**HOME HEALTH CARE AND MISCELLANEOUS HOME SERVICES   
GENERAL LIABILITY APPLICATION**

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| --- | --- |
| Applicant’s Name:    Mailing Address:    Location Address: | Agency Name:  Agent No.:  Address:    E-mail:  Phone No.: |

**PROPOSED EFFECTIVE DATE:** From       To       **12:01 A.M., Standard Time at the address of the Applicant**

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE “NOT APPLICABLE” (N/A)

**Applicant is:**  Individual  Corporation  Partnership  Joint Venture  Limited Liability Company

Other (Specify):

**Website Address:**

**E-mail Address:**       **Phone No.:**

**Limits Of Liability and Deductible Requested:**

|  |  |  |
| --- | --- | --- |
| General Aggregate (other than Products/Completed Operations) | | $ |
| Products and Completed Operations Aggregate | | $ |
| Personal and Advertising Injury (any one person or organization) | | $ |
| Each Occurrence | | $ |
| Damage To Premises Rented To You (any one premise) | | $ |
| Medical Expense (any one person) | | $ |
| Errors and Omissions Coverage (Included up to General Liability Limits) | Each Claim  Aggregate | $  $ |
| Sexual and/or Physical Abuse Coverage | | $50,000/$100,000 (included)  $100,000/$300,000 |
| Other Coverages, Restrictions and/or Endorsements: | | $ |
| Deductible | | $ |

**1. Number of years in operation:**

**2. How long under present management?**

(If fewer than five years, attach principals’ resumes. If principals in the firm do not have a health care background, then also include the resume of the Director of Nursing or the individual responsible for hiring, screening and monitoring the work activities of applicant’s employees.)

**3. Services provided by percentage of total operations (must total one hundred percent [100%]):**

|  |  |  |  |
| --- | --- | --- | --- |
| Assisted Living Facilities | % | Medical Equipment Supplier | % |
| Babysitters | % | Medical Marijuana Caregivers | % |
| Clinical Trials | % | Midwives/Doula | % |
| Clinics Owned/Operated | % | Nanny/Au Pair | % |
| Convalescent/Nursing Home | % | Nurse—General (LPN, LVN) | % |
| Dietician/Nutritionist | % | Nurse—Practitioner | % |
| Errand Service | % | Nurse—Registered (RN) | % |
| Homemaker Aides | % | Nurse—Student | % |
| Homemaker Health Aides | % | Nurses Aides (CNA, STNA, NA/R) | % |
| Hospice | % | Occupational Therapy | % |
| Hospital | % | Patient Care Assistants | % |
| Infant/Pediatric Care | % | Personal and Home Care Aides (AKA—Caregivers, Companions, Personal Attendants, and Sitters) | % |
| Infusion Therapy Centers | % | Personal Trainers | % |
| Infusion Therapy: | % | Pharmacist | % |
| Antibiotic Therapy | % | Pharmacy | % |
| Antiviral Therapy | % | Physical Therapy | % |
| Blood Transfusion | % | Physician | % |
| Chemotherapy | % | Physician Assistant | % |
| Dialysis | % | Radiation Therapy | % |
| Home Enteral Nutrition (HEN) | % | Rehabilitation | % |
| Hydration Therapy | % | Respiratory Therapy | % |
| Pain Management | % | Respite Care | % |
| Total Parenteral Nutrition (TPN) | % | Shopping Service | % |
| Other (describe): | % | Social Worker | % |
| Speech Therapy | % |
| Laboratory Services | % | Ventilator | % |
| Licensed Counselors | % | Other (describe): | % |
| Mail Pick-up | % |
| Meals on Wheels | % | Other (describe): | % |
|  |  |

**4. Employees and independent contractors are placed (by percentage) at the following locations:**

|  |  |  |  |
| --- | --- | --- | --- |
| Assisted Living Facilities | % | Laboratories | % |
| Clinics | % | Owned Facility  Describe services: | % |
| Convalescent/Nursing/ACLF Homes | % |
| Home Health—Private Homes | % |
| Hospice Facilities | % | Physician’s Office | % |
| Hospitals | % | Schools | % |
| Infusion Therapy Centers | % | Other (describe): | % |
| Jails/Prisons/Detention Centers | % |

(Attach any brochures, literature or descriptive materials provided to the client.)

