

**PROFESSIONAL AND GENERAL LIABILITY APPLICATION FOR HOME HEALTH CARE AGENCIES &  
MEDICAL PERSONNEL STAFFING SERVICES**

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

2. Mailing Address: \_\_\_\_\_

3. Location Address: \_\_\_\_\_  
(If multiple name and locations, please attach list)

4. Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

5. a) Date Established: \_\_\_\_\_

b) Entity Type: Corp. \_\_\_\_\_ Partnership \_\_\_\_\_ Prof. Assoc. \_\_\_\_\_ Individual \_\_\_\_\_

c) For Profit \_\_\_\_\_ Non-Profit \_\_\_\_\_

6. Funding is: Medicare \_\_\_\_\_% Medicaid \_\_\_\_\_% Private Pay \_\_\_\_\_%

7. a) Desired Effective Date: \_\_\_\_\_

b) Desired Limits of Liability: \$ \_\_\_\_\_ / \$ \_\_\_\_\_

c) Desired Deductible: \$ \_\_\_\_\_

8. a) Gross Receipts for the Past 12 Months: \$ \_\_\_\_\_

b) Gross Receipts Estimated for the Next 12 Months: \$ \_\_\_\_\_

9. Entity is a: Home Health Agency (medical services provided) \_\_\_\_\_

Home Health Agency (only non-medical services provided) \_\_\_\_\_

Medical Personnel Staffing/Nurse Registry for Home Health Care Services Only \_\_\_\_\_

Medical Personnel Staffing/Nurse Registry (Other than Home Health Care) \_\_\_\_\_

Other (please describe) \_\_\_\_\_

10. Full description of services provided:

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

11. Does the applicant have any ancillary operations not stated above? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12. Is the firm engaged in, owned by, associated with or controlled by any other business? If yes, give detail

\_\_\_\_\_

13. a) List the number and type of applicant's employees estimated over the next 12 months. If none, state none.

<u>Profession</u>	<u>Number</u>	<u>Profession</u>	<u>Number</u>
Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Physical Therapist	_____	Aide/Homemaker	_____
Occupational Therapist	_____	Social Worker	_____
Respiratory Therapist	_____	Pharmacists	_____
Speech Therapist	_____	Clerical/Admin	_____
Nurse Practitioner	_____	Other (please describe)	_____
Physician Assistant	_____		

b) List the number and type of independent contractors estimated over the next 12 months. If none, state none.

<u>Profession</u>	<u>Number</u>	<u>Profession</u>	<u>Number</u>
Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Physical Therapist	_____	Aide/Homemaker	_____
Occupational Therapist	_____	Social Worker	_____
Respiratory Therapist	_____	Pharmacists	_____
Speech Therapist	_____	Clerical/Admin	_____
Nurse Practitioner	_____	CRNA/Surgical Technician	_____
Physician Assistant	_____	Other (please describe)	_____

c. Are all the above individuals licensed in accordance with applicable state and federal regulations

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, attach explanation.

14. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, at what limits? \$ \_\_\_\_\_ / \$ \_\_\_\_\_

If no, is coverage desired with shared limits on this policy? Yes \_\_\_\_\_ No \_\_\_\_\_

15. Enter where services are provided, broken down by percentage for each category, by employees & independent contractors:

Private Homes \_\_\_\_\_ %  
Hospitals \_\_\_\_\_ %  
Nursing Homes \_\_\_\_\_ %  
Assisted/Independent Living \_\_\_\_\_ %  
Medical Clinics/Private Doctors \_\_\_\_\_ %  
Other (please describe) \_\_\_\_\_ %

16. For Medical Personnel Staffing Agencies, enter which departments/areas are staffed broken down by percentage (please estimate if this is a start-up):

Emergency Room \_\_\_\_\_ %  
Urgent Care \_\_\_\_\_ %  
Labor & Delivery Rooms \_\_\_\_\_ %  
Intensive Care Unit \_\_\_\_\_ %  
Operating Room \_\_\_\_\_ %  
Other (please describe) \_\_\_\_\_ %

17. Enter the percentages for the following exposures based on total services provided (please estimate if this is a start-up):

IV Therapy \_\_\_\_\_ %  
Live-in Services \_\_\_\_\_ %  
Pediatric/Infant Childcare \_\_\_\_\_ %  
Cardiac Care \_\_\_\_\_ %  
Respiratory Support \_\_\_\_\_ %

18. Does the applicant provide any beds for overnight stays or provide any treatment or services on their premises? If yes, give details: \_\_\_\_\_

19. Do you sell, rent or otherwise provide any equipment to products or others? If yes, give details including types of products & gross receipts from each: \_\_\_\_\_

20. Do you provide any legal and/or financial services and/or act as legal guardian or power of attorney for anyone? If so, please provide details: \_\_\_\_\_

21. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician?

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, give details: \_\_\_\_\_

22. a) Do you conduct pre-employment screening and investigation? Yes \_\_\_\_\_ No \_\_\_\_\_
- b) Do you question prospects about previous claims or suits? Yes \_\_\_\_\_ No \_\_\_\_\_
- c) Are employees required to actively participate in continuing education? Yes \_\_\_\_\_ No \_\_\_\_\_
- d) Do you prepare job descriptions and instructional manuals for your staff? Yes \_\_\_\_\_ No \_\_\_\_\_
- e) Do you have a written incident/occurrence reporting policy and procedures? Yes \_\_\_\_\_ No \_\_\_\_\_

23. Check all the following that apply if obtained, verified & kept on file as part of the employee hiring & screening process:

Applications _____	Criminal Background Checks _____
Drug / HIV/ Hepatitis Testing _____	Licenses Held _____
Education/Training/Competence _____	Multi-State Registry _____

24. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

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25. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	_____	_____
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
c) Ever been treated for alcoholism or drug addiction?	_____	_____
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?	_____	_____

26. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give details, including name, location size and number of beds.

27. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? \_\_\_\_\_

28. Give General Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? \_\_\_\_\_

29. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give details \_\_\_\_\_

30. Has any insurer cancelled or refused to renew any similar insurance during the past five years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give details \_\_\_\_\_

31. Has any claim ever been made against the firm or any of its employees?

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3)name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

32. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, please give full details.

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

**FOR KENTUCKY RISKS:** 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 act, which is a crime.

Name of Applicant: \_\_\_\_\_  
Please Print Title

Signature: \_\_\_\_\_  
Name Date

(NOTE: Application must be signed by the owner or president or principal)