

MISCELLANEOUS HEALTHCARE FACILITIES HOME HEALTH CARE APPLICATION

Instructions For Completing This Application

Please read the instructions carefully, and complete and submit all requested information and required attachments. This application and all materials submitted or required shall be held in confidence.

All application questions must be fully answered. If a question does not apply, please write "N/A".

If you need more space, continue on a separate sheet of your firm's letterhead and indicated question number.

To this application, please attach copies of:

1. Marketing or Advertising brochures, if any.
2. Descriptive materials provided to clients.
3. Other attachments as required in response to application questions.
4. Copy of JCAHO accreditation report or other similar, if applicable.

I. GENERAL INFORMATION

Name of Applicant (legal name): _____

Main Location Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Tax Identification Number: _____ Telephone Number: (____) _____

Years in Business: _____

Are you currently enrolled in a PCF? Yes No

Mailing Address (if different than above): _____

City: _____ State: _____ Zip Code: _____ County: _____

Provide names and descriptions of all legal entities, including subsidiaries for which the Applicant desires coverage. Provide a description of the entity, as well as the percentage owned and the date acquired, if applicable, and the requested Prior Acts date. If more space is required, please provide by attachment.

Name	Description	% Owned	Date Acquired	Prior Acts Date

II. COVERAGE REQUESTED

Requested Effective Date: _____

Professional Liability

Claims-Made Occurrence

If Claims-Made, Prior Acts Date: _____

Limits of Liability: \$ _____ each claim, \$ _____ aggregate

Deductible or SIR Amount \$ _____

Is Prior Acts coverage being requested? Yes No

III. PREVIOUS PROFESSIONAL LIABILITY COVERAGE

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	<input type="checkbox"/> Deductible <input type="checkbox"/> Self-Insured Retention \$ _____	<input type="checkbox"/> Deductible <input type="checkbox"/> Self-Insured Retention \$ _____	<input type="checkbox"/> Deductible <input type="checkbox"/> Self-Insured Retention \$ _____
Coverage Form	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Prior Acts Date			
Policy Period			
Premium			

Has any insurance company cancelled, refused to issue or renew applicants Professional and/or General Liability Insurance policy(s)? Yes No

If Yes, please provide details.

IV. ORGANIZATION/OPERATIONS

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

- Corporation
- Partnership
- Home Health Care
- Proprietary Agency
- Community based non-profit
- Hospital based
- Count-Municipal Health Dept.
- Supplemental Staffing
- Medical Equipment Supplier
- Nurse Registry
- Other _____

2. Are all of applicants services provided out of a central location: Yes No
If No, how many branches are there in addition to the central location? _____

Please provide listing of addresses.

3. Date Entity was established: _____

4. Are there any subsidiaries that are to be included in this coverage? Yes No

If Yes, please attach a list providing subsidiary name, description of operations, % of ownership, and date acquired.

Note: If subsidiaries are not 100 % owned by the parent, provide details of other owners and the percentage of each.

5. Within the next 12 month period, does applicant plan to:
- | | | |
|--|------------------------------|-----------------------------|
| a. obtain another operation or entity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. add to the number of employees? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. expand the number of locations? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. eliminate any current services? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. add any services? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. operate in other states? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please provide details on any "Yes" answers to above questions.

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

If Yes, please provide details.

7. Does applicant own, control, or staff any of the following?

- | | | |
|--|------------------------------|-----------------------------|
| Medical Laboratory (in house) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nursing Home | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rehabilitation Facility | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hospital - General Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Substance Abuse Programs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Adult Day Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Dialysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Infusion/Respiratory/Radiation Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rental and/or Leasing Services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emergency Rooms | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emergency Vehicles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

8. Does applicant run or participate in hospice activities? Yes No

If Yes:

- | | | |
|--|------------------------------|-----------------------------|
| a. Does applicant have any contractual agreements with regard to hospice activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. How many hospice patients will be cared for within the next 12 months? | _____ | |
| c. Does applicant employ the services of a medical director? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Are the medical directors services solely for the hospice activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Does the medical director carry his/her own malpractice insurance? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If Yes, how much? _____ | | |

Please attach copies of any brochures or information given to clients, and contractual agreements applicant has with regard to hospice activities.