**5. If employees or independent contractors are placed in hospitals,   
clinics, physician’s offices, hospice, convalescent/nursing/ACFL homes, jails, prisons or detention centers, advise if hired by:**  Facility  Patient  Patient’s Guardian

**6. Employees and Independent Contractors—Annual Staffing:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Professional Classification Type** | **EMPLOYEES** | | **INDEPENDENT CONTRACTORS** |
| **Number of Employees** | | **Number of  Subcontracted Workers** |
| **Full Time** | **Part Time** |
| Dietician/Nutritionist |  |  |  |
| Infant/Pediatric Care |  |  |  |
| Licensed Counselors |  |  |  |
| Medical Director |  |  |  |
| Medical Marijuana Caregiver |  |  |  |
| Nurse—Practitioner |  |  |  |
| Nurse—Registered (RN) |  |  |  |
| Nurse—General (LPN, LVN) |  |  |  |
| Occupational Therapist |  |  |  |
| Pharmacist |  |  |  |
| Physical Therapist |  |  |  |
| Physician |  |  |  |
| Physician Assistant |  |  |  |
| Psychologist |  |  |  |
| Rehabilitation Therapist |  |  |  |
| Respiratory Therapist |  |  |  |
| Social Worker |  |  |  |
| Speech Therapist |  |  |  |
| X-Ray Technicians |  |  |  |
| Other (describe): |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Non-Professional Classification Type** | **EMPLOYEES** | | | | **INDEPENDENT CONTRACTORS** |
| **Number of Employees** | | | | **Number of Subcontracted Workers** |
| **Full Time** | | **Part Time** | |
| Certified Nursing Assistants (CNA) |  | |  | |  |
| Homemaker Health Aides |  | |  | |  |
| Midwives/Doula |  | |  | |  |
| Nurse Aides |  | |  | |  |
| Nursing Assistants—Registered (NA/R) |  | |  | |  |
| Patient Care Assistants |  | |  | |  |
| Personal and Home Care Aides |  | |  | |  |
| Social Worker |  | |  | |  |
| Student Nurses |  | |  | |  |
| Other (describe): |  | |  | |  |
| **Miscellaneous Services Classification Type** | | **EMPLOYEES** | | | **INDEPENDENT CONTRACTORS** |
| **Number of Employees** | | | **Number of Subcontracted Workers** |
| **Full Time** | | **Part Time** |
| Babysitters | |  | |  |  |
| Errand Service | |  | |  |  |
| Homemaker Aides (not Homemaker Health Aides) | |  | |  |  |
| Mail Pick-up | |  | |  |  |
| Nanny/Au Pair | |  | |  |  |
| Shopping Service | |  | |  |  |

**7. Operations conducted in the following states:**

State:       Licensed with state?  Yes  No License No.:

State:       Licensed with state?  Yes  No License No.:

State:       Licensed with state?  Yes  No License No.:

**8. Schedule of Hazards:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Operations—Payroll and  Sales Information** | **PROFESSIONAL** | | **NON-PROFESSIONAL** | |
| **Annual  Payroll/Cost** | **Annual Sales/Receipts** | **Annual  Payroll/Cost** | **Annual Sales/Receipts** |
| Employees providing services away from owned or operated health care facilities | $ | $ | $ | $ |
| Employees providing services at owned or operated health care facilities | $ | $ | $ | $ |
| Independent Contractors providing services away from owned or operated health care facilities | $ | $ | $ | $ |
| Independent Contractors providing services at owned or operated health care facilities | $ | $ | $ | $ |
| Medical Equipment/Supplies Sales and Rental | $ | $ | $ | $ |
| Pharmacy owned or operated by applicant | $ | $ | $ | $ |
| Transportation Services | $ | $ | $ | $ |
| Other (describe): | $ | $ | $ | $ |
| **Total:** | **$** | **$** | **$** | **$** |

**9. Has applicant’s license ever been revoked, suspended, voluntarily surrendered, or had enforcement action?**  Yes  No

|  |
| --- |
| If yes, provide details and corrective action taken: |

|  |
| --- |
| **10. Name all subsidiary companies/locations and others coming under applicant’s control (if none, please state):** |

