



**Diamond State**  
GROUP

Return to:

**HOME HEALTH CARE /  
TEMPORARY STAFFING  
APPLICATION**

**INSTRUCTIONS:**

- A. Please type or print clearly. Answer ALL questions completely.
- B. If any question, or part thereof, does not apply, print "N/A" in the space provided.
- C. If more space is needed, continue on a separate sheet of your firm's letterhead, indicating question number.
- D. To this application, please attach copies of
  - Marketing or advertising brochures.
  - Descriptive materials provided to clients.
  - Copy of JCAHO accreditation report, or other similar, if applicable.
  - Other attachments as required in response to application questions.
  - Most current annual financial statement prepared by a CPA.
- E. All materials submitted or required shall be held in confidence.

**GENERAL INFORMATION**

1. Insured \_\_\_\_\_

Main Location Address

Street	City	State/Zip	County

2. Tax Identification Number \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

3. Years in Business \_\_\_\_\_ Are you currently enrolled in a Patient Compensation Fund?  Yes  No

4. Mailing Address (if different than above)

Street	City	State/Zip	County

5. List all locations and areas of operations

Street	City	State/Zip	County

Street	City	State/Zip	County

6. Provide names of all legal entities, including subsidiaries desiring coverage. Please provide a description of the entity, percentage owned and date acquired. If applicable, the requested Prior Acts date.

Name	Description	% Owned	Date Acquired	Prior Acts Date

7. Within the past 5 years, has applicant acquired, sold or discontinued any operations?  Yes  No
8. Applicant is:  Individual  Partnership  Corporation Other \_\_\_\_\_
9. Total Annual Gross Receipts (Please attach financial statement prepared by a CPA.) \$ \_\_\_\_\_
10. Does the applicant provide any overnight bed facilities?  Yes  No
11. Does the applicant perform any treatment or services on the applicant's premises?  Yes  No

**COVERAGE REQUESTED**

12. Requested Effective Date \_\_\_\_\_  
 (If new venture, please provide owner's resume' and description of related industry experience.)
13. \_\_\_\_\_ **Professional Liability**  Occurrence  Claims Made  Prior Acts Date \_\_\_\_\_  
 (Attach copy of prior claims made policy Declarations if requesting prior acts.)
- \$ 100,000 per Incident / \$ 300,000 Aggregate
  - \$ 250,000 per Incident / \$ 750,000 Aggregate
  - \$ 500,000 per Incident / \$ 500,000 Aggregate
  - \$1,000,000 per Incident / \$1,000,000 Aggregate
  - \$1,000,000 per Incident / \$2,000,000 Aggregate
  - \$1,000,000 per Incident / \$3,000,000 Aggregate
  - \$2,000,000 per Incident / \$4,000,000 Aggregate
  - \$2,000,000 per Incident / \$6,000,000 Aggregate
  - \$3,000,000 per Incident / \$5,000,000 Aggregate
- (Higher limits options available upon request)**

14. \_\_\_\_\_ **General Liability**       Occurrence    Claims Made    Prior Acts Date \_\_\_\_\_

(Attach copy of prior claims made policy Declarations if requesting prior acts.)

Each Occurrence (cannot be excess PL limit)      \$ \_\_\_\_\_  
 Medical Expense Limit (Per Person)                      \$ \_\_\_\_\_  
 Fire Damage Limits of Liability (Any one Fire)      \$ \_\_\_\_\_  
 Products / Completed Operation Aggregate              \$ \_\_\_\_\_  
 General Aggregate (Other than Products)              \$ \_\_\_\_\_

15. Per Claim Deductible

(Same deductible must be selected for both Professional and General Liability.)

none                       \$1,000                       \$5,000  
 \$10,000                       \$25,000                       Other \_\_\_\_\_

16. List Professional Liability policies covering the firm indicated in Question #1 over the past 5 years. If **No** insurance was in effect for a given year, state "**None**" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
<b>Current Yr.</b>							
<b>Prior Yr.</b>							
<b>2<sup>nd</sup> Prior Yr.</b>							
<b>3<sup>rd</sup> Prior Yr.</b>							
<b>4<sup>th</sup> Prior Yr.</b>							

