GREENHILL
INSURANCE SERVICES

Mailing Address:
1707 Post Oak, Suite 279
Houston, Texas 77056
WWW.GRNHLL.COM

Home Health Care / Medical Staffing Application

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 dba's): _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (_____) _____ Fax (_____) _____

Email: _____

Website: _____

1.6 The Applicant is (Please check all that apply)

A. The **APPLICANT** is a: ☐ Staffing Agency ☐ Home Healthcare Agency/Hospice Services

1.7 Entity is: ☐ For Profit ☐ Non-Profit

Please describe source of funds: _____

_____

1.8 Requested Limits of Liability (if available): $_____/$ _____

1.9 Annual Gross Receipts: Estimated next twelve months - $_____

Last twelve months - $_____

1.10 Annual Remuneration: Estimated next twelve months - $_____

Last twelve months - $_____

1.11 List all memberships in professional organizations: _____

_____

PART II. EXPOSURES

2.1 Healthcare Staff: Please indicate the next twelve months estimated figures for each of the following categories of staff, hours worked and compensation.

2.1.1 Employed Staff (W-2):

Type	Maximum No.	Annual Hours of Service	Annual Remuneration
Registered Nurse			$
Licensed Practical Nurse			$
Nurse Practitioner			$
Physical Therapist			$
Occupational Therapist			$
Respiratory Therapist			$
Psychotherapist Speech			$
Therapist Social			$
Workers			$
Aides, Homemakers			$
Physicians*			$
Other:			$
Employed Subtotal			$

2.1.2 Contracted Staff (1099):

Type	Maximum No.	Annual Hours of Service	Annual Remuneration
Registered Nurse			$
Licensed Practical Nurse			$
Nurse Practitioner			$
Physical Therapist			$
Occupational Therapist			$
Respiratory Therapist			$
Psychotherapist Speech			$
Therapist			$

Social Workers	_____	_____	$_____
Aides, Homemaker	_____	_____	$_____
Physicians*	_____	_____	$_____
Other:	_____	_____	$_____
Contracted Subtotal **Total**	_____	_____	**$**_____

*Other than Medical Director, show no. of patient visits in lieu of hours of service, and complete Physician 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:

___% Skilled Care _____% Companion Care/ HHA

2.1.5 Enter percentage of services provided by location including contracted staff:

Home Healthcare Services:

_____% Nursing Homes / Assisted Living
_____% Private Home Care
_____% Hospitals
_____% Private Doctors/Clinics
_____% Other (Describe):_____

Of the total of all home health care services, indicate the percentage of services for the following:

_____% IV Therapy
_____% Wound Care
_____% Vent/Trach/G-Tube Care
_____% Alz/Dementia Care
_____% Pediatric/infant childcare including "babysitting"
_____% Live-in/24 hour care.
If any, is this handled in shifts? Yes ____ No____
If any, what percentage is care administered by a family member ____%

Healthcare Staffing Services:

_____ % Nursing Homes / Assisted Living
_____ % Private Home Care
_____ % Correctional Staffing
_____ % Private Doctors/Clinics
_____ % Hospitals
_____ % Hospice
_____ % Physical Rehab Facility
_____ % Behavioral Health Facility
_____ % Substance Abuse Facility
_____ % Other (Describe): _____

If staffing hospitals, please provide a breakdown by department:

_____ % ICU
_____ % Emergency Room/Dept
_____ % Labor &Delivery/OB
_____ % NICU/PICU
_____ % Med/Surg/OR
_____ % Other (Describe): _____

2.2 Does the Applicant need coverage for Hired-Non Owned Auto Exposure? Yes ____ No____

If Yes, Please answer the following questions:

Does the Applicant check MVRs annually? Yes ____ No____

Does the Applicant require drivers to maintain state minimum personal insurance limits? Yes ____ No____

Please Provide number of annual reimbursable mileage or Driver Count : _____

PART III. RISK MANAGEMENT

3.1 Name, qualifications and number or years of experience of the Medical Director:

Name	Title	Experience/Training	Association Membership

3.2 Does your Agency have a written credentialing policy and procedure for all individual's associated with or practicing within the Agency? ☐ Yes ☐ No

3.3 Does the applicant 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 Does the applicant 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 applicant's 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 Is the applicant equipped with an emergency 24 hour telephone call line for all of staff and patients? ☐ Yes ☐ No

3.10 Does the applicant 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 contracts. ☐ 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 Does the applicant maintain a written clinical record showing the total number of visits by each category of staff for each patient? ☐ 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

Please explain any exceptions: _____

_____

_____

3.14 Does applicant's 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,** please 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, joint ventures in which your facility is Currently engaged which would fall outside the scope of typical home healthcare operations.

☐ None ☐ Description Attached

PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date? _____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date? _____

4.3 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).

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 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,** please 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 Greenhill Insurance Services, LLC. 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 <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

Date Applicant Title