



P.O. Box 768 Hendersonville, TN 37077  
 800-768-7475 Fax (615) 264-3980  
 www.bsris.com

**ALLIED MEDICAL HOME HEALTH CARE MEDICAL STAFFING AGENCY  
 SUPPLEMENTAL APPLICATION  
 SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION**

**TYPE OF FIRM:**

- Home Health Care                       Medical Equipment Supplier (Complete DME Supplement)  
 Nurse Registry                               Supplemental Staffing                       Other

**GENERAL INFORMATION:**

- Number of independent contractors: \_\_\_\_\_  
 Cost of independent contractors: \$ \_\_\_\_\_
- Do you require and keep certificates of insurance for all independent contractors?       No  Yes
- Does the applicant utilize a formal written Quality Assurance & Risk Management Program?  No  Yes  
 If "No," explain: \_\_\_\_\_
- Is the overall responsibility for Risk Management assigned to one individual in your firm?       No  Yes  
 If "Yes," explain: \_\_\_\_\_
- Is an informed consent document placed in the patient's medical record?       No  Yes  
 Does the applicant conduct patient/client surveys? **(If "Yes," attach sample)**       No  Yes  
 Are the results of patient/client surveys used to improve day to day operations?       No  Yes

**THIS SECTION MUST BE COMPLETED:**

- Description of employees or contracted personnel:

	Number of Employees	Number of Independent Contractors	Do All Workers Carry Their Own Insurance	Where are services rendered?				
				% in Hospitals		% in Nursing Homes		% in Private Homes
				*S.S.	*P.D.	S.S.	P.D.	
Aids			<input type="checkbox"/> No <input type="checkbox"/> Yes					
LPN's			<input type="checkbox"/> No <input type="checkbox"/> Yes					
RN's			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Nurse Practitioner			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Physical Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Respiratory Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Speech Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Occupational Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Social Worker			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Pharmacist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Special Training			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Physicians' Assistants			<input type="checkbox"/> No <input type="checkbox"/> Yes					
CRNA's			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Other (specify):			<input type="checkbox"/> No <input type="checkbox"/> Yes					

\*S.S. = Supplemental Staffing, P.D. = Private Duty

7. Give percentage of patients in the following age ranges: \_\_\_\_\_% 0-4      \_\_\_\_\_% 5-17  
 \_\_\_\_\_% 18-35      \_\_\_\_\_% 36-50      \_\_\_\_\_% 51-65      \_\_\_\_\_% 65+
8. Indicate percentage of revenue derived from IV Therapy: \_\_\_\_\_%

Percentage of Types of Services Provided (total must equal 100%)

Personal Care Chore or Ccompanion	_____%	Respiratory Therapy (trach care?/ventilator care?)	_____%
Rehabilitation	_____%	Radiation Therapy	_____%
Infusion Therapy	_____%	Skilled Nursing Care	_____%
Hospice	_____%	Social Services	_____%
Supplemental Staffing	_____%	Infant Care	_____%
Obstetrical Services	_____%	Pediatric Care	_____%
Adult Day Care*	_____%	Retail Pharmacy	_____%
Child Day Care*	_____%	Closed Pharmacy	_____%
Medical Equipment Supplier	_____%	Clinics Owned/Operated	_____%
Meals on Wheels	_____%	Other Services (please specify)	_____%
Skin Care or Bedsore Wound Care	_____%		

\*Firms providing day care may be required to complete a supplemental application

9. Are employees/contractors references contacted before hired/placed?  No  Yes  
 How are references checked? \_\_\_\_\_Written      \_\_\_\_\_Verbal      \_\_\_\_\_Both  
 If "Verbal only," please explain: \_\_\_\_\_
- Do you perform criminal background checks on prospective employees/contractors?  No  Yes  
 If "No," please explain: \_\_\_\_\_
- Do you question prospective employees in their previous involvement as defendants in professional malpractice litigation?  No  Yes  
 If "No," please explain: \_\_\_\_\_
- Is certification and/or professional licensure status of employees & independent contractors verified?  No  Yes
- Are employees screened to rule out drug, alcohol and/or sexual abuse?  No  Yes
- Are job descriptions provided for all professional and nonprofessional employees?  No  Yes
10. Describe services performed by your LPN's/RN's: \_\_\_\_\_  
 \_\_\_\_\_
11. Do you supply medical equipment or are your personnel responsible for monitoring equipment?  No  Yes  
 If "Yes," describe all such equipment: \_\_\_\_\_
12. Do you sell or lease any equipment?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_
13. Do you repair or maintain any medical equipment?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_
14. Receipts from equipment sales, leasing or repair: \$ \_\_\_\_\_
15. Provide details for licensing or certification needed for this operation: \_\_\_\_\_

16. How long have you been licensed/certified? \_\_\_\_\_

17. Has your license ever been suspended or revoked?  No  Yes  
If "Yes," please explain: \_\_\_\_\_

18. Your premium is adjustable based on your total receipts. Our auditor will verify your total receipts. If this information is kept by your accountant, provide the accountants name, address and phone number: \_\_\_\_\_  
\_\_\_\_\_

If this information is kept by you, provide the telephone number and address where the records are kept.  
\_\_\_\_\_

19. Physical abuse/sexual molestation coverage for protection of alleged acts of your employees?  No  Yes

**SUPPLEMENTAL STAFFING:**

20. Do you provide temporary workers to other businesses or institutions?  No  Yes

21. Do you acknowledge that the Colony Insurance policy does not cover liability you assume in any contract or agreement?  No  Yes

**SUPPLEMENTAL STAFFING (continued):**  No  Yes

22. Do contracts you sign make your company liable for negligent acts of those temporary workers while they are working in and being supervised by those other businesses or institutions?

