

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

PROASSURANCE  
**MID-CONTINENT**  
UNDERWRITERS, INC



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

<u>RNs &amp; LPNs</u>	<u>Aides/Orderlies</u>
_____ % Hospitals	_____ % Hospitals
_____ % Nursing Homes/Assisted Living	_____ % Nursing Homes/Assisted Living
_____ % Private Doctors	_____ % Private Doctors
_____ % Private Home Care	_____ % Private Home Care
_____ % Other; Describe: _____	_____ % 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?  
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.**

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Date

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Applicant Signature / Title

# IV Therapy in the Home Health Setting Supplement



Home Health Agency: \_\_\_\_\_

Please complete this supplement if any IV therapy is/will be done by your agency's personnel.

	Yes	No
A. The client and significant others are instructed concerning the IV therapy treatments?	_____	_____
1. The instruction includes precautions, signs, and symptoms of possible/actual problems, simple first-aid measures, and when and whom to call for assistance?	_____	_____
2. A return demonstration is required before any manipulation/handling of supplies or equipment occurs?	_____	_____
3. The medical record is documented concerning instruction?	_____	_____
B. Policies and procedures concerning IV therapy are written?	_____	_____
1. They are readily available for use by the registered nurse?	_____	_____
2. They are reviewed and/or revised annually?	_____	_____
3. They include:		
a) Drug administration?	_____	_____
1) IV fluids in general?	_____	_____
2) Specific drugs by category and method of infusion (direct push, IV infusion)?	_____	_____
b) Site care?	_____	_____
c) Infection control?	_____	_____
d) Care of equipment, including infusion pumps?	_____	_____
e) Protocols for emergency interventions? (These should be developed with the assistance of the physician.)	_____	_____
C. The registered nurse has, at a minimum, institutional certification for IV therapy?	_____	_____
1. The certification process verifies:		
a) Performance competency: a skills inventory/checklist is maintained which documents observed demonstration?	_____	_____
b) Knowledge competency: a test of theoretical knowledge to include actions of various drugs administered, contraindications, complications, and nursing intervention?	_____	_____
2. The registered nurse will be recertified annually?	_____	_____
D. IV therapy will be included as part of the quality assurance program?	_____	_____
1. Criteria will be established for use in monitoring the program?	_____	_____
2. The medical record, patient interview, and patient assessment are included in the review process?	_____	_____

\_\_\_\_\_  
Date

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

# Medical Products Sales or Equipment Rental Supplemental Application

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

Describe Product/Equipment Line	Annual Receipts	
	From Rental	From Sales
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

B. Describe clients applicant sells/rents to, and % 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, explain: \_\_\_\_\_

C. Who does the servicing and repair of the products? \_\_\_\_\_

Who does the servicing and repair of rental equipment? \_\_\_\_\_

D. Are any products manufactured by others and sold under your entity's label?  Yes  No

If yes, which products? \_\_\_\_\_

E. Are any additional products planned in the next twelve months?  Yes  No

If yes, include them under question A, and estimate the receipts in the next 12 months.

F. How are products marketed? (attach ad copy or brochures) \_\_\_\_\_

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

H. Is formal written inspection program for rental equipment conducted prior to each rental?  Yes  No

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

J. Do the manufacturers or distributors of any of the above listed items:

- 1) Name your entity as an additional insured under their products liability policies?  Yes  No
- 2) Provide Certificates of Insurance for Products Liability to you?  Yes  No
- 3) Provide maintenance/service agreements for their product(s)?  Yes  No
- 4) 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: \_\_\_\_\_

K. Are all manufacturers/suppliers well-known U.S. firms?  Yes  No If no, give details of which are not and any foreign products: \_\_\_\_\_

L. If sales of medicines or drugs are made by applicant, is a licensed pharmacist employed or contracted?  Yes  No

If, yes indicate number: \_\_\_\_\_ Employed (W-2) \_\_\_\_\_ Contracted (1099)

Does pharmacist carry his/her own professional liability insurance?  Yes (Limits: \_\_\_\_\_)  No

\_\_\_\_\_  
Date

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



# Non-Owned Auto Supplemental Application



**If non-owned auto coverage is desired, please complete the following:**

**Note:** Non-owned coverage is written only as an endorsement to the General Liability policy, does not include Hired Car, and shares the limits, deductibles and other conditions of the general liability policy. This coverage is not intended to cover livery operations by the insured, whether a fee is charged or not, and therefore excludes bodily injury to passengers of any insured non-owned autos.

1. How many employees drive their personal auto in connection with your business: \_\_\_\_\_  
How many of these are part-time employees? 15-25 hrs wk \_\_\_\_\_ Under 15 hrs wk \_\_\_\_\_

If persons other than employees use their personal auto in connection with your business, please describe and give number:

\_\_\_\_\_  
\_\_\_\_\_  
None \_\_\_\_\_

2. What are the ages of the drivers?  18-25  25-35  35-45  45-5  55-65  Over 65

3. Does applicant check all driver's MVRs? Yes \_\_\_\_\_ No \_\_\_\_\_

4. Does applicant require minimum limits of at least 100/300 BI - 50 PD? Yes \_\_\_\_\_ No \_\_\_\_\_  
Please attach evidence of each driver's auto insurance showing the limits carried.

5. Does applicant require employees or others to provide transportation for patients/clients in their personal auto? Yes \_\_\_\_\_ No \_\_\_\_\_

6. Does applicant have owned, leased, or hired autos used in business? Yes \_\_\_\_\_ No \_\_\_\_\_  
Insurance coverage: Carrier: \_\_\_\_\_  
Limit: \_\_\_\_\_ Effective Date: \_\_\_\_\_

7. Have any auto claims been made or occurrences reported during the past five years? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, describe, indicate open/closed status, and amounts paid or reserved:

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

\_\_\_\_\_  
Date

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