HIIG ALLIED HEALTH & SOCIAL SERVICES PROGRAM

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HOME HEALTH & HOSPICE APPLICATION
GENERAL INFORMATION – ALL LOCATIONS

Policy Effective Date: _____ Current Professional Liability Retro Date: _____ OR ☐ Occurrence

Current General Liability Retro Date: _____ OR ☐ Occurrence

Name of Applicant _____

Mailing Address: _____

(Street) (City) (State) (Zip Code) (County)

Location Address: _____

Sq. Ft. _____ *(Street) (City) (State) (Zip Code) (County)*

Phone: _____ Fax: _____ FEIN (Federal Tax ID) #: _____

E-mail Address: _____ Website Address: _____

Inspection and Insurance Contact Name: _____

Contact Phone #: _____ Contact E-mail Address: _____

How many years have you been in operation? _____

Is your organization: ☐ Non-Profit ☐ For-Profit ☐ Governmental

What is your organizational structure? (Choose One) ☐ Corporation ☐ Partnership ☐ Joint Venture

☐ Limited Liability Company ☐ Other (describe) _____

Are there additional entities that are to be included as Additional Insureds? ☐ Yes ☐ No

If "yes", please list the name of each entity and a brief description of their operations. Please include a copy of your organization chart.

_____

_____

SECTION I – PROPERTY *(if more than one location, please provide Property ACORD application)*

1. How many years has the applicant been at the current location? _____
2. Construction: ☐ Frame ☐ Joisted Masonry ☐ Non-combustible ☐ Masonry non-combustible
   ☐ Modified Fire-resistive ☐ Fire-resistive
3. Protection Class: _____ Deductible: ☐ $1,000 ☐ $2,500 ☐ $5,000 Coinsurance: ☐ 80% ☐ 90% ☐ 100%
4. Building limit: $ _____
5. Business Personal Property limit: $ _____
6. Business Income w/Extra Expense limit: $ _____
   Coinsurance: ☐ 80% ☐ 90% ☐ 100% OR Monthly Limitation: ☐ 1/3 ☐ 1/4 ☐ 1/6
7. What year was the building constructed? _____
8. What is the square footage? _____
9. Is the building fully protected by an operational sprinkler system covering 100% of the premises? ☐ Yes ☐ No

SECTION II – LIABILITY SECTION

1. **Projected Payroll/Receipts for Next 12 Months – <u>Payroll includes Independent Contractors but excludes Admin/Clerical Staff</u>**

Payroll $ _____ Receipts $ _____

2. **Types of Services Provided *(please use whole numbers only)*:**

	Service			Service	
☐	Adult Day Care	%	☐	Occupational Therapy	%
☐	Chemotherapy	%	☐	Pediatric Care	%
☐	Child Day Care	%	☐	Personal Care	%
☐	Clergy	%	☐	Pet Therapy	%
☐	Clinical Care	%	☐	Pharmacy	%
☐	Companion/Sitter	%	☐	Physical Therapy	%
☐	Dialysis	%	☐	Radiation Therapy	%
☐	Dietician/Nutritionist	%	☐	Rehabilitation	%
☐	General Nursing (LPN/LVN)	%	☐	Respiratory Therapy	%
☐	Hospice	%	☐	Speech Therapy	%
☐	Infant Care	%	☐	Skilled Nursing Care	%
☐	Infusion Therapy	%	☐	Ventilator	%
☐	Meals on Wheels	%	☐	Other _____	%
☐	Medical Equip. Supplier	%	☐	Other _____	%
☐	Nurse Practitioner	%			
				ABOVE MUST TOTAL 100%	%

3. **Location of Services Provided *(please use whole numbers only)*:**

	Type			Type	
☐	Private Homes	%	☐	Nursing Homes	%
☐	Doctor's Offices	%	☐	Clinics	%
☐	Assisted Living Facilities	%	☐	Owned Facility	%
☐	Hospitals	%	☐	Other _____	%
			☐	Other _____	%
				ABOVE MUST TOTAL 100%	%

4. **Employee Type including Independent Contractors - Please show full time (FT) and part time (PT)**

		# FT	# PT		Type	# FT	# PT
☐	Registered Nurses			☐	Social Worker		
☐	LPN/LVN			☐	Homemaker/Companion		
☐	Physical/Resp. Therapists			☐	Nurse Practitioners		
☐	Occupational Therapists			☐	Physicians		
☐	Speech Therapists			☐	Other _____		
☐	Nursing Aides			☐	Other _____		
☐	Counselors			☐	Other _____		
					TOTAL # EMPLOYEES		