23. Do you require those temporary workers to maintain their own professional liability policies?  No  Yes  
Do you verify coverage?  No  Yes  
How often? \_\_\_\_\_

24. Do you staff any hospitals?  No  Yes  
If "Yes," do you staff any Labor & Delivery, Emergency Room or Surgery positions?  No  Yes  
If "Yes," estimated annual revenue from these placements: \$ \_\_\_\_\_

25. Do you staff any correctional facilities?  No  Yes

**DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Sub-Producer

\_\_\_\_\_  
Title/Date

\_\_\_\_\_  
Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.



## ALLIED MEDICAL GENERAL APPLICATION

### APPLICANT'S INFORMATION:

DESIRED EFFECTIVE DATE:

APPLICANT NAME:			
MAILING ADDRESS:			
CITY, STATE, ZIP:			
COUNTY:		PHONE NUMBER:	
INSPECTION CONTACT:		DATE ESTABLISHED:	
YEARS IN BUSINESS UNDER CURRENT MGMT:			
Type of Enterprise:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Municipality <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other: _____		
Estimated receipts/operating budget for the next 12 months:			
Estimated payroll for the next 12 months:			
Type of Operation:	<input type="checkbox"/> Mental Health Inpatient <input type="checkbox"/> Group Home (Elderly) <input type="checkbox"/> Shelters <input type="checkbox"/> Group Home (Non-Elderly) <input type="checkbox"/> Alcohol/Drug Inpatient <input type="checkbox"/> Foster Care (children) <input type="checkbox"/> Alcohol/Drug Detox. <input type="checkbox"/> Independent Living (Elderly) <input type="checkbox"/> Halfway House <input type="checkbox"/> Independent Living (Non-Elderly) <input type="checkbox"/> Apartments <input type="checkbox"/> Other (specify)		
Full description of services rendered:	_____ _____ _____		

### Current Insurance:

Has applicant had previous insurance for this enterprise?

No     Yes

If "Yes," complete the following:

General Liability		Professional Liability	
Current Carrier		Current Carrier	
Policy term		Policy term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	
Retro date if Claims Made		Retro date if Claims Made	

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? If "Yes," complete the following (use a separate sheet if necessary):  No  Yes

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, been aware of any circumstances which may result in a claim?  No  Yes  
 If "Yes," provide full details: \_\_\_\_\_  
 \_\_\_\_\_

Has any license or accreditation ever been suspended, denied or revoked?  No  Yes  
 Of what professional association(s) is Insured a member in good standing? \_\_\_\_\_

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation:

Criminal Background Checks  Verification of certification or professional licensing  
 Drug, alcohol and sexual abuse screening or testing  Reference Checks  
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation.

Schedule of Physicians – on Staff or Contracted:					
Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you want the physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If "Yes," please explain: _____					<input type="checkbox"/> No <input type="checkbox"/> Yes
Is electroshock therapy utilized? If "Yes," how many per year? _____					<input type="checkbox"/> No <input type="checkbox"/> Yes

**Schedule of Location:** (if more than three locations, attach a separate sheet of locations)

#1 Address	
Types of Services Provided	

#2 Address	
Types of Services Provided	
#3 Address	
Types of Services Provided	

Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? If "Yes," describe and submit brochure or detailed narrative of activities.	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any animal exposures on premises? <input type="checkbox"/> Owned? <input type="checkbox"/> Non-owned? If "Yes," please explain, including number of animals and type/breed: _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any swimming or boating activities?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is pool fenced with a self-locking gate?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Diving board?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Slide?	<input type="checkbox"/> No <input type="checkbox"/> Yes

<input type="checkbox"/> Residential or Inpatient – <b>complete supplemental application</b>
<input type="checkbox"/> Foster Care or Adoption – <b>complete supplemental application</b>

<b>Check the coverages and limits that the applicant would like quoted:</b>				
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach acord app)	<input type="checkbox"/> Excess _____ (attach acord app)
	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500	
	<input type="checkbox"/> 1/1	<input type="checkbox"/> 1/2	<input type="checkbox"/> 1/3	
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees?				
At what limits:	<input type="checkbox"/> 25/50	<input type="checkbox"/> 50/100	<input type="checkbox"/> 100/300	
	<input type="checkbox"/> 250/250	<input type="checkbox"/> 500/500	<input type="checkbox"/> Other _____	

\*\*\*\*\*

**Please attach a copy of the following with your submission:**

- (If Prior Acts coverage is desired) Prior Acts supplement, available on the website: [www.colonyins.com](http://www.colonyins.com)
- Five years of currently dated loss runs (if in business less than five years, please attach a resume of the owner/director)
- Brochure(s) available or other information pertaining to the programs offered

**DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Sub-Producer

\_\_\_\_\_  
Title/Date

\_\_\_\_\_  
Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.