17. List General Liability policies covering the firm indicated in Question #1 over the past 5 years. If **No** insurance was in effect for a given year, state "**None**" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
<b>Current Yr.</b>							
<b>Prior Yr.</b>							
<b>2<sup>nd</sup> Prior Yr.</b>							
<b>3<sup>rd</sup> Prior Yr.</b>							
<b>4<sup>th</sup> Prior Yr.</b>							

**CLAIM HISTORY**

18. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier?  Yes  No

If **YES**, please attach information for each claim, suit or incident that includes the following:

- Date of Accident and Date of Notice
- Claimant Name
- Amount Paid or Reserved
- Status – Open or Closed
- Insurance Carrier
- Allegations
- Description of Treatment Rendered.

19. Has any company cancelled, declined or refused to issue similar insurance?  Yes  No

If **Yes**, please explain:

\_\_\_\_\_

**EMPLOYEES / INDEPENDENT CONTRACTORS**

20. Total Employees \_\_\_\_\_ # Total Independent Contractors \_\_\_\_\_ #

21. Where are employees / independent contractors placed, (by percentage)?

Private Homes \_\_\_% Hospitals \_\_\_% Nursing Homes \_\_\_% Assisted Living \_\_\_%  
Medical Clinics \_\_\_% Doctor's Offices \_\_\_% Other (describe) \_\_\_\_\_ %

22. What percentage of clients require:

Pediatric Care \_\_\_% Cardiac Care \_\_\_% Respiratory Support \_\_\_% Infusion Therapy \_\_\_%

23. Are any of your employees assigned to temporarily staff the:

Emergency Room  Yes  No  
Labor & Delivery Rooms  Yes  No  
Intensive Care Units  Yes  No

If Yes, number of staff:

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

**24. Health Care Professionals**

<u>Employees/ Contracted Services</u>	<u>Number of Employees</u>	<u>Number of Ind. Contractors</u>	<u>Est. Hours Worked Employees</u>	<u>Est. Hours Worked Contractors</u>	<u>Est. Annual Payroll Employees</u>	<u>Est. Annual Payroll Ind. Contractors</u>
Physical & Respiratory Therapists						
Nurses Temporary Staffing						
Nurses-Other than Temporary Staffing						
Nurse Aides / Home Health Aides / Homemakers						
Medical Technicians						
Pharmacists						
Occupational Therapists / Speech & Hearing Therapists						
Social Workers						
Physician/Physician Assistant						
Nurse Practitioner/ Clinic Nurse Specialist						
Live-In Companions						
All Others (Describe)						

(Complete job descriptions must accompany this application for those professionals indicated in Q. 26 above.)

25. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations.)

	Ins. Carrier & Effective Date	Policy Limits	State of Licensure	License Number	Employee or Contractor	Hours Per Month
Name - Medical Dir.						
Name - Physician						
Name - Physician						

**HIRING / SCREENING AND EMPLOYMENT PROCEDURES**

26. Are employees' / contractors' references contacted before hiring or placement?  Yes  No  
 Check all that apply: \_\_\_\_\_ Written \_\_\_\_\_ Verbal

27. Check all the following that apply if obtained, verified, and filed as part of each employee screening and hiring process:

Applications \_\_\_\_\_ Multi-State Registry \_\_\_\_\_  
 Drug / HIV / Hep. Testing \_\_\_\_\_ Criminal Background Checks \_\_\_\_\_  
 Education/Competency \_\_\_\_\_ Licenses/Annual Confirmation \_\_\_\_\_

28. Does applicant question prospects about previous claims or suits?  Yes  No

29. Are employees required to actively participate in continuing education?  Yes  No

30. Does applicant verify any pending license suspensions, revocations? or pending disciplinary actions?  Yes  No

31. Are professional employees required to carry their own insurance?  Yes  No  
 If Yes, what minimum is required? \$ \_\_\_\_\_  
 Are certificates of insurance kept on file?  Yes  No

