ARGO PRO
Member Argo Group

BSR
PO Box 768 · Hendersonville, TN 37075
(T) 800-768-7475 · (F) 615-264-3980
www.bsrins.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:

1. Number of independent contractors:_____Cost of independent contractors:$_____
2. Do you require and keep certificates of insurance for all independent contractors? ☐ No ☐ Yes
3. Does the applicant utilize a formal written Quality Assurance & Risk Management Program? ☐ No ☐ Yes
   If "No," explain:_____
4. Is the overall responsibility for Risk Management assigned to one individual in your firm? ☐ No ☐ Yes
   If "Yes," explain:_____
5. 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:

6. 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			☐ No ☐ Yes					
LPN's			☐ No ☐ Yes					
RN's			☐ No ☐ Yes					
Nurse Practitioner			☐ No ☐ Yes					
Physical Therapist			☐ No ☐ Yes					
Respiratory Therapist			☐ No ☐ Yes					
Speech Therapist			☐ No ☐ Yes					
Occupational Therapist			☐ No ☐ Yes					
Social Worker			☐ No ☐ Yes					
Pharmacist			☐ No ☐ Yes					
Special Training			☐ No ☐ Yes					
Physicians' Assistants			☐ No ☐ Yes					
CRNA's			☐ No ☐ Yes					
Other (specify):			☐ No ☐ 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 Companion	_____%	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

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

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.

COLONY SPECIALTY
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ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Desired Effective Date: _____
2. Applicant Name: _____
3. Mailing Address: _____
4. City, State, Zip: _____
5. County: _____ 6. Telephone Number: _____
7. Inspection Contact: _____ 8. Website Address: _____
9. Date Established: _____ 10. Years in Business Under Current Management: _____
11. Type of Enterprise: ☐ Corporation ☐ Individual ☐ Partnership ☐ Joint Venture
    ☐ Municipality ☐ In-Patient -Psychiatric
    ☐ Other (describe): _____
12. Enterprise is: ☐ For Profit ☐ Not For Profit
13. Estimated receipts/operating budget for the next twelve (12) months: _____
14. Estimated payroll for the next twelve (12) months: _____
15. Type of Operation:
    ☐ Mental Health Inpatient ☐ Group Home (Non-Elderly)
    ☐ Prison/Jail ☐ Boot Camp ☐ Lock-down Facility ☐ Shelters/Halfway House
    ☐ Alcohol/Drug Detox. ☐ Alcohol/Drug Inpatient ☐ Apartments ☐ Foster Care (children)
    ☐ Independent Living (Elderly) ☐ Assisted Living Facility
    ☐ Other (describe): _____
16. Full description of services rendered: _____

II. CURRENT INSURANCE

This section must be completed for prior acts consideration. Attach a copy of expiring policy declarations page.

1. a. Has Applicant had previous insurance for this enterprise? ☐ Yes ☐ No

   b. If Yes, complete the following for prior three (3) years of general/professional liability coverage:

Name of Carrier	Effective Date	Expiration Date	Limit	Deductible	Premium	Claims Made (CM) or Occurrence?	CM Retroactive Date

III. CLAIMS ACTIVITY AND INCIDENT REPORTING PROCEDURES

1. Claims and Incident Activity

Important Notice: All known claims and/or incidents that could reasonably result in a claim are specifically excluded from coverage. Report all such claims or incidents to your current insurer. Your failure to disclose any claim, or incident that could reasonably result in a claim, may result in the proposed insurance being void and/or subject to rescission.

a. Claims Activity - Please list all claims that have been presented to you or to your past or your current insurer during the past five years. Please continue on a separate sheet of paper if necessary.

