Home Health Care - Application
Professional Liability

CHRIS-LEEF GENERAL AGENCY, INC.
P.O. BOX 3747 • SHAWNEE MISSION, KS 66203
(913) 631-1232 • (800) 548-0491 • FAX (913) 631-1128
In California: Chris-Leef General Insurance Agency/License # OI81028
www.chris-leef.com

Applicant Information
Applicant Name:
Mailing Address
Location Address (If Different):
County (ies) doing business in:
Telephone Number:
Corporate Structure ☐Individual ☐Corporation ☐LLC ☐Other: ☐Not For Profit

Coverage Information	
Proposed Effective Date:	Retroactive Date:
Requested Limits of Liability: Professional Liability:	General Liability:
Requested Deductible:	
Other Coverages ☐ Defense Outside Limits ☐ Punitive Damages ☐ Physical & Sexual Abuse ☐ Hired & Non-Owned Auto	
Annual Gross Receipts Estimated Next 12 Months:	
Last 12 Months:	
Annual Remuneration Estimated Next 12 Months:	
Last 12 Months:	

History (Explain any 'Yes' answers on a separate sheet)
Has the insured, in the last 10 years in business ever been without professional and/or general liability Insurance? ☐Yes ☐No
Have any claims been made or occurrences reported during the past ten years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐Yes ☐No
Does any proposed insured have any knowledge of an event, circumstance, or occurrence prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? ☐Yes ☐No
Has the applicant or any employee ever had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms, or has the applicant or any of their employees voluntarily surrendered any professional license? ☐Yes ☐No
Has the applicant or any employee ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐Yes ☐No

Prior Insurers (List prior Professional Liability insurers for the past five years, starting with the most recent year. If none, so state.)					
Insurer	**Policy Number**	**Limits of Liability**	**Premium**	**Eff. Date**	**Claims Made**

Exposures			
Total square footage of premises occupied by Applicant:			
List all memberships in professional organizations:			
Employed Staff (W-2):	Maximum No.	Annual Hours of Service	Annual Remuneration
Registered Nurse			
Licensed Practical Nurse			
Physical Therapist			
Occupational Therapist			
Respiratory Therapist			
Psychotherapist			
Speech Therapist			
Social Worker			
Aides/Homemakers			
Physicians*			
Other:			
Employed Subtotal			

Exposures (cont.)			
Contracted Staff (1099):	Maximum No.	Annual Hours of Service	Annual Remuneration
Registered Nurse			
Licensed Practical Nurse			
Physical Therapist			
Occupational Therapist			
Respiratory Therapist			
Psychotherapist			
Speech Therapist			
Social Worker			
Aides/Homemakers			
Physicians*			
Other:			
Contracted Subtotal			
Total			
*Other than Medical Director, show number of patient visits in lieu of hours of service, and complete Physician Exposure Supplement.			
Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on their policy while they are working on their behalf)? ☐Yes ☐No			

Exposures (cont.)
Enter the percentage of services provided by category of staff including contracted staff:
RN's & LPN's Hospitals: Nursing Homes / Assisted Living: Private Doctors: Private Home Care: Other (describe):
AIDES / ORDERLIES Hospitals: Nursing Homes / Assisted Living: Private Doctors: Private Home Care: Other (describe):
OTHER Hospitals: Nursing Homes / Assisted Living: Private Doctors: Private Home Care: Other (describe):
OTHER Hospitals: Nursing Homes / Assisted Living: Private Doctors: Private Home Care: Other (describe):
Of the total payroll for all home health care staff, indicate the percentage of payroll attributable to each of the following; ***if any, please also complete supplement for IV Therapy** IV Therapy*: AIDS Therapy*: Chemotherapy*: Infant Monitoring (SIDS, etc.): Pediatric / infant childcare including "babysitting":
Number of estimated patients in the next twelve months:
Number of patients in the last twelve months:
Is applicant's facility owned by an M.D.? ☐Yes ☐No If yes, owner name(s):
Does applicant sell, rent, or otherwise provide any equipment or products to patients? ☐Yes ☐No To others? ☐Yes ☐No If yes to either question, please complete Product Sales / Rental Supplement
Is applicant eligible for certification or accreditation? ☐Yes ☐No

Exposures (cont.)
If yes, is the applicant certified and/or accredited? Yes No If no, explain the reason
Is the applicant approved to receive Medicare and Medicaid payments? Yes No
Does the patient desired Hired and Non-Owned Auto coverage? Yes No If yes, please specify the number of drivers:

Risk Management			
Name, qualifications, and number of years of experience of the Medical Director:			
Name	Title	Experience/Training	Association Membership
Does your agency have a written credentialing policy and procedure for all individuals associated with or practicing within the agency? Yes No			
Does the applicant conduct pre-employment screening and investigation? Yes No			
Does the staff supervisor make regular audit visits of staff in the field? Yes No			
Does the applicant require contracted staff (if any) to carry their own Professional Liability Insurance? Yes No			
Does the applicant secure Certificates of Insurance as evidence of such coverage? Yes No			
Describe the applicant's procedures for matching staff to patients. Who does the matching/assigning of staff to client, and what is his/her experience?			
Who does the supervising of staff, and what is his/her experience?			
Describe the referral source(s) by which patients are directed to the entity.			
Is the applicant equipped with an emergency 24 hour telephone call line for all staff and patients? Yes No			
Does the applicant enter into any contractual agreements (other than lease of premises agreements) in which others are held harmless? Yes No If yes, please attach copies of all such contracts.			
Does the home health agency advertise its services other than an ordinary local telephone directory listing? Yes No If yes, please attach a copy of each advertisement.			
Does the applicant maintain a written clinical record showing the total number of visits by each category of staff for each patient? Yes No			

Risk Management (cont.)
Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? Yes No Please explain any exceptions:
Does the applicant's agency have a written incident/occurrence reporting policy and procedure(s)? Yes No
Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? Yes No If no, please attach explanation of any exception.

