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? [ ] Yes [ ] No

If yes, provide description/locations of operations._____

_____

_____

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

Last 12 Months: $_____

EXPOSURES

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

[ ] Home health care agency

[ ] Medical personnel staffing for home health care

[ ] Medical personnel staffing (other)

[ ] Other (describe):_____

9. Nature of Operations:

Describe the specific services provided and the scope of activities conducted (e.g., skilled nursing, therapy services, pediatric care, etc.):

_____

_____

10. Care Plan Protocol

a) Is a care plan prepared for each patient? [ ] Yes [ ] No

If yes:

b) Is each care plan signed off by a physician or guardian?? [ ] Yes [ ] No

c) How frequently is each care plan reviewed?? [ ] Yes [ ] No

11. Client Screening and Refusal Policy:

a) Are staff trained to refuse requests for services outside the care plan scope? [ ] Yes [ ] No

b) Is there a policy to refuse intake for clients with certain high-risk conditions (e.g., history of wander/elopement, severe mental impairment)? [ ] Yes [ ] No

12. Locations and Services Breakdown (By percentage):

_____% Hospitals

_____% Nursing Homes/Assisted Living Facilities

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

_____% Other; Describe:_____

13. Services Breakdown (By percentage):

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

_____% AIDS Therapy*

_____% Chemotherapy*

_____% Infant Monitoring (SIDS, etc.)

_____% Pediatric/infant childcare including "babysitting"

14. Specialty Staffing for Hospitals:

Does your agency provide staff for specific specialties? [ ] Yes [ ] No

If yes, enter percentage of services provided

_____% OR (Operating Room)

_____% Labor/delivery

_____% ICU/CCU

_____% ER

_____% Other; Describe:_____

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

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

STAFFING AND LICENSING

16. Job Descriptions & Manuals:

a. Are detailed job descriptions and manuals provided to staff? [ ] Yes [ ] No

b. Are records maintained of specific areas of experience for each staff member? [ ] Yes [ ] No

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

18. Professional Staff (Employed or Contracted):

(List by category, indicating "E" for Employed and "C" for 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			_____

19. Equipment Sales/Rentals:

Does your agency sell or rent equipment? [ ] Yes [ ] No

If yes, complete Product Sales/Rental Supplement

20. Medication Administration:

Is medication administered as part of services? [ ] Yes [ ] No

If yes, provide details on types and controls used.

21. Residential Facilities and Treatments:

a. Do you operate any residential facilities? [ ] Yes [ ] No

b. Do you provide methadone or other specific treatments? [ ] Yes [ ] No

If so, please provide an explanation

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

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

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

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

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

If not, explain: _____

_____

26. 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.

RISK MANAGEMENT

27. Incident Reporting:

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

b. Are records of incidents kept on file? [ ] Yes [ ] No

28. Emergency Arrangements:

Describe arrangements for medical emergencies (e.g., physician on call, transfer to hospital):

_____

_____

29. Licensing & Certification Compliance:

Are all staff licensed and certified as required by state and federal laws?? [ ] Yes [ ] No

CLAIMS AND HISTORY

30. 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?_____

31. 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?_____

32. 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.

_____

_____

_____

_____

33. 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):

_____

_____

_____

_____

34. 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 JaVA Underwriting, 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