Date of Loss	Current Reserve or Paid Amount	Description of Loss	Insurer

b. Incident Activity - Please outline the details below regarding any of the following incidents that have taken place at any of your facilities for which coverage is being requested, but where such incidents have not been reported to any insurer:

Death of a client, patient or resident from other than natural causes;

Injury to a client, patient or resident that required hospitalization;

Incident involving abuse, molestation, sexual assault, rape or improper contact;

Incident that generated a formal complaint or notice from any federal or state regulatory body;

Injury resulting from an elopement or unauthorized absence of a client, patient or resident;

Improper medication or improper dosage resulting in hospitalization; or

Decubitus ulcer(s) first acquired under your care that have reached Stage IV.

_____

_____

_____

_____

_____

1) Are there any other known incidents that could reasonably be expected to result in a claim against the Applicant? ☐ Yes ☐ No

2) Have all known incidents that could reasonably be expected to result in a claim been reported to your current or prior insurer? ☐ Yes ☐ No

2. Risk Management Protocols

a. Are there procedures in place requiring the documentation of all incidents in a written report? ☐ Yes ☐ No

b. Who is responsible for receiving and recording information relating to incidents and reporting them to your insurer?

Name: _____ Title: _____

3. Other

a. Has any license or accreditation ever been suspended, denied or revoked? ☐ Yes ☐ No

b. Please list all professional association(s) in which the Applicant is a member in good standing:

_____

c. Has the Applicant ever had its professional liability insurance policy cancelled or non-renewed? ☐ Yes ☐ No

d. If Yes, please explain: _____

_____

IV. OPERATIONS

1. Indicate current staffing levels:

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

2. 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

3. **Schedule of Physicians** – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer, Contracted or Employed	Has Malpractice Insurance
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

4. List the duties of the physician(s) in 3. above: _____

_____

5. Do you want any listed physician to be covered under the facility's policy? ☐ Yes ☐ No

6. a. Are any drugs or medications administered or prescribed? ☐ Yes ☐ No

b. If Yes, please explain: _____

_____

V. LOCATION INFORMATION

1. **Schedule of Locations:** If more than five locations, please attach a separate sheet of locations.

	Address	Types of Services Provided
# 1		
# 2		
# 3		
# 4		
# 5		

2. a. Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? ☐ Yes ☐ No

   b. If Yes, please submit brochure or describe activities: _____

3. a. Are there any firearms on the premises? ☐ Yes ☐ No

   b. If Yes, please describe: _____

   c. Are the firearms locked in a secure place away from the residents? ☐ Yes ☐ No

   d. If No, please describe: _____

4. a. Are there any animal exposures on the premises?Yes ☐ No b.☐If

   Yes, are the animal exposures: ☐ Owned? ☐ Non-owned?

   c. If Yes, please describe, including number of animals and type/breed: _____

5. a. Are there any lakes, ponds, rivers, pools or other bodies of water on the premises? ☐ Yes ☐ No

   b. If Yes, please describe: _____

   c. Are there any swimming or boating activities? ☐ Yes ☐ No

   d. If there is a pool or body of water, then is it fenced with a self-locking gate? ☐ Yes ☐ No

   e. If there is a pool or body of water, then is there a diving board and/or slide? ☐ Yes ☐ No

VI. COVERAGE REQUESTED

1. Complete and attach the appropriate supplemental application with your submission.
2. Check the coverages and limits that the Applicant would like quoted:

   a. Coverages: ☐ GL ☐ Professional ☐ Excess (Attach Acord App)

   b. Limits: ☐ $100,000/$100,000 ☐ $300,000/$300,000 ☐ $500,000/$500,000
   ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/$3,000,000

3. a. Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? ☐ Yes ☐ No

   b. If Yes, at what limits? ☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000
   ☐ $250,000/$250,000 ☐ $500,000/$500,000 ☐ Other: _____

Please attach a copy of the following with your submission:

Five (5) years of currently dated loss runs (if in business less than five (5) years, please attach a resume of the owner/director)

Brochure(s) available or other information pertaining to the programs offered

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* Not applicable in all states

WARRANTY STATEMENT AND SIGNATURE:

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

Authorized Signature on behalf of Applicant	Sub-Producer
Title/Date	Producer

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