**11. Is the applicant a member of any:**

**a.** State Association?  Yes  No

If yes, name of association(s):

**b.** Industry Association?  Yes  No

If yes, name of association(s):

**c.** Health Care accrediting organization?  Yes  No

If yes, name of organization(s):

**12. Has applicant sold, acquired or discontinued any operations in the last five years or plan to change operations within the next year?**  Yes  No

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| --- |
| If yes, explain: |

**13. Is at least one of the principals or an Administrator/Director of Nursing involved in the operation on a full time basis?**  Yes  No

**14. Does applicant provide foster care placement?**  Yes  No

**15. Applicant’s workforce is comprised of:**

Employees:      % Independent Contractors:      %

**16. As part of hiring/screening of new employees or independent contractors, does applicant:**

**a.** Verify certifications and/or professional licenses and confirm status?  Yes  No

**b.** Contact applicants’ references before they are hired/placed?  Yes  No

**c.** Require, if hired/placed, that they sign a formal confidentiality statement?  Yes  No

**d.** Obtain criminal background checks?  Yes  No

**e.** Review sexual abuse registry?  Yes  No

**f.** Conduct a personal interview?  Yes  No

**g.** Validate education?  Yes  No

**h.** Validate work history?  Yes  No

**i.** Have a formalized disease, drug or alcohol screening process?  Yes  No

**j.** Validate driver’s license?  Yes  No

**k.** Ask if any previous involvement as a defendant in professional malpractice litigation?  Yes  No

**l.** Ask if they ever had their license revoked, suspended, or had disciplinary action taken against   
them?  Yes  No

**17. When using independent contractors, does applicant require the following information from them:**

**a.** Professional Liability Certificate of Insurance?  Yes  No

If yes, specify minimum limits required: $

**b.** Historical Loss Information?  Yes  No

**c.** Hold Harmless and indemnification clauses favorable to the applicant?  Yes  No

**18. Does applicant have formal documented training in place for the following:**

**a.** Crisis Management?  Yes  No

**b.** Disposal of medical waste, controlled substances, contaminated supplies or equipment?  Yes  No

**c.** First Aid, CPR, and AED Training?  Yes  No

**d.** Infusion Therapy?  Yes  No

**e.** Safe lifting, transferring and client handling?  Yes  No

**f.** Blood borne Pathogen?  Yes  No

**g.** Safe use and operation of equipment?  Yes  No

**19. Are job descriptions, detailing job duties and responsibilities, given to all employees and independent contractors?**  Yes  No

**20. What is the applicant’s average staff turnover rate in a calendar year for:**

Professional Staff:      % Non-Professional Staff:      %

**21. Are any professional services provided on applicant’s premises (doctor’s office, clinic, infusion therapy center, etc.)?**  Yes  No

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| --- |
| If yes, explain: |

**22. Does applicant provide bed and board facilities (convalescent home, hospice, assisted living facility, etc.)?**  Yes  No

|  |
| --- |
| If yes, explain: |

**23. Does applicant have written policies and/or procedures for the following:**

**a.** Complete treatment plan prescribed by the physician, including follow-up plans?  Yes  No

**b.** Assessments of clients prior to and after accepting the clients?  Yes  No

**c.** Client care and home visits documented?  Yes  No

**d.** Documentation of all homecare training?  Yes  No

**e.** All changes in the condition of the client are documented in the records and reported to the family and physician?  Yes  No

**f.** Client incident report procedure is in place with notification also given to family and physician?  Yes  No

**g.** Medications and dosage, including documentation of administering medications?  Yes  No

**h.** A copy of all literature given to clients explaining services and fees?  Yes  No

**i.** Termination of services and discharge criteria?  Yes  No

**24. Are medications ordered by a licensed physician and administered, discarded and documented by or under the close supervision of a qualified medical professional in accordance with legal requirements for controlled substances?**  Yes  No

|  |
| --- |
| **25. If applicant provides advanced skilled care (i.e., infusion therapy, ventilator, chemotherapy, radiation therapy, etc.), what are the clinical expertise requirements and/or professional training for the staff that provides these services?** |

**26. Does applicant have Workers’ Compensation coverage in force?**  Yes  No

**27. Does applicant have any contractual agreements wherein applicant assumes the liability of   
others?**  Yes  No

If yes, attach a list of each entity and the type of service(s) applicant provides.

