APPLICATION FOR HOME HEALTHCARE AGENCY AND MEDICAL PERSONNEL STAFFING

Instructions: Please answer all questions. If a question does not apply, state "N/A." Attach additional sheets if needed. The applicant's name must include all businesses and locations for which coverage is desired.
Please type or print in ink.

GENERAL INFORMATION

1. Applicant Name:_____

2. Mailing Address:_____

_____

3. Location Address(es):_____

_____

4. Date Established:_____

5. Business Structure (check one):

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

6. Do you have any other premises or operations not stated in this application? If yes, provide description/locations of operations [ ] Yes [ ] No

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

RISK PROFILE

8. Type of Facility (Check One or Describe):

[ ] Adoption Agency*
[ ] Child Day Care*
[ ] Day Care (Senior Citizens)*
[ ] Employee Assistance Program
[ ] Foster Care*
[ ] Hotlines (Phone Crisis Service)
[ ] Meals on Wheels
[ ] Nanny Services
[ ] Referral Agency*
[ ] Sheltered Workshop*
[ ] Other:_____

*Applicable supplemental questionnaire must be completed.

9. Nature of Operations:

Describe the specific services provided and the scope of activities conducted

_____

_____

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

If no, explain:_____

11 Is the facility:

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

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

12. Does the facility provide "Day" services? [ ] Yes [ ] No

If yes, what is the number of "day patients" (include "independent living" persons):

Maximum # _____ Average #_____

13. What is the average duration of patient visits? _____

14. Do you conduct a Sheltered Workshop? [ ] Yes [ ] No

If yes, the application for Sheltered Workshops for Retarded and Developmentally Disabled Persons must be completed.

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

If not, explain:_____

16. Is medication administered at the facility? [ ] Yes [ ] No

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

STAFFING AND LICENSING

18. 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:_____

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

Please describe:_____

_____

20. 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

21. Do you offer any transportation services for patients? [ ] Yes [ ] No

22. Is there a formal patient grievance process in place? [ ] Yes [ ] No

23. Are there policies for managing behavioral issues or patient aggression? [ ] Yes [ ] No

Please describe:_____

_____

_____

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

_____

_____

HISTORY

25. 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?_____

26. 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?_____

27. 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

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.

_____

_____

_____

_____

28. Have any claims been made or accidents reported during the past five 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):

_____

_____

_____

_____

29. Does any proposed insured have any knowledge of an event, circumstance, or accident (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? [ ] 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 Diamarc Underwriters LLC, 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

(09/24)