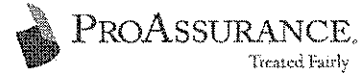


# Professional Liability Application for Home Health Care Agencies & Medical Personnel Staffing

PROASSURANCE  
**MID-CONTINENT**  
UNDERWRITERS, INC



Send submissions to [midcsubmis@proassurance.com](mailto:midcsubmis@proassurance.com).

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired. If the answer is none, state none. If the answer is not applicable, state not applicable (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

**Note:** Application must be dated and signed by owner, partner, officer, or administrator.

**Please type or print in ink.**

## Part I. General Information

- 1.1 Applicant Name (including DBAs): \_\_\_\_\_
- 1.2 Mailing Address: \_\_\_\_\_  
\_\_\_\_\_
- 1.3 Location Address(es): \_\_\_\_\_  
\_\_\_\_\_
- 1.4 County (parish) of Each Location: \_\_\_\_\_
- 1.5 Telephone Number: Office: \_\_\_\_\_ Fax: \_\_\_\_\_
- 1.6 Person to Contact for Survey: Name: \_\_\_\_\_ Title: \_\_\_\_\_
- 1.7 Year Entity Established: \_\_\_\_\_
- 1.8 Entity is:  Individual  Corporation  Partnership  Professional Association/Corporation  
 Other; Describe: \_\_\_\_\_
- 1.9 Entity is:  For Profit  Non-Profit  
Describe Source of Funds: \_\_\_\_\_
- 1.10 Entity is:  Home Health Care Agency  
 Medical Personnel Staffing (Home Health Care Services Only)  
 Medical Personnel Staffing (All Other)  
 Other; Describe: \_\_\_\_\_
- 1.11 Accreditation Information (check whichever applies):  
Type:  SAS Distinguished or Gold Standards  SAS Full Accreditation  
 Other; Describe: \_\_\_\_\_
- 1.12 Proposed Effective Date: \_\_\_\_\_
- 1.13 Requested Limits of Liability (if available):  
Professional Liability \$ \_\_\_\_\_ /\$ \_\_\_\_\_  
General Liability \$ \_\_\_\_\_ Each Occurrence  
\$ \_\_\_\_\_ General Aggregate
- 1.14 Annual Gross Receipts: Estimated next 12 Months: \$ \_\_\_\_\_  
Last 12 Months: \$ \_\_\_\_\_
- 1.15 Total premises square footage occupied by applicant: \_\_\_\_\_
- 1.16 List all memberships in professional organizations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Part II. Exposures**

2.1 Health care Staff: Indicate the next 12 months estimated figures for each of the following categories of staff, hours worked, and compensation.

2.1.1 **Employed Staff (W-2):**

	Maximum No.	Annual Hours of Service	Annual Payroll
Registered Nurse	_____	_____	\$ _____
Licensed Practical Nurse	_____	_____	\$ _____
Physical Therapist	_____	_____	\$ _____
Occupational Therapist	_____	_____	\$ _____
Respiratory Therapist	_____	_____	\$ _____
Psychotherapist	_____	_____	\$ _____
Speech Therapist	_____	_____	\$ _____
Social Worker	_____	_____	\$ _____
Aide, Homemaker	_____	_____	\$ _____
Physician*	_____	_____	\$ _____
Other: _____	_____	_____	\$ _____
Employed Subtotal:	_____	_____	\$ _____

2.1.2 **Contracted Staff (1099):**

	Maximum No.	Annual Hours of Service	Annual Payroll
Registered Nurse	_____	_____	\$ _____
Licensed Practical Nurse	_____	_____	\$ _____
Physical Therapist	_____	_____	\$ _____
Occupational Therapist	_____	_____	\$ _____
Respiratory Therapist	_____	_____	\$ _____
Psychotherapist	_____	_____	\$ _____
Speech Therapist	_____	_____	\$ _____
Social Workers	_____	_____	\$ _____
Aide, Homemaker	_____	_____	\$ _____
Physician*	_____	_____	\$ _____
Other: _____	_____	_____	\$ _____
Contracted Subtotal:	_____	_____	\$ _____
Total:	_____	_____	\$ _____

\*Other than Medical Director, show number of patient visits in lieu of hours of service, and complete the Physician's Exposure Supplement.

2.1.3 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf)?  Yes  No

2.1.4 Enter percentage of services provided, by category, of staff including contracted staff:

RNs & LPNs

\_\_\_\_\_ % 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: _____	Other: _____
_____ % Hospitals	_____ % Hospitals
_____ % Nursing Homes/Assisted Living	_____ % Nursing Homes/Assisted Living
_____ % Private Doctors	_____ % Private Doctors
_____ % Private Home Care	_____ % Private Home Care
_____ % Other; Describe: _____	_____ % Other; Describe: _____

2.2 Of the total payroll for all home health care staff, indicate the percentage of payroll attributable to each of the following:

\_\_\_\_\_ % IV Therapy\*  
 \_\_\_\_\_ % AIDS Therapy\*  
 \_\_\_\_\_ % Chemotherapy\*  
 \_\_\_\_\_ % Infant Monitoring (SIDS, etc.)  
 \_\_\_\_\_ % Pediatric/infant childcare including "babysitting"  
 \*If any, also complete supplement for IV Therapy.

2.3 Number of patients next 12 months: \_\_\_\_\_

2.4 Number of patients last 12 months: \_\_\_\_\_

2.5 Is your facility owned by an M.D.?  Yes  No  
 If yes, owner name(s): \_\_\_\_\_

2.6 Do you sell, rent, or otherwise provide any equipment or products to patients?  Yes  No  
 To others?  Yes  No  
 If yes, to either question, complete Product Sales/Rental Supplement.

2.7 Is the applicant eligible for certification or accreditation?  Yes  No  
 If yes, is applicant certified and/or accredited?  Yes  No  
 If no, explain the reason: \_\_\_\_\_

2.8 Is applicant approved to receive Medicare and Medicaid payments?  Yes  No

**Part III. Risk Management**

3.1 Name, qualifications, and number or years of experience of the Medical Director:

Name	Title	Experience/Training	Association Membership
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3.2 Does your agency have a written credentializing policy and procedure for all individuals associated with or practicing within the agency?  Yes  No

3.3 Do you conduct pre-employment screening and investigation?  Yes  No

3.4 Does the staff supervisor make regular audit visits of staff in the field?  Yes  No

3.5 Do you require contracted staff (if any) to carry their own Professional Liability Insurance?  Yes  No  
 Do you secure Certificates of Insurance as evidence of such coverage?  Yes  No

3.6 Describe your procedures for matching staff to patients. Who does the matching/assigning of staff to client, and what is his/her experience? \_\_\_\_\_

3.7 Who does the supervising of staff, and what is his/her experience? \_\_\_\_\_

3.8 Describe the referral source(s) by which patients are directed to the entity: \_\_\_\_\_

3.9 Are you equipped with an emergency 24-hour telephone call line for all staff and patients?  Yes  No

3.10 Do you enter into any contractual agreements (other than lease of premises agreements in which you hold others harmless)? If yes, please attach copies of all such contacts.  Yes  No

3.11 Does the home health agency advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement.  Yes  No

3.12 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client?  Yes  No

3.13 Are patients accepted for health care services only upon a written plan of treatment established by an attending physician?  Yes  No

Explain any exceptions: \_\_\_\_\_

\_\_\_\_\_

3.14 Does your agency have a written incident/occurrence reporting policy and procedures?  Yes  No

3.15 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception.  Yes  No

3.16 Has the applicant or any of its employees:

- a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital, or professional association?  Yes  No
- b) Had any professional license refused, suspended, revoked, renewal refused, or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license?  Yes  No
- c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No

**If the answer to any of 3.16 is yes, please attach a detailed explanation.**

3.17 Please describe in detail any additional operations, business pursuits, or joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations.  None  Description Attached

#### Part IV. Medical Staffing Services Only

If you do not provide staffing services, please initial here and proceed to Part V: \_\_\_\_\_

4.1 Is any staff provided to hospitals specifically to serve a particular specialty (e.g., OR, ICU, CCU, ER, etc)?  Yes  No

If yes, enter percentage of services provided, by category, of staff including contracted staff:

\_\_\_\_\_ % OR

\_\_\_\_\_ % Labor/delivery

\_\_\_\_\_ % ICU/CCU

\_\_\_\_\_ % ER

\_\_\_\_\_ % Other; Describe: \_\_\_\_\_

4.2 Do you prepare job descriptions and instructional manuals for your staff?  Yes  No  
If yes, enclose a copy of each.

4.3 Do you maintain records of specific areas of experience of each staff member?  Yes  No

4.4 Do you require staff to report all incidents (accidents) that might result in a liability claim AND are records of such reports kept on file by you?  Yes  No

**Part V. History**

5.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, state none.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date? \_\_\_\_\_

5.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, state none.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date? \_\_\_\_\_

5.3 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

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5.4 Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 5.3 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

If yes, describe the event and indicate the reason for anticipation of a claim:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance 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 of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and ProAssurance Mid-Continent Underwriters, Inc., any documents, records, or other information bearing upon the foregoing.

I understand and agree 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.

**Important: This application must be signed by the applicant. Signing this form does NOT bind the company to complete the insurance.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature / Title