yes ☐No

If yes, enclose a copy of each.

4.3 Do you maintain records of specific areas of experience of each staff member? ☐Yes ☐No

4.4 Do you require staff to report all incidents (accidents) that might result in a liability claim AND are records of such reports kept on file by you? ☐Yes ☐No

**Part V. History**

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

| | Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made Yes | Claims-Made No |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |

If claims-made, what is the most recent retroactive date? _____

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

| | Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made Yes | Claims-Made No |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |

If claims-made, what is the most recent retroactive date? _____

5.3 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? ☐Yes ☐No

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

5.4 Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 5.3 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? ☐Yes ☐No

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 ProAssurance Mid-Continent Underwriters, Inc., 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 that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

**Important: This application must be signed by the applicant. Signing this form does NOT bind the company to complete the insurance.**

Date

Applicant Signature / Title

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# IV Therapy in the Home Health Setting Supplement

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**Home Health Agency:** _____

**Please complete this supplement if any IV therapy is/will be done by your agency's personnel.**

Tax ID/SSN: _____

| | Yes | No |
|---|---|---|
| A. The client and significant others are instructed concerning the IV therapy treatments? | | |
| 1. The instruction includes precautions, signs, and symptoms of possible/actual problems, simple first-aid measures, and when and whom to call for assistance? | | |
| 2. A return demonstration is required before any manipulation/handling of supplies or equipment occurs? | | |
| 3. The medical record is documented concerning instruction? | | |
| B. Policies and procedures concerning IV therapy are written? | | |
| 1. They are readily available for use by the registered nurse? | | |
| 2. They are reviewed and/or revised annually? | | |
| 3. They include: | | |
| a) Drug administration? | | |
| 1) IV fluids in general? | | |
| 2) Specific drugs by category and method of infusion (direct push, IV infusion)? | | |
| b) Site care? | | |
| c) Infection control? | | |
| d) Care of equipment, including infusion pumps? | | |
| e) Protocols for emergency interventions? (These should be developed with the assistance of the physician.) | | |
| C. The registered nurse has, at a minimum, institutional certification for IV therapy? | | |
| 1. The certification process verifies: | | |
| a) Performance competency: a skills inventory/checklist is maintained which documents observed demonstration? | | |
| b) Knowledge competency: a test of theoretical knowledge to include actions of various drugs administered, contraindictions, complications, and nursing intervention? | | |
| 2. The registered nurse will be recertified annually? | | |
| D. IV therapy will be included as part of the quality assurance program? | | |
| 1. Criteria will be established for use in monitoring the program? | | |
| 2. The medical record, patient interview, and patient assessment are included in the review process? | | |

Date _____ Signature/Title _____

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# Medical Products Sales or Equipment Rental Supplemental Application

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Tax ID/SSN: _____

A. List each product or equipment line individually and provide receipts for each. Attach a copy of your products/equipment brochures.

| Describe Product/Equipment Line | Annual Receipts From Rental | From Sales |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

B. Describe clients applicant sells/rents to, and % each:

_____% Individuals using products in their home
_____% Individuals in nursing homes*
_____% Nursing homes or similar residential facilities*
_____% Hospitals*
_____% Clinics/labs*
_____% Physicians*
_____% Other*; Describe _____

* If other than individuals in their home, is there a financial/ownership relationship between applicant and client or facility? ☐ Yes ☐ No If Yes, explain: _____

C. Who does the servicing and repair of the products? _____

Who does the servicing and repair of rental equipment? _____

D. Are any products manufactured by others and sold under your entity's label? ☐ Yes ☐ No

If yes, which products? _____

E. Are any additional products planned in the next twelve months? ☐ Yes ☐ No

If yes, include them under question A, and estimate the receipts in the next 12 months.

F. How are products marketed? (attach ad copy or brochures) _____

_____

G. Is a rental/lease agreement signed by customers prior to releasing any rental equipment?☐ ☐ Yes ☐ No
If yes, please enclose a copy of the rental agreement.

H. Is formal written inspection program for rental equipment conducted prior to each rental? ☐ Yes ☐ No

I. Are manufacturer's labels/directions/instructions provided to customers for all rentals? ☐ Yes ☐ No

J. Do the manufacturers or distributors of any of the above listed items:

1) Name your entity as an additional insured under their products liability policies? ☐ Yes ☐ No
2) Provide Certificates of Insurance for Products Liability to you? ☐ Yes ☐ No
3) Provide maintenance/service agreements for their product(s)? ☐ Yes ☐ No
4) Hold you harmless for loss arising from their products? ☐ Yes ☐ No

If the answer is yes for some products, please specify which product line and which answers: _____

_____

K. Are all manufacturers/suppliers well-known U.S. firms? ☐ Yes ☐ No If no, give details of which are not and any foreign products: _____

L. If sales of medicines or drugs are made by applicant, is a licensed pharmacist employed or contracted? ☐ Yes ☐ No

If, yes indicate number: _____ Employed (W-2) _____ Contracted (1099)

Does pharmacist carry his/her own professional liability insurance?☐ ☐ Yes (Limits: _____) ☐ No

_____ _____
Date Signature/Title

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# Non-Owned Auto Supplemental Application

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**If non-owned auto coverage is desired, please complete the following:**

**Note:** Non-owned coverage is written only as an endorsement to the General Liability policy, does not include Hired Car, and shares the limits, deductibles and other conditions of the general liability policy. This coverage is not intended to cover livery operations by the insured, whether a fee is charged or not, and therefore excludes bodily injury to passengers of any insured non-owned autos.

Tax ID/SSN: _____

1. How many employees drive their personal auto in connection with your business: _____
   How many of these are part-time employees? 15-25 hrs wk _____ Under 15 hrs wk _____

   If persons other than employees use their personal auto in connection with your business, please describe and give number: _____

   _____

   None _____

2. What are the ages of the drivers? ☐18-25 ☐25-35 ☐35-45 ☐45-5 ☐55-65 ☐Over 65

3. Does applicant check all driver's MVRs? Yes _____ No _____

4. Does applicant require minimum limits of at least 100/300 BI - 50 PD? Yes _____ No _____
   Please attach evidence of each driver's auto insurance showing the limits carried.

5. Does applicant require employees or others to provide transportation for patients/clients in their personal auto? Yes _____ No _____

6. Does applicant have owned, leased, or hired autos used in business? Yes _____ No _____
   Insurance coverage: Carrier: _____
   Limit: _____ Effective Date: _____

7. Have any auto claims been made or occurrences reported during the past five years? Yes _____ No _____
   If yes, describe, indicate open/closed status, and amounts paid or reserved:

   _____

   _____

   _____

_____ _____
Date Applicant/Title

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