

# HOME HEALTH APPLICATION

## I. APPLICANT INFORMATION

Applicant: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Requested Policy Period: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 12:01 a.m. to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 12:01 a.m.

Website: \_\_\_\_\_ Federal Tax ID: \_\_\_\_\_

## II. OPERATIONS

Are you part of a franchise system or membership group?  YES  NO Name: \_\_\_\_\_

Type of Operation: (✓)

1.  Home Health Care
2.  Non-Medical Services
3.  Medical Staffing
4.  Durable Medical Equipment
5.  Adult Day Care
6.  Other \_\_\_\_\_

Years in Business under this name: \_\_\_\_\_

Gross Receipts for the last 12 months: \$ \_\_\_\_\_

Estimated Gross Receipts for the next 12 months: \$ \_\_\_\_\_

Do you provide services in any of the following areas? If so, please note what % of total revenue comes from that service.

<input type="checkbox"/> Nursing Home, Assisted Living or Independent facilities	_____ %	<input type="checkbox"/>	Prisons	_____ %
<input type="checkbox"/> Private Homes	_____ %	<input type="checkbox"/>	Hospitals	_____ %
<input type="checkbox"/> Pediatrics	_____ %	<input type="checkbox"/>	Physicians Offices/Clinics	_____ %

Do you use independent contractors in lieu of employees?  YES  NO

Do employees provide incidental patient/client transportation in their personal vehicles?  YES  NO

If YES, number of transports per year \_\_\_\_\_

Are MVRs checked annually for all employees driving for company business or transporting patients/clients?  YES  NO

Do you require your employees to carry at least minimum liability limits on their personal auto policy?  YES  NO

Do you keep a copy of evidence of insurance for your employees driving their vehicle for company business?  YES  NO

**III. GENERAL UNDERWRITING INFORMATION**

Are you currently insured for General & Professional Liability?  YES  NO

If YES, please complete the following items:

- a) Name of Insurance Company \_\_\_\_\_
- b)  Claims Made Form  Occurrence Form
- c) If Claims-Made
  - a. GL Retroactive Date: \_\_\_\_\_
  - b. PL Retroactive Date: \_\_\_\_\_
- d) Limits of Insurance: \$ \_\_\_\_\_
- e) Premium: \$ \_\_\_\_\_
- f) Liability Deductible: \$ \_\_\_\_\_
- g) Physical Sexual Abuse sublimit: \$ \_\_\_\_\_

NOTE: This information can be found on your current policy declarations page – or attach a copy of your policy.

Has the Applicant (including owners, managers, partners or administrators) ever:  
(If yes, attach complete explanation)

- a. Been involved in any personal or business bankruptcy? Yes  No
- b. Been arrested, charged or convicted of any civil or criminal violations? Yes  No
- c. Had insurance cancelled or non-renewed? Yes  No

Have any claims/suits been made within the last 5 years against the applicant?  \*YES  NO  
*\*If YES, please attach information specifying date, description, amount paid and amount reserved for each claim.*

Is the applicant aware of any circumstances, which may result in any claim or suit being made, including requests for medical info?  \*YES  NO  
*\*If YES, please attach information specifying date, description, amount paid and amount reserved for each claim.*

Has any insurance company declined, cancelled or refused to renew any of the applicant’s insurance?  \*YES  NO  
*\*If YES, please attach information describing why coverage was denied or cancelled.*

Has the applicant had any incidents or claims reported for physical sexual abuse or any other allegation of abuse?  \*YES  NO  
*\*If YES, please provide FULL details.*

Are there written guidelines regarding sexual misconduct?  \*YES  NO  
*\*If YES, please provide copies of all policies and procedures, including training materials.*

Does the applicant perform background checks on all employees?  \*YES  NO  
*\*If YES, please describe all background checks performed.*

What steps have been taken to prevent or avoid a sexual misconduct incident?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IV. DESIRED COVERAGE INFORMATION (Please provide ACORD apps\*)**

Professional Liability:

Hired & Non-Owned Auto:

Property:

General Liability:

\*Workers Comp:

\*Crime:

Check the professional categories below that are applicable to your operation and provide head count, billed hours and receipts for each:

