INCLUDE THE FOLLOWING WITH THIS COMPLETED AND SIGNED SUPPLEMENTAL APPLICATION

- ACORD applications, completed and signed
- 5 years of currently valued loss runs
- Marketing or Advertising brochures or descriptive materials provided to clients

(PLEASE TYPE OR PRINT IN INK)

1. GENERAL APPLICANT INFORMATION

Applicant Name: ____________________

Preferred Effective Date: ____________________ Website: ____________________

Primary owner(s) or principal(s): ____________________

Please identify any other subsidiary organization(s) that should appear as additional named insureds:

____

Professional Organization Memberships: ____________________

Federal Employee Identification Number: ____________________

Description of all operations and types of clients served: ____________________

____

Describe any changes in operations planned within the next year: ____________________

Number of years in operation*: ______ Years under present management: ______

Within the past five years has the applicant acquired, sold, or discontinued any operations? ☐ Yes ☐ No

If Yes, please provide details: ____________________

***A copy of the Director's resume is REQUIRED on all operations in business less than 3 years (please attach)**

1. Type of firm (check all that apply):

   ☐ Adult Daycare ☐ Companion Care ☐ Home Healthcare
   ☐ Hospice ☐ Infusion Therapy ☐ Nurse Registry
   ☐ Respiratory Therapy ☐ Staffing ☐ Other: ____________________

2. Is the Applicant licensed and certified? ☐ Yes ☐ No
3. Is Applicant currently accredited? ☐ ACHC ☐ CARF ☐ CHAP ☐ COA ☐ Other ____________
4. Is the Applicant licensed in all states in which you're operating? ☐ Yes ☐ No

STATE OF OPERATION	LICENSURE REQUIRED?
1.	☐ Yes ☐ No
2.	☐ Yes ☐ No
3.	☐ Yes ☐ No

5. Has the Applicant or any staff member ever been disciplined by any local, state, or federal authority, or has their license ever been revoked or suspended? ☐ Yes ☐ No

   If Yes, please explain: ____________________

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6. Do you provide any treatment on your premises or provide bed/board facilities? ☐ Yes ☐ No
   If Yes, please explain: ____
   ____

7. Prior Carrier Information

	NO PRIOR COVERAGE	COMPANY	LIMITS	COVERAGE FORM	RETROACTIVE DATE	ANNUAL PREMIUM
Professional Liability	☐			☐ Occurrence ☐ Claims Made		$
General Liability	☐			☐ Occurrence ☐ Claims Made		$
Abuse & Molestation	☐			☐ Occurrence ☐ Claims Made		$
Hired and Non-owned Auto Liability	☐			☐ Occurrence ☐ Claims Made		$
					Or, provide Annual Policy Premium	$

8. Is the Applicant aware of ANY claims or specific facts or circumstances which may give rise to a claim being made against any person or entity applying for this insurance that have NOT been reported to your previous carrier? ☐ Yes ☐ No
   If Yes, please provide details including dates, current status, and any amount paid/incurred. (attach additional page if necessary)

2. SERVICES PROVIDED

1. What are your projected Total Annual Revenues/gross receipts for the upcoming 12 months? **(REQUIRED)** $________________

	ANNUAL REVENUES	ANNUAL VISITS
Cardiac Care	$	#
Case Management	$	#
Dialysis	$	#
Dietician/Nutritionist	$	#
Hospice	$	#
Infusion Therapy	$	#
Infant Care/OB Services	$	#
Rehabilitation: Physical, Occupational or Speech therapy	$	#
Respiratory Therapy	$	#
Skilled Nursing	$	#
Supplemental Staffing	$	#
Special Care (Alzheimer's/Dementia)	$	#
Trach/Ventilator	$	#
Other (describe)	$	#

Non-skilled Services:

	ANNUAL REVENUES	ANNUAL VISITS
Companion/Sitter/Personal Care	$	#
Other (describe)	$	#

Miscellaneous Services:

	ANNUAL REVENUES	ANNUAL VISITS
Adult Daycare (licensed slots _____)	$	#
Child Daycare (licensed slots _____)	$	#
Handyman	$	#
Pharmacy	$	#
Other (describe)	$	#

2. Indicate percentage of patients based on age: 0-18 _____% 19-55 _____% 56+ _____%
3. Location of Services Provided (must equal 100%):

   Adult Day Care Facilities: _____% Assisted Living Facilities: _____% Clinics: _____%
   Correctional Facilities: _____% Doctors Offices: _____% Hospitals: _____%
   Nursing Homes: _____% Outpatient Facilities: _____% Owned Facilities: _____%
   Private Homes: _____% Other: _____%
4. Do you provide live-in care (greater than 24 hours of continuous medical attention provided by the same caregiver)? ☐ Yes ☐ No

   If Yes, what percentage of overall services? _____%
5. Do you rent and/or sell medical equipment? ☐ Yes ☐ No

   If Yes, what is annual revenue? $_________________

3. RISK MANAGEMENT

1. Does the Applicant utilize a formal Risk Management Program? ☐ Yes ☐ No
2. Does your risk management program address use of portable devices and social media? ☐ Yes ☐ No
3. Is the overall responsibility for Risk Management assigned to one individual within your organization? ☐ Yes ☐ No
4. Does the Applicant have a formal incident reporting procedure in place? ☐ Yes ☐ No
5. Are all incidents reviewed and considered for further investigation? ☐ Yes ☐ No
   a. Who investigates the incidents? ____
6. Do you survey your clients to measure overall satisfaction with services provided? ☐ Yes ☐ No
7. Are the results of incident investigations and client surveys used to improve day to day operations? ☐ Yes ☐ No
8. Does the Applicant have a formal grievance process? ☐ Yes ☐ No
9. Are grievances investigated to determine opportunities for improvement? ☐ Yes ☐ No
10. Does the Applicant have formal HIPAA compliance procedures in place? ☐ Yes ☐ No
    a. How often is training updated? ____

4. QUALITY OF CARE

1. Do all staff members complete a formal orientation? ☐ Yes ☐ No
2. Does Applicant document within each providers' file the formal training provided in:
   a. Infection Control ☐ Yes ☐ No
   b. CPR ☐ Yes ☐ No
   c. Disposal of medical waste ☐ Yes ☐ No
   d. Infusion therapy ☐ Yes ☐ No
   e. Oxygen therapy ☐ Yes ☐ No
   f. Safe Lifting and transfers ☐ Yes ☐ No
   g. Incident/occurrence reporting ☐ Yes ☐ No
   h. Policies and procedures for all treatments performed ☐ Yes ☐ No

      If Yes, how and at what frequency? ______________________________
3. Is there a standardized format for patient records? ☐ Yes ☐ No
4. Are medications dispensed? ☐ Yes ☐ No
   a. If Yes, who has authority to dispense?______________________________
   b. Can over-the-counter medication be dispensed without written permission from a doctor? ☐ Yes ☐ No
   c. Are written records kept as to time, type of medication, and dosage? ☐ Yes ☐ No
5. Does the Applicant provide interpretive services for non-English speaking clients? ☐ Yes ☐ No
6. Does the Applicant provide alternative language options for educational materials? ☐ Yes ☐ No
7. Is all staff informed of AIDS/HIV patients? ☐ Yes ☐ No
8. Is there an established protocol to address level of care changes? ☐ Yes ☐ No
9. How do you verify that staff reports timely and care has been provided?______________________________

   ____

5. HIRING PROCESS

1. Are formal written procedures in place for staff hiring? ☐ Yes ☐ No
2. Does the Applicant employ relatives of the patient as their care provider? ☐ Yes ☐ No
3. Does the Applicant require all staff to complete an employment application? ☐ Yes ☐ No
4. Are personal interviews completed for each prospective staff member? ☐ Yes ☐ No
5. Does the Applicant verify employment related references? ☐ Yes ☐ No
6. Does the Applicant verify all licenses and certifications? ☐ Yes ☐ No
7. Do you perform criminal background checks on all providers? ☐ Yes ☐ No

   If Yes, what type (check all that apply):

   ☐ National ☐ State ☐ County ☐ National Sexual Offender Public Registry
8. Are criminal background checks reverified? ☐ Yes ☐ No

   If Yes, with what frequency? ______________________________
9. Do you require drug tests on all providers and drivers? ☐ Yes ☐ No

   If Yes, with what frequency? ______________________________
10. What actions are taken if any reports are unfavorable? ______________________________

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11. Does the Applicant have written procedures on how to prevent theft from the client's home? ☐ Yes ☐ No

12. What are your staff turnover ratios? Professional _____% Non-Professional _____%

13. Indicate number of providers:

POSITION	EMPLOYEE		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Administrator								
Child Care Worker								
Clergy								
Clerical/Office Staff								
Companion								
Counselor (other)								
Home Health Aides								
Nurse Practitioner								
Nurse—LPN								
Nurse—RN								
Nutritionist								
Physician								
Psychiatrist								
Resident Manager								
Social Worker								
Teacher/Tutor/Aid								
Therapist—Occupational								
Therapist—Physical								
Therapist—Speech/Hearing								
Therapist Assistant–PT/OT/ST								
Other Positions (specify)								

14. Are any employed providers required to carry their own individual professional liability coverage? ☐ Yes ☐ No

    If Yes, which staff and what limits of liability? ____________________

15. Does the Applicant require all contracted professionals to sign a hold harmless or indemnification agreement? ☐ Yes ☐ No

16. Are all contracted professionals on staff required to carry their own individual professional liability coverage? ☐ Yes ☐ No

    If Yes, what limits of liability? ____________________

17. If separate professional liability coverage is not maintained, is the Applicant requesting to add contracted professional staff to this coverage? ☐ Yes ☐ No

6. ABUSE & MOLESTATION

1. Does the Applicant have a written "zero tolerance" sexual abuse and molestation policy? ☐ Yes ☐ No

2. Does the Applicant's written policy include:
   i. Definition of sexual abuse/molestation? ☐ Yes ☐ No
   ii. Incident reporting procedures? ☐ Yes ☐ No
   iii. Investigation procedures? ☐ Yes ☐ No
   iv. Disciplinary procedures? ☐ Yes ☐ No
   v. Retaliation warning? ☐ Yes ☐ No
3. Is the policy consistently enforced, requiring periodic review with individual sign off by each employee and/or volunteer? ☐ Yes ☐ No
4. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? ☐ Yes ☐ No
5. Are there written procedures that govern staff in day-to-day relationships with clients, both on and off premises? ☐ Yes ☐ No
6. Is there formal staff training on abuse prevention, 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

Please attach a copy of your current abuse and molestation prevention policy.

7. HIRED AND NON-OWNED AUTO

1. Do you have a Commercial Business Auto Policy for owned autos? ☐ Yes ☐ No
2. Are any vehicles titled in the applicants name? ☐ Yes ☐ No
   If No, do you wish to apply for Hired and Non-Owned Auto Liability? ☐ Yes ☐ No
3. Will you be renting or leasing vehicles for business purposes? ☐ Yes ☐ No
   If Yes, how often and for what purposes? ____
   ____
4. Do you or your employees drive personal vehicles for/on business? ☐ Yes ☐ No
   If Yes, how many staff, how often, and for what purposes? ______________________________
   ____
5. Do you run MVRs on all homecare providers? ☐ Yes ☐ No
   i. If Yes, How often? ☐ At the time of hire ☐ Annually ☐ Randomly
   ii. What action is taken if an unacceptable driver is identified?__________________________
6. Do you have a driver safety training program? ☐ Yes ☐ No
7. Do you reimburse employees for mileage on their personal vehicles? ☐ Yes ☐ No
   If Yes, indicate total annual miles reimbursed for all employees: _______________________
8. Estimated total number of homecare provider FTEs that use their own vehicle in the course of business: _______
   i. Does the Applicant require all homecare providers who use their own vehicles for company business to carry personal auto insurance? ☐ Yes ☐ No
      If Yes, what limits are required? $_________________
   ii. Does the Applicant confirm all homecare providers' personal auto policies do not exclude claims arising out of the course of driving if part of their profession? ☐ Yes ☐ No
   iii. Does the Applicant obtain certificates of insurance or a copy of the declarations page from each homecare provider's automobile insurer? ☐ Yes ☐ No

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9. Does the Applicant transport clients? ☐ Yes ☐ No
   If Yes:
   i. How often is transportation provided: ☐ Yes ☐ No
   ii. Does the Applicant require evidence of preventative vehicle maintenance for staff members transporting client's within their personal vehicles? ____________________
   iii. Are the clients non-ambulatory? ☐ Yes ☐ No
   iv. Are the drivers trained on wheelchair securement protocols and procedures? ☐ Yes ☐ No
10. Does the Applicant allow employees to operate a patient or client's vehicle? ☐ Yes ☐ No
   i. How does the Applicant verify patient and/or client owned automobile liability coverage is in force? ____________________
   ii. Does the Applicant require evidence of regular preventative maintenance? ☐ Yes ☐ No
11. Does the Applicant contract with an ambulance or livery service to transport clients? ☐ Yes ☐ No
   i. If Yes, is applicant listed on the policy as an additional insured? ☐ Yes ☐ No
12. Does the Applicant make sure travel logs are kept for all drivers? ☐ Yes ☐ No

DECLARATION AND SIGNATURE

Authorized Representative Designation

The person named herein is an authorized representative of the person(s) or entity(ies) proposed for this insurance and designated to give and receive any and all notices on behalf of such person(s) or entity(ies) concerning this insurance.

Named Individual: ____________________

Title/Position: ____________________ **Date:** ____________________

Authorization

By signing this application the undersigned declares that they have reviewed the application for accuracy before it was signed, answered the questions in this application to the best of their ability and that, to the best of their knowledge following reasonable inquiry, the statements set forth herein and in any attachments or other documents submitted with this application are true, complete, accurate, correct and no material facts have been omitted, misrepresented, or misstated. The undersigned understands that the Insurer will have relied on all such information provided by the undersigned in issuing the policy. The undersigned further represents that any fact, circumstance or situation indicating the probability of a claim or legal action now known to any entity official or employee has been declared, and it is agreed by all concerned that the omission of such information shall exclude any such claim or action from coverage under the insurance being applied for. The signing of this application does not bind the insurance company to issue a policy, but it is agreed that this application shall be the basis of the contract should a policy be issued.

Signature of Authorized Entity Representative: ____________________ **Date:** ____________________

Fraud Notice

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to civil fines and criminal penalties.

Signature in Full: ____________________ **Date:** ____________________

FRAUD NOTICE – Where Applicable Under The Law of Your State

Notice to Alabama Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who 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.

Notice to Arkansas Applicants 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.

Notice to California Applicants: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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Notice to Colorado Applicants: 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 purposes of defrauding or attempting to defraud the policyholder 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.

Notice to District of Columbia Applicants: 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.

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

Notice to Hawaii Applicants: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Notice to Kentucky Applicants: 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.

Notice to Louisiana, Rhode Island and West Virginia Applicants: 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.

Notice to Maine Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to Maryland Applicants: 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 or confinement in prison.

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

Notice to New Mexico Applicants: 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.

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 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.

Notice to Ohio Applicants: 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.

Notice to Oklahoma Applicants: 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 (365:15-1-10, 36 §3613.1).

Notice to Oregon Applicants: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Notice to Pennsylvania Applicants: 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.

Notice to Tennessee and Virginia Applicants: 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.

Notice to Washington Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.