SECTION III – RISK MANAGEMENT

1. Does the Applicant perform criminal background checks on prospective employees, independent contractors and volunteers? ☐ Yes ☐ No

   If yes, what level of background check is performed? (Select all that apply) ☐ County ☐ State ☐ Federal

2. Are job descriptions provided for all professional and nonprofessional employees? ☐ Yes ☐ No
3. Do Employees actively participate in continuing educational programs? ☐ Yes ☐ No
4. Does the Applicant verify employment related references? ☐ Yes ☐ No
5. Does the Applicant verify certification and/or professional licensure status of employees and independent contractors? ☐ Yes ☐ No
6. Does the Applicant confirm in writing any of the following related to prospective employees:
   a. Whether their medical Professional Liability insurance has been denied or cancelled? ☐ Yes ☐ No
   b. Whether they have been involved in any Professional Liability claims or litigation? ☐ Yes ☐ No
   c. Whether any action has ever been taken on their clinical privileges? ☐ Yes ☐ No
7. Are independent contractors required to carry their own individual professional liability coverage? ☐ Yes ☐ No

   Limits of Liability: $ _____
8. Are certificates of insurance maintained on file for all independent contractors and updated annually? ☐ Yes ☐ No
9. Does the Applicant screen employees for drug and alcohol abuse? ☐ Yes ☐ No
10. Does the Applicant utilize a formal written Quality Assurance Risk Management Program? ☐ Yes ☐ No

    If "no", please explain: _____

    _____

    _____
11. Does the Applicant have formal HIPAA compliance procedures in place? ☐ Yes ☐ No
12. Has the Applicant developed written protocols that govern the admission and medical treatment of patients for the following policies and procedures? ☐ Yes ☐ No
13. Complete treatment plan prescribed by the physician, including follow-up plans? ☐ Yes ☐ No
14. Assessments of clients prior to and after accepting the clients? ☐ Yes ☐ No
15. Client's care and home visits documented? ☐ Yes ☐ No
16. Documentation of all homecare training? ☐ Yes ☐ No
17. All changes in the condition of the client or incidents involving the client documented in the records and reported to the family and physician? ☐ Yes ☐ No
18. Is the overall responsibility for Risk Management assigned to one individual in your organization? ☐ Yes ☐ No

    If "yes", please list name and title: _____

    If "no". please describe how these functions are monitored: _____

    _____

    _____
19. Does the Applicant have a formal incident report procedure in place? ☐ Yes ☐ No

20. Is there a peer or committee who reviews the incident reports to improve upon any allegations previously outlined in the surveys or reports? ☐ Yes ☐ No

21. Does the Applicant have formal documented training in place for the following?

    a. Crisis Management ☐ Yes ☐ No
    b. Disposal of Medical waste ☐ Yes ☐ No
    c. First Aid ☐ Yes ☐ No
    d. AED Training ☐ Yes ☐ No
    e. Infusion Therapy ☐ Yes ☐ No
    f. Safe lifting, transferring and client handling ☐ Yes ☐ No
    g. Blood borne Pathogen ☐ Yes ☐ No
    h. Safe use of equipment ☐ Yes ☐ No
    i. Other (please list) _____ ☐ Yes ☐ No

22. Do all contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and assisted living homes include a hold harmless agreement? ☐ Yes ☐ No
23. Is the staff informed of AIDS/HIV Patients? ☐ Yes ☐ No
24. Do patient records include the following? ☐ Yes ☐ No
25. A complete treatment plan prescribed by a physician, including follow-up plans? ☐ Yes ☐ No
26. An “informed consent” document obtained and placed in the patient’s medical record? ☐ Yes ☐ No
27. Patient care home visits meticulously documented? ☐ Yes ☐ No
28. Complete medical records maintained on all patients? ☐ Yes ☐ No
29. Patient records kept on file (hardcopy or electronic) for a minimum of 6 years? ☐ Yes ☐ No
30. All changes in condition and incidents documented to the physician and family? ☐ Yes ☐ No
31. Is documentation of all homecare training provided? ☐ Yes ☐ No
32. Medications and dosage, including documentation of administering medications? ☐ Yes ☐ No
33. A copy of literature given to clients explaining services and fees? ☐ Yes ☐ No
34. Termination of services and discharge criteria? ☐ Yes ☐ No
35. Does the Applicant conduct patient/client surveys? ☐ Yes ☐ No
36. Are the results of the patient/client surveys used to improve day-to-day operations? ☐ Yes ☐ No
37. Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional? ☐ Yes ☐ No
38. Are medications kept in a locked area to prevent tampering? ☐ Yes ☐ No
39. Describe the organization’s policy for disposal of controlled substances (if applicable):

