Home healthcare agency/nurse registry/ allied healthcare staffing

Application

Applicant information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

3. Telephone:

4. Date established:

5. Applicant's practice is a:

☐ solo practitioner (unincorporated) ☐ solo practitioner (incorporated)
☐ corporation (for-profit) ☐ corporation (non-profit)
☐ partnership ☐ professional association
☐ individual, employee of (provide name of employer):

6. Type of operations (check all that apply):

☐ home health care ☐ nurse registry ☐ infusion therapy
☐ hospice-homebound ☐ hospice-institutional ☐ other medical staffing

If other medical staffing, please specify:

7. Please state sources and amounts of total revenue:

	Last 12 months	Next 12 months
Charitable contributions		
Government funding		
Fee for services		
Other – specify:		
Total gross revenue:		

8. State approximate division of applicant's patients among:

a. alcoholics	%	b. psychiatric	%
c. communicable	%	d. dental	%
e. drug addicts	%	f. general	%
g. hemodialysis	%	h. holistic medicine	%
i. medical	%	j. mentally retarded	%
k. obstetrical	%	l. pediatric	%
m. counseling/family planning	%	n. research or experimental	%
o. senile or aged	%	p. stress testing	%

q. surgical	%	r. tubercular		%
s. Other (please specify):				%

9. Does the applicant perform:

a.	acupuncture or acupuncture anesthesia?	Yes ☐ No ☐
b.	angiography/arteriography/venography?	Yes ☐ No ☐
c.	catheterization (other than urinary or umbilical)?	Yes ☐ No ☐
d.	closed reduction of compound fractures and/or normal deliveries and/or dermabrasion?	Yes ☐ No ☐
e.	injection of radioisotopes and/or use of irradiated substances?	Yes ☐ No ☐
f.	radiation therapy and/or chemotherapy?	Yes ☐ No ☐
g.	psychiatric shock therapy?	Yes ☐ No ☐
h.	silicone injections?	Yes ☐ No ☐
i.	laser treatments?	Yes ☐ No ☐
j.	hypnosis?	Yes ☐ No ☐
k.	spinal anesthesia (other than saddle blocks or caudals)?	Yes ☐ No ☐

If Yes, to any of the above, please describe/explain:

10. Does the applicant perform:

a.	surgery other than incision of superficial boils or suturing superficial fascia?	Yes ☐ No ☐
b.	circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers?	Yes ☐ No ☐
c.	obstetric procedures?	Yes ☐ No ☐
d.	cosmetic plastic surgery?	Yes ☐ No ☐
e.	excision of large cysts and/or I&D of deep-seated boils or carbuncles?	Yes ☐ No ☐
f.	hysterectomies?	Yes ☐ No ☐
g.	open reduction of fractures?	Yes ☐ No ☐
h.	surgery for weight reduction of patients?	Yes ☐ No ☐
i.	silicone implants?	Yes ☐ No ☐
j.	sterilization procedures?	Yes ☐ No ☐
k.	biopsies and/or endoscopies?	Yes ☐ No ☐
l.	sex change operations?	Yes ☐ No ☐
m.	other surgery?	Yes ☐ No ☐

If Yes, to any of the above, please describe:

Home healthcare agency/nurse registry/ allied healthcare staffing

Application

11. Where are services provided? (Total must equal 100%)

private home	%	doctor's office/clinic	%	hospital	%
hospice	%	adult day care	%	child day care	%
surgicenter	%	nursing home/assisted living facility	%	correctional facility	%
other – please specify:					%

12. If staffing to a hospital, please indicate the percentage of time staff spends in each of the following:

emergency room % intensive care unit % labor and delivery %

13. If staffing to nursing homes and/or assisted living facilities:

a. please specify which healthcare professionals from question 7. are placed into nursing homes and/or assisted living facilities:

b. does the applicant require the nursing home/assisted living facility(s) to carry professional liability insurance? Yes ☐ No ☐

If Yes, please indicate what limits of liability are required:

c. is there any common ownership between the nursing homes and/or assisted living facilities and the applicant in question 1.? Yes ☐ No ☐

If Yes, please describe/explain:

Staffing information

14.

Type of healthcare provider	Number of employees	Number of independent contractors	Annual billable hours in last 12 months	Annual billable hours projected for next 12 months
Registered nurse				
Licensed practical nurse				
Nurse practitioner/ physician assistant				
Certified nurse assistant				
Physical/speech/ occupational therapist				
Respiratory therapist				
Social worker				
Companion/home health aide				
Other (specify):				
Total:				

Home healthcare agency/nurse registry/ allied healthcare staffing

Application

15. a. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐

If No, please explain in the comments section.

b. i. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

ii. Do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐

c. Has the applicant or have any of the above employees:

i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

iii. ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

If Yes, to any of the above, please explain in the comments section.

Employee hiring practices

16. a. Are employee/contractor references checked prior to hiring? Yes ☐ No ☐

b. How are references checked? Written ☐ Verbal ☐ Both ☐

c. Does the applicant utilize criminal background checks? Yes ☐ No ☐

d. Are job descriptions provided for each employee/contractor? Yes ☐ No ☐

e. Are any professsional employees/contractors required to carry their own insurance? Yes ☐ No ☐

If Yes, please provide details:

If Yes, what minimum limit is required?

17. Does the applicant maintain any beds for overnight occupancy? Yes ☐ No ☐

If Yes, please give total number:

Insurance and claims history

18. Does any person to be insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐

If Yes, please attach complete details including a description of the incident(s).

19. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐

If Yes, please complete a supplemental claims information form for each claim and attach currently valued company loss runs.

Home healthcare agency/nurse registry/ allied healthcare staffing

Application

20. If this is a new operation, please attach a copy of resumes of key staff as well as the applicant's pro forma business plan/financials.

21. a. List prior professional liability insurers for the past five years (if none, please tick box) ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim/ aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

22. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim/ aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

23. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please explain in the comments section.

Comments section

Home healthcare agency/nurse registry/ allied healthcare staffing

Application

It is understood and agreed that with respect to questions 18. and 19., that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:	
Signature of person authorized to execute on behalf of the applicant:	
Name/title of person authorized to execute on behalf of the applicant:	
Date:	

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.