9. Total Annual Gross Receipts \$ _____

10. Supplemental Staffing by % of Gross Receipts

Private Home _____% Doctors Office _____% Hospital _____%
 Hospice _____% Nursing Home _____% Clinic _____%
 Surgicenter _____% Day Care _____%

Other (describe with percentages): _____

11. Services Provided by % of Gross Receipts

Adult Day Care _____% Housekeeping _____% Rehabilitation _____%
 Changing Dressings _____% Infant Day Care _____% Rental/Leasing _____%
 Cooking _____% Infusion _____% Self Help Instructions _____%
 Dialysis _____% Intravenous Feeding _____% Simple Injections _____%
 Dietitian _____% Lifting _____% Staffing _____%
 Drug Administration _____% Medical Laboratory _____% Therapy Services _____%
 Drug Therapy _____% Nursing _____% Training _____%
 Hospital _____% Personal Companion _____% Transportation _____%

Other (describe with percentages): _____%

12. Employee Annual Staffing and Visits (Note: if more than one location, give breakdown by location):

	Number Full-Time	Number Part-Time	Annual Number of Visits	Annual Hours of Service	Annual Payroll
Nurse (RN, LPN, LVN)					
Nurse Practitioner					
Physical Therapist					
Respiratory Therapist					
Speech Therapist					
Occupational Therapist					
Social Worker					
Home Maker HHA					
Pharmacy					
Other (Specify)					

13. Independent Contractors Annual Staffing and Visits (Note: if more than one location, give breakdown by location)

	Full Time	Part Time	Annual Number of Visits	Annual Hours of Service	Annual Billings

**MISCELLANEOUS MEDICAL FACILITIES
HOME HEALTH CARE**

Nurse (RN, LPN, LVN)					
Nurse Practitioner					
Physical Therapist					
Respiratory Therapist					
Speech Therapist					
Occupational Therapist					
Social Worker					
Home Maker HHA					
Pharmacy					
Other (Specify)					

Does applicant want coverage to include independent contractors? Yes No
 If No, what limits does applicant require them to carry? \$ _____

Does applicant obtain certificates of insurance from independent contractors? Yes No
 If No, how does applicant verify that the required insurance is maintained?

14. Does the organization enter into contractual agreements (i.e. hospitals, nursing homes)? Yes No
 If Yes, please provide details: _____

15. Do contractual agreements contain hold harmless or indemnification clauses favorable to the applicant?
 N/A Yes No
 If No, please provide copies of those contracts.

16. Hiring/Screening and Employment Procedures

- a. Are employees/contractors references contacted before hiring or placement? Yes No
- b. How are references checked? Written Verbal Both
- c. Does applicant question prospective employees as to criminal record? Yes No
- d. Does applicant question prospects about previous claims or suits? Yes No
- e. Do employees actively participate in continuing education programs? Yes No
- f. Are job descriptions provided for all staff members? Yes No
- g. Are all employees properly trained before assignment? Yes No
- h. Are professional employees required to carry their own insurance? Yes No
 If Yes, what minimum is required? \$ _____
 Does applicant require them to furnish you with a certificate of insurance? Yes No

17. Accreditation

- a. Is applicant a member of:
 - National League for Nursing _____ National Homecare Council _____
 - American Public Health Association _____ JCAHO _____

National Association for Home Care _____ CHAP _____

Other (Specify) _____

- b. Is applicant licensed in all states in which it's operating? Yes No
- c. Is applicant certified for Medicare reimbursement? Yes No