**ACCREDITATION**

32. Is applicant a member of?  
 JCAHO \_\_\_\_\_ National Association of Home Care \_\_\_\_\_  
 CHAP \_\_\_\_\_ National League for Nursing \_\_\_\_\_  
 Nat'l Homecaring Council \_\_\_\_\_ Nat'l Assoc. For Home Care \_\_\_\_\_  
 Nat'l Assoc. of Private Duty \_\_\_\_\_ American League for Nursing \_\_\_\_\_  
 Am. Public Health Assoc. \_\_\_\_\_ Nat'l Hospice Organization \_\_\_\_\_  
 Other \_\_\_\_\_

33. Is applicant licensed to do business in the states listed above where required?  Yes  No  
 Has applicant's license ever been suspended, revoked or restricted?  Yes  No  
 (If yes, please provide details). \_\_\_\_\_

34. Is applicant certified for Medicare / Medicaid reimbursement?  Yes  No

**RISK MANAGEMENT**

35. What management body oversees the quality of patient care?  
 (i.e. medical director, advisory board, etc.) \_\_\_\_\_

36. Do you have a formal written quality assurance and risk management program?  Yes  No  
 Person Responsible: \_\_\_\_\_ Title: \_\_\_\_\_

37. Does applicant participate in any health fairs / health screening?  Yes  No

38. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers. Please explain in an attachment any "No" answers.

- a. Physician notification in the event of changes in the patient's condition  Yes  No
- b. Communication to supervisors and team members  Yes  No
- c. Drug administration procedures  Yes  No
- d. Medical emergencies  Yes  No
- e. Daily work reports (Nursing reports, hospital notes, etc.)  Yes  No
- f. Patient selection / Physician home care treatment plan  Yes  No
- g. Service discontinuation  Yes  No
- h. Safe lifting, transferring and ambulating  Yes  No
- i. Incident reporting (medication errors, patient injury, etc.)  Yes  No
- j. Sexual / Physical Abuse awareness training  Yes  No
- k. Advance directives (Living Will)  Yes  No
- l. Medical equipment training  Yes  No
- m. Patient's rights  Yes  No

**CONTRACTUAL AGREEMENTS**

39. Does applicant enter into contractual agreements (i.e. hospitals, nursing homes)?  Yes  No

40. Do contractual agreements contain hold harmless or indemnification clauses favorable to the applicant?  Yes  No

41. Is applicant required to name any other entity as an additional insured?  
 If so, please list name and address of each entity and the business relationship.

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

**GENERAL LIABILITY**

42. Does applicant sponsor any sporting, fundraising or social events?  Yes  No  
 Please explain \_\_\_\_\_

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

44. Does applicant rent or lease any medical supplies and/or equipment?  Yes  No  
If Yes, Annual Receipts \$ \_\_\_\_\_

**INVENTORY (products handled)** is based on your Gross Revenue in percentages. Gross Revenue percentages must equal 100%.

Apnea Monitors	___%	Oxygen Concentrators	___%	Wheelchairs	___%
Ventilators-Life Support	___%	Oxygen Valves/Reg.	___%	Tens Units	___%
Install Grab/Safety Bar	___%	Scooter/Tn-Carts	___%	Disposable	___%
Sell Grab/Safety Bar	___%	Motorized Wheelchairs	___%	Beds, crutches,	___%
Van Conversions	___%	Stair Lifts	___%	walkers, commodes	___%
Oxygen Cylinders	___%	<input type="checkbox"/> residential	___%	CPM	___%
(Pressure)	___%	<input type="checkbox"/> commercial	___%	Braces <input type="checkbox"/> pre-made	___%
Liquid Oxygen	___%	Wheelchair Lifts	___%	CPAP/ BiPAP	___%
Parenteral Therapy	___%	Enteral Therapy	___%	Nebulizers	___%
Pharmacy	___%	Other Items List Below	___%	Low Air Loss Mattress	___%
		_____	___%	Latex Gloves ***	___%

**TOTAL of all three columns (Must = 100%):** \_\_\_\_\_

45. Do you use any independent contractors for your HME business (1099's)?  Yes  No  
If yes, how many? \_\_\_\_\_

46. Do you contract or subcontract labor for installation, service or repair of any products?  Yes  No  
If yes, what items \_\_\_\_\_

47. Do you provide any type of warranty?  Yes  No  
If yes, please explain \_\_\_\_\_

48. Do you or your employees install any equipment (i.e. involving the use of tools of any kind) in customers homes?  Yes  No  
If yes, what equipment \_\_\_\_\_