Profession	Full Time Equivalent (40 Hr. Week)		Billed Hours		% of Receipts
	Employed (W-2)	Contracted (1099)	Employed (W-2)	Contracted (1099)	
Admin/Clerical					
Home Health Aide					
LPN/LVN					
Nurse Aide					
CNA					
Registered Nurse					
Occupational/Speech Therapist					
Social Worker					
Physical Therapist					
Resp. Therapist					
Rehab Therapist					

*NOTE: MD's, DD's, DDS's, Paramedics, PA's, EMT's, Nurse Midwives and Nurse Anesthesiologists are not eligible for coverage.*

List states of operation: \_\_\_\_\_

If multiple states, please complete Multi-state Supplemental at end of application

Are there any medical doctors on the premises?  YES  NO

If YES – are they operating in an administrative capacity?  YES  NO

If NO – Please describe their duties:

\_\_\_\_\_

\_\_\_\_\_

Applicant's Affidavit and Signature: I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that my answers and statements will be the basis for determining my insurability and premium for the applied coverage. I further understand that the completion and signing of this application does not bind the applicant or the company to complete the insurance and supplemental information may be requested to produce a binding quote.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please return your completed application to:



**DURABLE MEDICAL EQUIPMENT SUPPLEMENT**

Will you provide any durable medical equipment?  
(If yes, complete this page)

Yes  No

If yes,  Sale Only  Rental  Sales & Rental

Receipts broken down by category:

Category I: **EXPENDABLE ITEMS** – Intended for one time usage and disposed (i.e., adhesive tape, bandages, or hypodermic needles, etc.)

a. Annual Sales: \$ \_\_\_\_\_

Category II: **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 such as walkers, strollers, canes, crutches, wheelchairs, etc, and prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.

b. Annual Sales: \$ \_\_\_\_\_

c. Annual Lease / Rental Receipts: \$ \_\_\_\_\_

Category III: **DIAGNOSTIC OR TREATMENT DEVICES** – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.

d. Annual Sales: \$ \_\_\_\_\_

e. Annual Lease / Rental Receipts: \$ \_\_\_\_\_

Do you distribute oxygen tanks?

Yes  No

If yes, are they:

Pre-Filled  Self-Filled

If yes, does storage meet NFDA standards?

Yes  No

Category IV: **LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES** – This category includes dialysis or heart/lung machines, apnea monitors, 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 death or serious deterioration in health condition.

f. Annual Sales: \$ \_\_\_\_\_

g. Annual Lease / Rental Receipts: \$ \_\_\_\_\_

Category V: **DURABLE MEDICAL EQUIPMENT** – Does the account sell or rent any of the following types of durable medical equipment? (If yes, please check type below)

Surgical Implant Devices

Anesthesia Equipment

Radiology Equipment

Laboratory Equipment

Blood Cleansing Equipment

Laser Equipment

h. Annual Sales: \$ \_\_\_\_\_

i. Annual Lease / Rental Receipts: \$ \_\_\_\_\_

TOTAL ANNUAL RECEIPTS OF MEDICAL SUPPLIES AND / OR EQUIPMENT (ADD A – I) \$ \_\_\_\_\_

Does applicant rent, lease, repair or do maintenance on any medical or therapeutic supplies or equipment?

Yes  No

If yes, total annual rental receipts of such medical supplies and or equipment:

\$ \_\_\_\_\_

List type of equipment rented or attached schedule:

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

Are service records kept on rentals?

Yes  No



**MULTI-STATE SUPPLEMENTAL**

Location Addresses:

	Street	City	County	ST	ZIP
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____

Combined Revenue By State:

State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____
State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____
State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____
State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____
State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____



**WORKERS COMPENSATION**

Workers Compensation coverage is based on a percentage of your payroll.

To get coverage for the first year of business, we need an estimate of what you plan to pay your employees over the next 12 months. If you're unsure, we can give a quote based on \$30,000 to \$50,000 worth of payroll to get your started.

# of Full Time		# of Part Time		Annual Payroll by Class	Classification or Description
W-2	1099	W-2	1099		
					Certified Caregivers (CNA, LVN, RN)
					Non-Certified Caregivers (Comp. Care Aide)
					Clerical
					Outside Sales
					Other

Total Number of Employees: \_\_\_\_\_

Total Payroll: \$ \_\_\_\_\_

FEIN: \_\_\_\_\_

Ownership Information:

Name	DOB	% Ownership	Corporate Title