



## HOME HEALTHCARE APPLICATION

### GENERAL INFORMATION

VGM No. \_\_\_\_\_ Proposed Effective Date \_\_\_\_\_

1. Insured \_\_\_\_\_

Mailing Address \_\_\_\_\_

Street City State/Zip County

Location Address \_\_\_\_\_

Street City State/Zip County

Location Address \_\_\_\_\_

Street City State/Zip County

2. Tax Identification Number \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

Contact Person \_\_\_\_\_ Email \_\_\_\_\_

3a. Years in Business \_\_\_\_\_ 3b. Applicant is  Individual  Partnership  Corporation

4. Is applicant licensed in all in which they do business, where required?  Yes  No

5. Is applicant a member of?

- Accreditation Commission for Health Care (ACHC)
- Continuing Care Accreditation Commission (CCAC)
- Community Health Accreditation Program (CHAP)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Other \_\_\_\_\_

### 6. SERVICES

Please check all that apply:

- Housekeeping  Bathing/Grooming  Cooking  Client Transportation
- Medication Management  Nursing Services  Infusion Therapy  Hospice Care
- Physical/Occupational/Respiratory/Speech Therapy  Social Services/Case Management
- Nutritional Services  Wound Care  Companionship  Live-in

Other: \_\_\_\_\_

7. Where are services provided?

Private Homes \_\_\_% Hospitals \_\_\_% Nursing Homes \_\_\_% Assisted Living \_\_\_%

Medical Clinics \_\_\_% Doctor's Offices \_\_\_% Other (describe) \_\_\_\_\_%

8. What percentage of clients require:

Pediatric Care \_\_\_\_% Cardiac Care \_\_\_\_% Respiratory Support \_\_\_\_% Infusion Therapy \_\_\_\_%

**9. REVENUE AND PAYROLL HISTORY**

	Revenue	Payroll
Last 12 months		
Estimated next 12 months		

**10. LIMITS REQUESTED**

Professional Liability: \$ \_\_\_\_\_ Occurrence  Claims Made:  Retro Date: \_\_\_\_\_ Deductible: \_\_\_\_\_

General Liability: \$ \_\_\_\_\_ Occurrence  Claims Made:  Retro Date: \_\_\_\_\_ Deductible: \_\_\_\_\_

Sublimits: Physical/Sexual Abuse: \_\_\_\_\_ Hired & Non-owned Auto: \_\_\_\_\_

Employee Benefits: \_\_\_\_\_ StopGap: \_\_\_\_\_

**COVERAGE HISTORY**

11. List Professional Liability policies covering the firm indicated in Question #1 over the past five years. If no insurance was in effect for a given year, state "None" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							

12. List General Liability policies covering the firm indicated in Question #1 over the past five years. If no insurance was in effect for a given year, state "None" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							

**CLAIM HISTORY**

13. a. Has any claim or suit been brought in the past five years against the applicant or any of their employees or contractors?  Yes  No

b. Are you aware of any circumstance or incident, no matter how insignificant it may seem, that could become a claim or suit that has not been reported to your current insurance carrier?  Yes  No

14. Has any company cancelled, declined or refused to issue similar insurance?  Yes  No

If Yes, please explain:

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15. Does the applicant have at least three years of relevant experience in the medical industry?  Yes  No

16 Does the applicant provide overnight beds or residential services?  Yes  No

17. Does the applicant provide treatment or services on their own premises?  Yes  No

**HIRING/SCREENING AND EMPLOYMENT PROCEDURES**

19. Check all the following that apply as part of each employee screening and hiring process:

- Applications
- Multi-state registry
- Drug/HIV/Hep. Testing
- Criminal background checks
- Education/Competency
- Licenses/annual confirmation
- Reference verification

20. Are employees required to actively participate in continuing education?  Yes  No

21. Are professional employees required to carry their own insurance?  Yes  No

If Yes, what minimum is required? \$ \_\_\_\_\_

22. Are certificates of insurance kept on file?  Yes  No

23. Do you subcontract work out to other agencies?  Yes  No

**RISK MANAGEMENT**

24. Do you have a formal written quality assurance and risk management program?  Yes  No

Person responsible: \_\_\_\_\_ Title: \_\_\_\_\_

25. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers. Please explain in an attachment any “No” answers.

- a. Physician notification in the event of changes in the patient’s condition  Yes  No
- b. Communication to supervisors and team members  Yes  No
- c. Drug administration procedures  Yes  No
- d. Medical emergencies  Yes  No
- e. Daily work reports (nursing reports, hospital notes, etc.)  Yes  No
- f. Patient selection/physician home care treatment plan  Yes  No
- g. Service discontinuation  Yes  No
- h. Safe lifting, transferring and ambulating  Yes  No
- i. Incident reporting (medication errors, patient injury, etc.)  Yes  No
- j. Sexual/physical abuse awareness training  Yes  No
- k. Advance directives (living will)  Yes  No
- l. Medical equipment training  Yes  No
- m. Patient’s rights  Yes  No

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

**YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.**

**Applicant's Warranty Statement:** The undersigned represents to the best of his/her knowledge and belief the particulars and statements set forth are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The signing of the Application does not bind the undersigned to purchase the insurance, nor does the review of the Application bind the Company to issue a policy. It is understood the Company is relying on the Application in the event the policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued and may be attached to and become part of the policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

SIGNATURE OF APPLICANT \_\_\_\_\_ DATE \_\_\_\_\_  
(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

Producer's Address: \_\_\_\_\_  
Street City State/Zip

Surplus Lines Agent \_\_\_\_\_ License # \_\_\_\_\_