**Pharmacy – If there is any percentage shown above next to Pharmacy, please answer the following questions.**

49. Is pharmacy a closed door pharmacy or open door pharmacy?  Closed Door  Open Door

If closed door, what kind of meds are you doing? \_\_\_\_\_

50. Are you mixing?  Yes  No

If mixing, what is your procedure? \_\_\_\_\_

51. Is there a pharmacist on staff?  Yes  No

52. Does the pharmacist carry their own Professional Liability policy?  Yes  No

**EMPLOYEE BENEFITS LIABILITY** (General Liability Coverage must be selected)

53. Limits Requested: \$ 25,000 per Incident / \$ 50,000 aggregate  
\$ 100,000 per Incident / \$ 300,000 aggregate  
\$ 500,000 per Incident / \$ 500,000 aggregate  
\$ 500,000 per Incident / \$1,000,000 aggregate  
\$1,000,000 per Incident / \$1,000,000 aggregate  
\$1,000,000 per Incident / \$2,000,000 aggregate

54. Average professional turnover \_\_\_\_\_% Average non-professional turnover \_\_\_\_\_%

55. Employee Benefits provided:  Health  Life  401K  Section 125

**HIRED AND NON-OWNED AUTOMOBILE LIABILITY**

(General Liability Coverage must be selected. Hired Auto Liability will only be written in combination with Non-Owned Auto Liability.)

56. Limits Requested: \$ 100,000 per Incident / \$ 100,000 aggregate  
\$ 250,000 per Incident / \$ 250,000 aggregate  
\$ 500,000 per Incident / \$ 500,000 aggregate  
\$1,000,000 per Incident / \$1,000,000 aggregate

57. Do you have existing Auto coverage with another carrier?  Yes  No

58. Are driving records, MVR's checked annually?  Yes  No

59. Estimated annual number of non-medical patient transports:

Employee Vehicle Transports \_\_\_\_\_ Client Vehicle Transports \_\_\_\_\_

60. Are employees required to carry personal auto insurance?  Yes  No

If Yes, what minimum limit is required? \$ \_\_\_\_\_

Are certificates of insurance kept on file?  Yes  No

**HIRED AUTOMOBILE LIABILITY** (General Liability Coverage must be selected. Hired Auto Liability will only be written in combination with Non-Owned Auto Liability.)

61. For what purpose, do you require hired autos?

\_\_\_\_\_

62. Average number of hired autos rented/leased annually: \_\_\_\_\_

63. Average number of borrowed autos annually \_\_\_\_\_

64. Type of autos rented/leased/borrowed: \_\_\_\_\_

65. Average term of rental/lease agreement: \_\_\_\_\_

66. Estimated cost of rented/leased autos for this year: \_\_\_\_\_

**NON-OWNED AUTO LIABILITY** (General Liability Coverage must be selected. Non-Owned Liability will  
can be written stand alone or in combination with Hired Auto.)

67. How often are non-owned autos used in your business?  Daily  Weekly  Monthly

68. Are non-owned autos likely to be operated beyond 50 miles?  Yes  No

If yes, how often and why? \_\_\_\_\_

**STOP GAP LIABILITY**

69. Stop Gap Liability (General Liability Coverage must be selected)

Each Person \$ \_\_\_\_\_

Each Disease \$ \_\_\_\_\_

Total Limit \_\_\_ \$ \_\_\_\_\_

70. Total Annual Payroll by State: \_\_\_\_\_

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

**YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.**

**This applicant declares** that the information contained in the application is true and that no material facts have been suppressed or misstated.

**The applicant understands** that incorrect or incomplete information could void their protection.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Underwritten by United National Insurance Company, Diamond State Insurance or any members of United National Group.

**SIGNATURE OF APPLICANT X** \_\_\_\_\_ **DATE X** \_\_\_\_\_

(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Producer's Address:

\_\_\_\_\_  
Street City State/Zip

Surplus Lines Agent License #

**(Applicable in AL, CO, FL, LA, MA, MS, NH, NJ, NM, NY, OK, RI, SD, TN, WV, and HI)**

**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.