V. DURABLE MEDICAL EQUIPMENT

1. Does applicant sell any medical supplies and/or equipment? Yes No
If Yes, Annual Receipts \$ _____

2. Does applicant rent or lease any medical or therapeutic supplies and/or equipment to others: Yes No
If Yes, Annual Receipts \$ _____

3. If you have answered "Yes" to either 1 or 2 above, please check the appropriate categories below and indicate the receipts:

Category I. Expandable items - Intended for one-time usage and disposed (i.e. adhesive tape, bandages, hypodermic needles, etc.)
Sales Receipts _____ Lease Receipts _____

Category II. Durable Medical Equipment (DME) - Non-Expendable items excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids, walkers, strollers, canes, crutches, wheelchairs, and prosthetic devices and IV stands.
Sales Receipts _____ Lease Receipts _____

Category III. Diagnostic or Treatment Devices - Includes treatment devices or equipment not used to sustain life or perform critical life monitoring functions. This category includes items such as blood pressure gauges, I.V. pumps, portable EKG machines or sensing devices.
Sales Receipts _____ Lease Receipts _____

Category IV. Life sustaining or Critical Life Monitoring Equipment or Devices. This category includes oxygen and other medical gases used in conjunction with respiratory therapy, dialysis or heart/lung machines, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction, failure or improper function of which, could result in the death or serious deterioration of the patients health condition.
Sales Receipts _____ Lease Receipts _____

4. Does the applicant perform any maintenance or repairs on equipment sold or leased? Yes No
If Yes, please indicate the category:

Category I Category II Category III Category IV

5. If another company performs the maintenance or repairs, please indicate:

Maintenance Repairs

If either, or both boxes are checked, does applicant obtain certificates of insurance for all companies performing maintenance or repairs?

Yes No

6. Are all devices/equipment checked and documented as to condition prior to release? Yes No
7. Does the applicant perform, or have performed, preventive maintenance on all equipment/devices according to a written schedule? Yes No
8. Is the applicant named as an additional insured or vendor on the manufacturers policy for any/all products? Yes No
9. Does the applicant obtain certificates of insurance from their product suppliers? Yes No
10. Has the applicant ever, or does the applicant currently import products from a foreign manufacturer? Yes No
If Yes, does the manufacturer have a U.S. location? Yes No
Provide details, by attachment, of any imported products.
11. Are written instructions for the use of the products provided to the buyer/user? Yes No
If Yes, are these instructions reviewed and required to be signed off by buyer/user? Yes No
12. Does the applicant modify the product in any way from its original form/use? Yes No
If Yes, please describe.
13. Does the applicant do any re-packaging or re-labeling of items obtained from suppliers? Yes No
14. Is any of the equipment sold with the applicants label? Yes No
15. Does the applicant maintain a written quality control program? Yes No
16. Does the applicant have its own sales staff? Yes No
If Yes, are they trained by the manufacturer? Yes No
17. Does the applicant repair or sell used equipment of others? Yes No
If Yes, please provide details.
18. Are serial numbers of finished products shown on shipment invoices and are complete records kept of inventory shipments? Yes No

VI. RISK MANAGEMENT/QUALITY ASSURANCE

MISCELLANEOUS MEDICAL FACILITIES
HOME HEALTH CARE

1. Does applicant utilize a formal written Quality Assurance & Risk Management Program? Yes No
If Yes, please attach a copy.
2. Does applicant have a Peer Review Committee? Yes No
3. Does applicant conduct patient/client surveys? Yes No
4. Does applicant provide for continuing education programs? Yes No
5. Are informed consent forms used? Yes No
If Yes, when? _____
6. Is there a written policy or procedure document describing:
- a. patient acceptance Yes No
 - b. advance directives (Living Will) Yes No
 - c. employee training Yes No
 - d. safety for workers in offsite locations Yes No
 - e. lifting requirements Yes No
 - f. patient evaluations Yes No
 - g. incident reporting Yes No
 - h. drug administration procedures Yes No
 - i. food preparation Yes No
 - j. medical equipment training Yes No
 - k. patient discharge procedures Yes No
 - l. patients rights Yes No
 - m. medical reports Yes No

If Yes to any, please attach a copy of the written policy/procedure document.

