PROFESSIONAL LIABILITY APPLICATION

for

HOME HEALTH CARE AGENCIES

INSTRUCTIONS: ANSWER ALL QUESTIONS; IF THE ANSWER IS NONE, STATE NONE; IF THE QUESTION 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 1. GENERAL INFORMATION

1.1 **Applicant Name:**

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 **Proposed effective date**

1.11 **Requested Limits of Liability (if available):**

Professional Liability	$	/$	
General Liability	$		**each occurrence**
	$		**general aggregate**

1.12 **Annual Gross Receipts:** **Estimated next twelve months -** $
Last twelve months - $

1.13 **Total Premises Square Footage Occupied by Applicant:**

1.14 **List all memberships in professional organizations:**

NOTICE

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PART 11. EXPOSURES

2.1 **Healthcare Staff: Indicate the next twelve months estimated figures for each of the following categories of staff, hours worked and compensation.**

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

Type	Maximum No.	Annual Hours of Service	Annual Remuneration
Registered Nurse			$
Licensed Practical Nurse			$
Physical Therapist			$
Occupational Therapist			$
Respiratory Therapist			$
Psychotherapist			$
Speech Therapist			$
Social Workers			$
Aides, Homemakers			$
Physicians*			$
Other:			$
Employed Subtotal			$

2.1.2 **Contracted Staff (1099):**

Type	Maximum No.	Annual Hours of Service	Annual Remuneration
Registered Nurse			$
Licensed Practical Nurse			$
Physical Therapist			$
Occupational Therapist			$
Respiratory Therapist			$
Psychotherapist			$
Speech Therapist			$
Social Workers			$
Aides, Homemakers			$
Physicians*			$
Other:			$
Contracted Subtotal			$
Total			$

***other than Medical Director, show no. of patient visits in lieu of hours of service, and complete Physician Exposure Supplement.**

2.1.3 **Breakdown percentage of services provided by category of staff including contracted staff:**

RN's & LPN's

- % Hospitals/Nursing Homes
- % Private Doctors
- % Home Care
- % Other (Describe):

AIDES/ORDERLIES

- % Hospitals/Nursing Homes
- % Private Doctors
- % Home Care
- % Other(Describe):

OTHER:

- % Hospitals/Nursing Homes
- % Private Doctors
- % Home Care
- % Other (Describe):

OTHER:

- % Hospitals/Nursing Homes
- % Private Doctors
- % Home Care
- % Other(Describe):

2.2 **Of the total payroll for home all 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 estimated patients next twelve months:
2.4 Number of patients last twelve 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 individual's 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?**

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 of 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?** Yes **No If yes, attach copies of all such contracts.**
3.11 **Does the home health agency advertise its services other than an ordinary local telephone directory** listing? **Yes No If yes, please attach a copy of each advertisement.**
3.12 **Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient? 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?** Yes **No If no, attach explanation of any exception.**
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, joint ventures in which your facility is currently engaged which would fall outside the scope of typical home healthcare operations.
None Description Attached

PART IV. <u>HISTORY</u>

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

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?

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

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?

4.3 **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).**

4.4 **Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 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 Mid-Continent General Agency, 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/Title ______________________

SUPPLEMENT
IV THERAPY IN THE HOME HEALTH SETTING

HOME HEALTH AGENCY:

PLEASE COMPLETE THIS SUPPLEMENT IF ANY IV THERAPY ISIWILL BE DONE B Y YO UR A GENCY'S PERSONNEL.

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, contradictions, 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?

Underwritten by The Reciprocal Alliance Risk Retention Group

Date Signature Title

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MEDICAL PRODUCTS SALES OR EQUIPMENT RENTAL
SUPPLEMENTAL APPLICATION

A. LIST EACH PRODUCT OR EQUIPMENT LINE INDIVIDUALLY and provide receipts for each. Attach 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
% Nursing Homes or similar residential facilities*
% Clinics / Labs*
% Other*, Describe
% Individuals in nursing homes*
% Hospitals*
% Physicians*

* 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 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/directionshnstructions 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 9 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

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Supplementary Page

Please reference the number of the question to which these responses apply.