**28. Does applicant sell, rent or lease any medical supplies and/or equipment?**  Yes  No

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| --- |
| If yes, provide details: |

**29. Does applicant own/operate a pharmacy or provide pharmaceutical products?**  Yes  No

**30. Does applicant manufacture any products?**  Yes  No

|  |
| --- |
| If yes, advise: |

**31. Has applicant ever distributed directly imported products from a foreign manufacturer?**  Yes  No

|  |
| --- |
| If yes, advise: |

**32. Does applicant modify any product or repackage/relabel any items obtained from suppliers?**  Yes  No

|  |
| --- |
| If yes, advise: |

**33. Is all equipment checked and its condition documented prior to release?**  Yes  No

|  |
| --- |
| **34. Explain arrangement for medical emergencies (i.e., M.D. on call, transfer arrangement with hospital, etc.):** |

**35. Is staff informed of all patients with AIDS/HIV?**  Yes  No

**36. Copy of applicant’s State(s) Home Health Care License and most recent State Licensure Survey attached (if any):**  Yes  No

**37. Does applicant and/or employees provide transportation services for patients?**  Yes  No

If yes:

**a.** Are there any emergency transportation services provided?  Yes  No

**b.** Transportation services are provided in conjunction with:

Professional home health care services

Non-Professional home health care services

Miscellaneous home health care services

|  |
| --- |
| Provide details: |

**c.** Does applicant and/or employees use their personal vehicles to transport patients?  Yes  No

**d.** Is Auto Liability coverage in place with limits equal to or greater than the applicant’s General Liability limits for all vehicles utilized?  Yes  No

**e.** Are certificates of insurance obtained for Auto Liability for employees’ vehicles?  Yes  No

**f.** Does applicant obtain Waiver of Liability from patients?  Yes  No

**38. Additional Insured Information:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Address** | **Interest** |
|  |  |  |
|  |  |  |
|  |  |  |

**39. Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies?**  Yes  No

|  |
| --- |
| If yes, describe: |

**40. Does applicant have other business ventures for which coverage is not requested?**  Yes  No

|  |
| --- |
| If yes, explain and advise where insured: |

**41. Does applicant have any other premises, operations or exposures not stated in this   
application?**  Yes  No

|  |
| --- |
| If yes, explain: |

**42. During the past five years, have any claims been made or suits brought against the applicant because of alleged malpractice, error, mistake or premises accident arising in any manner out of applicant’s operation?**  Yes  No

If yes, date:

|  |
| --- |
| If yes, explain: |

**43. During the past three years, has any company canceled, declined or refused similar insurance to the applicant?** (Not applicable in Missouri)  Yes  No

|  |
| --- |
| If yes, explain: |

**44. Prior Carrier Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Year:** | **Year:** | **Year:** | **Year:** | **Year:** |
| **Carrier** |  |  |  |  |  |
| **Policy No.** |  |  |  |  |  |
| **Coverage** |  |  |  |  |  |
| **Occurrence or Claims Made** |  |  |  |  |  |
| **Total Premium** | $ | $ | $ | $ | $ |

**45. Loss History—Five Year Period:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior five years.  Check if no losses in the last five years. | | | | |
| **Date of Loss** | **Description of Loss** | **Amount Paid** | **Amount Reserved** | **Claim Status (Open or  Closed)** |
|  |  | $ | $ |  |
|  |  | $ | $ |  |
|  |  | $ | $ |  |
|  |  | $ | $ |  |
|  |  | $ | $ |  |

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Not applicable in AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT or WA.)

**FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON):** Any person who intentionally presents a materially false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON):** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

APPLICANT’S NAME AND TITLE:

APPLICANT’S SIGNATURE: DATE:

(Must be signed by an active owner, partner or executive officer.)

PRODUCER’S SIGNATURE: DATE:

|  |
| --- |
| NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT: |

|  |  |  |
| --- | --- | --- |
|  | **IMPORTANT NOTICE** |  |
|  |  |
| As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning  character, general reputation, personal characteristics and mode of living. Upon written request, additional  information as to the nature and scope of the report, if one is made, will be provided. | | |