7. Who has the overall responsibility for Risk Management & Quality Assurance?

Name: _____

Title: _____

Telephone Company: _____

VII. LITIGATION/CLAIMS HISTORY

1. Have there been during the last 5 years, or is there now pending any suit or claim against the Applicant or any of its subsidiaries? Yes No

If Yes, please provide details.

2. Does the Applicant have knowledge of any threatened or pending civil or criminal actions or litigation? Yes No

If Yes, please provide details.

GENERAL LIABILITY

1. Owned or Leased Premises - Description of Hazards

	Address	Own/Lease	Occupancy	Square Footage
#1				
#2				
#3				

Please attach a list of all other locations.

2. Employee Benefits Liability

Total number of employees: _____

3. Hired and Non-Owned Auto Liability

Total number of employees: _____

Are all employees required to have personal automobile insurance? Yes No

What is the mandatory limit of underlying insurance required? \$ _____

Is proof of personal automobile insurance verified (i.e., a copy of the certification provided)? Yes No

Who is responsible for checking certification? _____

4. Stop Gap Liability

Total Annual Payroll \$ _____

5. General Information

- a. Does applicant sponsor any sporting or social events? Yes No

If Yes, please explain _____

- b. Does applicant participate in trade shows, exhibits, conventions? Yes No

If Yes, please explain _____

- c. Does applicant utilize services of an advertising agency? Yes No

If Yes, please explain _____

- d. Does applicant utilize any other form of media? Yes No

If Yes, please provide:

Annual Cost _____

Description _____

6. Prior Carrier Information

- a. General Liability (past three years):

Company	Limit of Liability	Effective Date	Annual Premium	Claims-Made or Occurrence	Prior Acts Date (if Claims-Made)

- b. Is Products Liability provided under your General Liability policy? Yes No

- c. Have any claims or suits been made within the past five (5) years against the applicant, or is the applicant aware of any circumstances which may result in any claim or suit being brought against the applicant? Yes No

If so, please attach information, including date of loss, allegations, status (open or closed), paid or reserved amount, and the insurance company.

UMBRELLA/EXCESS INFORMATION

The following information is required for consideration of excess liability coverage:

1. Professional Liability/General Liability

Insurance Company: _____
Policy Number: _____ Policy Period: _____
Prior Acts Date: _____ Limits of Liability: _____
Deductible: _____ Premium: _____

2. Worker's Compensation/Employers Liability

Insurance Company: _____
Policy Number: _____ Policy Period: _____
Prior Acts Date: _____
Employers Liability Limit \$ _____ each accident
Occupational Disease Limit \$ _____ per person
Occupational Disease Limit \$ _____ per policy

3. Automobile Liability Coverage

Please list below the number of vehicles owned, leased or operated by the facility. If there are none in a particular category, please indicate with "N/A".

_____ Private Passenger
_____ Motor Homes
_____ Buses
_____ Ambulances
_____ Vans
_____ Trucks

_____ Light _____ Medium _____ Heavy

Present Automobile Insurer: _____
Policy Number: _____ Policy Period: _____
Limits of Liability: _____ Annual Premium: _____

Have any automobile liability losses during the last five years been paid or are currently reserved for an amount in excess of \$10,000? Yes No

If Yes, please include a copy of insurer loss report.

Please attach a copy of your primary policies.

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

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, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution, and confinement in state prison.

Applicable in *NY*: Fines will not exceed \$5,000 and the stated value of the claim for each such violation.

Applicable in *Colorado*: 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 purpose of defrauding or attempting to defraud the policyholder or claimant, 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.

Signature in full

_____/_____/_____
Date

Name - please print

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

Submitted By: _____

Please submit to: CNA HealthPro
Corporate Accounts
CNA Plaza
Chicago, IL 60685

This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation.