HAMILTON

Clear Form

HOME HEALTH CARE APPLICATION

Instructions:

- Please print or type clearly all response and answer all questions as instructed.
- If you need more space than is given, continue in the comments section of this application or attach a separate sheet of paper.
- Coverage will not be bound until this application is completed and signed, and all required documents are provided.

Required documents, in addition to this application:

- Loss runs, dated within 60 days of submission, covering the past five years
- Declarations page from current insurance carrier, showing retroactive date if claims-made coverage
- Most recent state survey reports, licensure reports and accreditation survey reports as applicable
- Current license
- Resume of owner or administrator

APPLICANT INFORMATION

Legal name of Applicant:	
Mailing Address: (Street, City, State, Zip Code):	
Location Address: (Street, City, State, Zip Code):	

(If there are multiple locations, please attach a list separately)

Date Established:		**Website:**		
Legal Structure:	For Profit ☐	Non-Profit ☐	Government ☐	Other (please explain) ☐
Sole proprietorship ☐	Corporation ☐	Partnership ☐	Joint Venture ☐	

Main Contact (name, position):		**Telephone Number:**	
Administrator/Executive Director:			
Director of Nursing (if applicable):			

COVERAGE REQUESTED

Requested Policy Period:				
Professional Liability Limits:	Per Claim:		Aggregate:	
General Liability Limits:	Per Claim:		Aggregate:	
Deductible:	**Retroactive Date:** (declarations page required)			
Other Coverage requests:				

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GENERAL INFORMATION

1. Years of operation:		**Under current ownership:**	
2. Licensing (please include copies of licenses):			
Has an Applicant's license ever been suspended, revoked or placed under probation?	Yes ○	No ○	

(If yes, provide a detailed explanation in a separate attachment with date of reinstatement)

3. Please provide details on any subsidiaries or affiliates:				
Subsidiary/Affiliate	Operations	Ownership %	Date Acquired:	Coverage Sought?

4. Please provide the total annual revenue for the years indicated below:			
Revenue Source	**Projected**	**Current**	**1 Year Prior**
Medicare:	$	$	$
Medicaid:	$	$	$
Private Pay:	$	$	$
Charitable:	$	$	$
Other:	$	$	$
Total Gross Revenue:	**$**	**$**	**$**

5. Has the applicant ever filed for bankruptcy?	Yes ○	No ○

(If yes, provide a detailed explanation in a separate attachment)

OPERATIONS

6. Type of Operations (please check all that apply)		
☐ Home Health Care	☐ Medical Staffing/Nurse Registry	☐ Medical Equipment Supplier
☐ Other (please explain):		

7. Are you accredited by the Joint Commission, Community Health Accreditation Program (CHAP) or any other accrediting organization?	If yes, explain:	No ○

8. Percentage of time spent in the following work locations (must total 100%):				
Private home	%		Hospital Staffing	%
Assisted Living	%		Operating Room	%
Nursing Home	%		Emergency Room	%
Institutional Hospice	%		Labor & Delivery	%
Ambulatory Surgery Center	%		Neonatal (NICU)	%
Adult Day Care	%		Adult Intensive Care Unit	%
Clinic	%		Pediatric Intensive Care Unit	%
Physician's Office	%		Other Hospital (specify below)	%
Correctional Facility	%		Other (specify below):	%
Additional space for details:				

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9. Percentage of types of services provided (must total 100%):				
Rehabilitation – Incl physical, occupational or speech therapy	%		Personal Care Chore or Companion	%
Infusion Therapy	%		Respiration Therapy	%
Hospice – In Home	%		Radiation Therapy	%
Supplemental Staffing	%		Skilled Nursing Care	%
Obstetrical Services	%		Pediatric Care	%
Chemotherapy	%		Skin Care or Bedsore Wound Care	%
Obstetrical Services	%		Medical Equipment Supplier	%
Chemotherapy	%		In Home Dialysis	%
Cardiac Care	%		Other (specify below):	%
Additional space for details:				

Does the applicant:

10. Provide any overnight bed facilities?				Yes ◯	No ◯
11. Perform any treatment services on the applicant's premises?				Yes ◯	No ◯
12. Provide care or treatment to ventilator or tracheotomy clients or patients?				Yes ◯	No ◯
If yes, please provide the percentage of services:		%			
13. Provide care or treatment to traumatic brain injury clients or patients?				Yes ◯	No ◯
If yes, please provide the percentage of services:		%			
14. Provide care or treatment to tube feeding patients?				Yes ◯	No ◯
If yes, please provide the percentage of services:		%			
15. Provide any temporary or permanent placements of staff?				Yes ◯	No ◯
If yes, please indicate:	temporary placement	%	permanent placement:		%

STAFFING

16. Staffing				
Type of Health Care Provider	# of Employees	Annual Employee Hours Worked	# of Independent Contractors	Annual Contractor Hours Worked
Personal Companion or Homemaker				
Live in Companions				
Certified Nurse Aid (CNA)				
Licensed Practical Nurse (LPN)				
Registered Nurse (RN)				
Medical Technician				
Nurse Practitioner				
Speech Therapist				
Occupational Therapist				
Physical Therapist				
Social Worker				
Physician Assistant				
Certified Registered Nurse Anesthetist (CRNA)				
Physicians (all types)				
Other				
Other				
Additional space for details:				

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17. Are all health care providers above licensed in accordance with all applicable state and federal regulations (if licensure is required:			Yes ○	No ○
18. Do **ALL** employees carry their own professional liability insurance?			Yes ○	No ○
If yes, what are the minimum limits of insurance required:				
Per Claim/Occurrence:		Aggregate:		
19. Do **ALL** independent contractors carry their own professional liability insurance?			Yes ○	No ○
If yes, what are the minimum limits of insurance required:				
Per Claim/Occurrence:		Aggregate:		
20. Does your facility have written job descriptions?			Yes ○	No ○
21. Medical Director details:				
Name:		Full time or Part Time		
Specialty:		Direct Patient Care?	Yes ○	No ○
Additional space for details:				
22. Are hiring/screening procedures in place for all workers providing patient care services?			Yes ○	No ○
23. Please indicate which of the following procedures are included in the hiring and screening process:				
Verification of educational background, including licensure and/or certification			Yes ○	No ○
Check for any license suspensions, revocations or any disciplinary actions			Yes ○	No ○
Check for criminal history			Yes ○	No ○
Reference check from prior employers			Yes ○	No ○
Require information regarding medical professional claims history			Yes ○	No ○
24. Do you have a formal documented orientation program in place?			Yes ○	No ○

INSURANCE AND LOSS HISTORY

25. Professional Liability Insurance History (Past 5 years)

Insurer	Dates covered	Limits of Insurance	Deductible	Premium	Claims-made or Occurrence
If the current policy is claim-made, what is the current retroactive date?					

26. General Liability Insurance History (Past 5 years)

Insurer	Dates covered	Limits of Insurance	Deductible	Premium	Claims-made or Occurrence
If the current policy is claim-made, what is the current retroactive date?					

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For any "Yes" answers to the following questions, please provide detailed information in the Supplemental Information section of this application or provide separate attachments.

27. Has any insurance company ever rescinded, cancelled or non-renewed any similar insurance for the applicant?	Yes ○	No ○
28. Has the applicant or any of its employees ever had any professional license or license to prescribe and/or dispense narcotics limited, suspended, revoked, denied or investigated by any licensing board or regulatory agency?	Yes ○	No ○
29. Has the applicant or any of its employees ever been charged with or convicted of a crime?	Yes ○	No ○
30. Has any claim or suit ever been made against the applicant or any other person proposed for this insurance?	Yes ○	No ○
31. Have there been any claims or do you have knowledge of information which might reasonably be expected to give rise to a claim of physical abuse or molestation?	Yes ○	No ○
32. Is the applicant or any person proposed for this insurance aware of any known losses, claims or suits that have not yet been reported?	Yes ○	No ○
33. Is the applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a claim?	Yes ○	No ○

SUPPLEMENTAL INFORMATION

Please use this section to provide additional details for Questions 27-33, or for any other questions requiring additional space for answers.

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FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA,WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for 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 insurance company files a statement of claim 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 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 denial of insurance benefits.

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 an 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 $5,000 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/she 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.

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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.

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 a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE 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 VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposeof defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant Signature _____ **Title:** _____

(Must be signed by an owner, principal, partner or officer) **Date:** _____