SECTION IV – ABUSE AND MOLESTATION

1. Does your current insurance program include Abuse and Molestation coverage? ☐ Yes ☐ No

   If "yes", what are the limits? $ _____

2. Does the Applicant's employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child abuse related offenses? ☐ Yes ☐ No

3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if you have an incident of abuse? ☐ Yes ☐ No

4. Are there written complaint procedures and are they displayed prominently? ☐ Yes ☐ No

   If "no", please explain: _____

   _____

   _____

5. Are there written procedures that monitor staff in day-to-day relationships with clients, both and off premises? ☐ Yes ☐ No

6. Is there formal staff training on sexual abuse, including how to recognize the signs? ☐ Yes ☐ No

7. Is there more than one person responsible for the welfare of any single patient? ☐ Yes ☐ No

8. Have any incidents resulted in an allegation of sexual abuse? ☐ Yes ☐ No

   If "yes", was the case settled? ☐ Yes ☐ No

   If "yes", was the case taken to trial? ☐ Yes ☐ No

   Amount paid for damages to the victim: $ _____

SECTION V – AUTO INFORMATION

1. Does the Applicant own or lease any vehicles? ☐ Yes ☐ No
2. Does the Applicant need coverage for non-owned automobiles? ☐ Yes ☐ No
3. Does the Applicant have a program to monitor an employee's personal auto liability insurance program:
   a. At time of hire? ☐ Yes ☐ No
   b. Annually? ☐ Yes ☐ No
4. Does the Applicant run MVRs on all employees:
   a. At time of hire? ☐ Yes ☐ No
   b. Annually? ☐ Yes ☐ No
   c. Randomly (based on accidents or suspicions)? ☐ Yes ☐ No
5. What action is taken if an "unacceptable" driver is identified? _____

   _____

6. Describe disqualification protocol: _____

   _____

7. Applicant's employees or volunteers transport clients in their own automobiles (appointments or errands)? ☐ Yes ☐ No
8. Does the Applicant transport non-ambulatory clients? ☐ Yes ☐ No

9. Does the Applicant contract with an ambulance or livery service to transport clients? ☐ Yes ☐ No

10. How many drivers use personal vehicles for business? _____ F/T* _____ P/T** _____ Volunteer

    * F/T = Full Time – over 20 hours per week

    **P/T = Part Time – up to 20 hours per week

11. What is the maximum and minimum age of drivers allowed to drive clients? _____ Max _____ Min

12. Does the Applicant allow personal use of a company-owned vehicle? ☐ Yes ☐ No

13. Does the Applicant make sure travel logs are kept for all drivers? ☐ Yes ☐ No

SECTION VI – PRESENT CARRIER INFORMATION

1. Has any company canceled, declined to renew, or refused insurance within the past five (5) years? ☐ Yes ☐ No

   If yes, please provide details:

	Name of Carrier	Limits	Annual Premium
Property			
Crime			
General Liability			
Professional Liability			
Automobile			
Hired/Non-Owned Automobile			
Computer Systems			
Excess Liability			

SECTION VII – CLAIMS MADE

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

Policy Effective Date: _____

Line of Business: _____

2. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific fact or circumstances which might give rise to a claim being made against the Applicant? ☐ Yes ☐ No

   If yes, please provide details:

   _____

3. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage (s) for which the Applicant is applying? ☐ Yes ☐ No

   If yes, please provide details:

   _____

FRAUD WARNINGS

For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

For residents of Alaska: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

For residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For residents of Arkansas, Louisiana, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Delaware: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

For residents of the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Kansas: 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 act material thereto may be guilty of fraud as determined by a court of law, and may be subject to criminal and civil penalties.

For residents of Kentucky: 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 insurance act, which is a crime.

For residents of Maine and Tennessee: 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 or denial of insurance benefits.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Hampshire: A person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For residents of North Carolina: Any person who knowingly and with intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a Class H felony and may be subject to criminal and civil penalties.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: 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.

For residents of Vermont and Virginia: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

For residents of 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.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive an insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of all other states: Any person who, knowingly and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information, may be guilty of insurance fraud.

APPLICANT'S NAME AND TITLE: _____

APPLIANT'S SIGNATURE: _____ **DATE:** _____

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

PRODUCER'S SIGNATURE: _____ **DATE:** _____

AGENCY NAME: _____