HOME HEALTHCARE/TEMPORARY STAFFING APPLICATION

GENERAL INFORMATION

1. Insured ____

   Mailing Address____
   Street City/State/Zip Code County

   Location
   Address____
   Street City/State/Zip Code County

2. Tax Identification Number _________________Telephone Number (____) ___________________________________

3a. Years in Business _____ 3b. Applicant is ☐ Individual ☐ Partnership ☐ Corporation

4. Is applicant licensed to do business in the states listed above 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)
   - ☐ The Joint Commission

   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 ☐ Temporary Staffing

   ☐ Nurse Registry

   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		
Est. next 12 months		

10. **LIMITS REQUESTED**

Professional Liability: $_______________ OCC ☐ CM ☐ Retro Date: ________ Deductible: _______

General Liability: $_______________ OCC ☐ CM ☐ 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:
____

15. Does the applicant have at least three years of relevant experience in the medical industry? ☐ Yes ☐ No
16. Does the applicant provide treatment or services on their own premises? ☐ Yes ☐ No
If **Yes**, please explain:
____

HIRING / SCREENING AND EMPLOYMENT PROCEDURES

17. 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

If results are not "clean," what action is taken?____
____

18. Are employees required to actively participate in continuing education? ☐ Yes ☐ No
19. Are professional employees required to carry their own insurance? ☐ Yes ☐ No
If **Yes**, what minimum is required? $______________________
20. Are certificates of insurance kept on file? ☐ Yes ☐ No

SUBCONTRACTING

21. Do you contract with other agencies to provide home health care services on your behalf to your clients?
☐ Yes ☐ No

a. If yes, please explain the circumstances under which you would use another agency to provide services to your clients rather than to provide those services yourself.
____

____

b. If yes, do you:
Keep records and files on each client? ☐ Yes ☐ No
Receive daily reports from the other agency? ☐ Yes ☐

RISK MANAGEMENT

22. Do you have a formal written quality assurance and risk management program? ☐ Yes ☐ No
    Person Responsible: ______________________________ Title: ______________________________________

23. 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
n.	Keep medical records on all patients	☐ Yes ☐ No

24. Do you perform any dry needling services? ☐ Yes ☐ No

25. Is any part of your business a nurse registry operation? ☐ Yes ☐ No

STAFFING ROSTER

(Numbers below should reflect total annual hours and payroll for all employees/contractors)

Employees/ Contracted Services	Est. Hours Worked Employees/Contractors	Est. Annual Payroll Employees/Contractors
Physical Therapists		
Nurses Temporary Staffing		
Nurses-Other than Temporary Staffing		
Nurse Aides/Home Health Aides/Homemakers		
Medical Technicians		
Pharmacists		
Speech & Hearing Therapists		
Social Workers		
Physician/Physician Assistant		
Nurse Practitioner/Clinic Nurse Specialist		
Live-In Companions		
Occupational Therapists		
Ultrasound/Sonography Technicians		
Laboratory Technicians		
X-Ray Technicians		
Respiratory Therapist		
All Others (Describe – A breakdown of each type of staff and applicable hours should be provided)		

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 X ____________________________ **DATE X** _____________________________

(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 #

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