

Application For
**Home Health Care Basic Non-Nursing
 Services**

1. Name of Applicant: _____
2. Individual Corporation Partnership Other (Explain) _____
 Date Established _____
3. Street Address: _____
 City: _____ State: _____ Zip: _____
 Applicant's Web Site Address: _____
4. Provide full name(s) of individual and partners. _____

5. What state/s are you licensed or certified in? Provide details of what your license/certification allows you to do.

6. Has applicant's license ever been suspended or revoked? Yes No
 Has applicant ever been investigated by the State Health Dept., State Licensing Board or other governmental body? Yes No
If yes to either question above, provide full details on Attachment to A102.
7. Is applicant's operation Medicare approved? Yes No Medicare sales? \$ _____
8. Is applicant accredited by any of the following?
 National Homecaring Council Yes Joint Commission on Accreditation of Healthcare Organizations Yes
 National Association of Home Care Yes Community Health Accreditation Program Yes
9. Sales from employees: \$ _____ Sales from independent contractors: \$ _____
 Sales from non-nursing operations: \$ _____ Total Sales: \$ _____
10. Do employed nurses have their own Professional Liability coverage? Yes No
 Limits Required? \$ _____
 Does the applicant require Certificates of Insurance from all nursing (RNs, LPNs) independent contractors? Yes No
 Limits Required? \$ _____
11. Applicant's premium is adjustable based on **gross sales**. *Our auditor will verify applicant's gross sales.*
 If this information is kept by the applicant's accountant, please provide accountant's name, address and telephone number.

 If this information is kept by the applicant, please provide the telephone number and address where the records are kept.

 If you are not normally at this location during working hours, please provide a beeper number or telephone number where you can be reached:
 Applicant's telephone number if not previously given: _____
12. Prior coverage:

Insurance Company	Year	Premium	Type? Occurrence/ Claims Made	Any Claims (Check One)	Description
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	<input type="checkbox"/> Occ <input type="checkbox"/> CM	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
13. Is the applicant aware of any circumstances which may result in a claim? Yes No
If yes, provide full details on Attachment to A102.
14. Does the applicant want the policy to cover employees? *There is a premium charge.* Yes No
 (Note: The policy already protects the applicant for the acts of his/her employees.)
15. Are applicant's employees or independent contractors responsible for monitoring any equipment? Yes No
 If yes, please provide full description. _____
 Check if continued on Attachment to A102.

16. Are employees required to complete daily work reports? Yes No
 Does applicant utilize a formal Quality Assurance/Risk Management program? Yes No
 Does applicant conduct patient/client surveys? Yes No
 Is there an informed consent process in place? Yes No
 Are there written policies in place for:
- | | | | | |
|---------------------------------|--|---|-----|----|
| Drug administration procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient acceptance? | Yes | No |
| Emergencies in the field? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient rights? | Yes | No |
| Employee training? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Physician orders? | Yes | No |
| Food preparation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Proper lifting? | Yes | No |
| Handling of complaints? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reporting of suspected physical/sexual abuse? | Yes | No |
| Medical equipment training? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Termination of Care? | Yes | No |

If the answer to any question is no, refer risk to Company.

17. Please provide details of employed or contracted personnel:

	Number Employed	Number Contracted	Contractors Ins. Limits Required	Percentage working in:		
				Hospital	Nursing Home*	Home
Aides/Homemaker Health Aides	_____	_____	_____	_____	_____	_____
LPN's	_____	_____	_____	_____	_____	_____
RN's	_____	_____	_____	_____	_____	_____
Home Companions	_____	_____	_____	_____	_____	_____
Certified Nursing Assistants	_____	_____	_____	_____	_____	_____
Others (Specify)	_____	_____	_____	_____	_____	_____

Percentage of Clients under 18 years of age? _____% Percentage of Clients over 65 years of age? _____%

* If yes, is contract with client for private duty work? Yes No *If no, please explain on Attachment to A102.*

18. Are the following background checks performed?
- | | | | |
|---|--|--------------------------------------|--|
| All prior employers? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Home telephone verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| All educational institutions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Professional licensing verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Driver's license information? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Residency information? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug screening required? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sex offender registry search? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Federal, State (if possible) and County criminal record search? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Social Security No. verification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If the answer to any question is no, refer risk to Company.

19. Is 24 Hour Service provided? Yes No If Yes, Percent of Operations _____ %
 If Yes, is this Live-in? Yes No Shift Work? Yes No

20. Please describe services performed by any other professionals. _____

 Check if continued on Attachment to A102.

21. Please list any medical equipment applicant supplies to clients. _____

22. Does the applicant sell or rent equipment to clients? Yes No
If yes, complete Application A-17.

23. Please provide details of licensing or certification needed for this operation. _____

 Check if continued on Attachment to A102.

24. **Limits of Insurance Requested**

General Aggregate Limit (Other than Products-Completed Operations)	\$	_____	
Products-Completed Operations Aggregate Limit	\$	_____	
Personal and Advertising Injury Limit	\$	_____	
Each Occurrence Limit	\$	_____	
Damage to Premises Rented to You (Up to \$100,000 limit available)	\$	_____	Any One (1) Premises
Medical Expense Limit (Up to \$5,000 limit available)	\$	_____	Any One (1) Person
Each Professional Incident Limit (if applicable)	\$	_____	

25. Effective Dates Desired – From: _____ To: _____

FOR SEXUAL MOLESTATION COVERAGE, PLEASE COMPLETE QUESTIONS 26. THROUGH 30.

\$25,000/50,000 limit is included at no additional charge. Higher limits are available for an additional premium charge (see below). If sexual molestation coverage is not desired, please check here Coverage is NOT requested.

26. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? Yes No
Please provide details: _____
27. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? Yes No
Describe: _____
28. Does your facility do background checks on all employees and volunteers? Yes No
Describe type of checks performed (prior employer, police, etc.): _____
29. Are there written guidelines in place regarding sexual misconduct? Yes No
If NO, please explain: _____
30. Please check the limits you are requesting: \$25,000/50,000 - included
 \$50,000/100,000 \$100,000/300,000 \$300,000/600,000 \$500,000/1MM \$1MM/2MM

FOR HIRED AND NON-OWNED AUTO COVERAGE, PLEASE COMPLETE QUESTIONS 31. THROUGH 35.

31. What types of non-owned autos will be used in your business? _____
32. Total Number of Non-owned autos used in your business? _____
33. Do you require your employees to have their own insurance? Yes No
If YES, what are the minimum liability limits required? _____
34. Will you use Non-owned autos other than those owned by your employees? Yes No
If YES, describe relationship and use: _____
35. Please check the limits you are requesting:
 \$100,000 \$300,000 \$500,000 \$1MM

Applicant's Signature _____ Date _____

Title _____ Producing Agent _____