Other Information (Explain any 'Yes' answers on a separate sheet)
Has the applicant or any of its employees:
Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency or a hospital professional association? ☐Yes ☐No
Had any professional license refused, suspended, revoked, or renewal refused or accepted only with special terms, or has the applicant or any of its employees voluntarily surrendered any professional license? ☐Yes ☐No
Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐Yes ☐No
Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐Yes ☐No
Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than listed above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? ☐Yes ☐No

I understand and agree that this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such insurance will be issued by relying upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations or release of documents containing information relative to moral character, professional reputation, and fitness to engage business. I authorize the release of any information public or private to Greenhill Insurance related to this purpose.

I understand and agree that these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

I confirm that I am authorized to sign this application on behalf of the applicant. Important: This application must be signed by the applicant. Signing this form does NOT bind Greenhill or the company to complete the insurance.

Signed ______________________________ Date __________________

Title ________________________________

Agency/Broker Information
Agency Name:
Broker/Contact Name:
Telephone:

IV Therapy in the Home Health Setting Supplement

PLEASE COMPLETE THIS SUPPLEMENT IF ANY IV THERAPY IS/WILL BE DONE BY YOUR AGENCY'S PERSONNEL
Are the client and significant others instructed concerning IV Therapy Treatments? ☐Yes ☐No
Does the instruction include precautions, signs and symptoms of possible/actual problems, simple first aid measures, and when and whom to call for assistance? ☐Yes ☐No
Is a return demonstration required before any manipulation/handling of supplies or equipment occurs? ☐Yes ☐No
Is the medical record documented concerning instruction? ☐Yes ☐No
Are policies and procedures concerning IV therapy written? ☐Yes ☐No
Are they readily available for use by the registered nurse? ☐Yes ☐No
Are they reviewed and/or revised annually? ☐Yes ☐No
Do they include: Drug administration? ☐Yes ☐No Fluids in general? ☐Yes ☐No Specific drugs by category and method of infusion (direct push, IV infusion)? ☐Yes ☐No Site care? ☐Yes ☐No Infection control? ☐Yes ☐No Care of equipment, including infusion pumps? ☐Yes ☐No Protocols for emergency interventions? (these should be developed with the assistance of a physician) ☐Yes ☐No
Does the registered nurse have, at a minimum, institutional certification for IV therapy? ☐Yes ☐No
Does the certification process verify: Performance competency - a skills inventory/checklist is maintained which documents observed demonstration? Knowledge competency - a test of theoretical knowledge to include actions of various drugs administered, contradictions, complications, and nursing intervention? ☐Yes ☐No Will the nurse be re-certified annually? ☐Yes ☐No
Will IV therapy be included as part of the quality assurance program? ☐Yes ☐No
Will criteria be established for use in monitoring the program? ☐Yes ☐No
Are the medical record, patient interview, and patient assessment included in the review process? ☐Yes ☐No
________ Date   ________________ Applicant   ________________ Title

Medical Products Sales or Equipment Rental Supplemental Application

Description of Products/Equipment

List each product or equipment line individually and provide receipts for each. Please attach a copy of your products/equipment brochures.

Describe Product/Equipment	From Rental	From Sales

Describe clients applicant sells/rents to and % of each:
Individuals using products in their home:
Individuals in nursing homes*:
Nursing Homes or similar residential facilities*:
Hospitals*:
Clinics/Labs*:
Physicians*:
Other* (describe):
*If other than individuals in their home, is there a financial/ownership relationship between applicant and client or facility? ☐Yes ☐No
If yes, please explain.

Who does the servicing and repair of the products?

Who does the servicing and repair of rental equipment?

Are any products manufactured by others and sold under your entity's label? ☐Yes ☐No
If yes, which products?

Are any additional products planned in the next twelve months? ☐Yes ☐No
If yes, please include them under the listing at the top, and estimate the receipts in the next twelve months.

How are products marketed? (Please attach ad copy or brochures)

Is a rental/lease agreement signed by customer prior to releasing any rental equipment? ☐Yes ☐No
If yes, please enclose a copy of the agreement.

Is there a formal written inspection program for rental equipment conducted prior to each rental?
☐Yes ☐No

Are manufacturer's labels/directions provided to customers for all rentals? ☐Yes ☐No

Products/Equipment (cont.)
Do the manufacturers or distributors of any of the above listed items: Name your entity as an additional insured under their products' liability policies? ☐Yes ☐No Provide certificates of insurance for products liability to you? ☐Yes ☐No Provide maintenance/service agreements for their product(s)? ☐Yes ☐No Hold you harmless for loss arising from their products? ☐Yes ☐No If the answer is yes for some products, please specify which product line and which answers:
Are all manufacturers/suppliers well known U.S. firms? ☐Yes ☐No If no, please give details of which are not and any foreign products.
If the sales of medicines or drugs are made by the applicant, is a licensed pharmacist employed or contracted? ☐Yes ☐No If yes, please indicate number of Employed (W-2) and Contracted (1099): Does the pharmacist carry his/her own professional liability insurance? ☐Yes ☐No Limits:
Date _______ Applicant _______ Title _______

Agent Name ______________ Agency Name ______________

Agency Phone Number ______________