



Quaker Special Risk
P.O. Box 1350
Eatontown, NJ 07724
Phone: 800 447-4180 Fax: 732 223 9072

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 PCF? 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
 - \$3,000,000 per Incident / \$5,000,000 Aggregate
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) \$ _____

For the next three coverage parts, please input the exposure information on pages 7 and 8.

15. ____ Non-Owned Auto Liability (General Liability Coverage must be selected)

- \$ 100,000 per Incident / aggregate
- \$ 250,000 per Incident / aggregate
- \$ 500,000 per Incident / aggregate
- \$1,000,000 per Incident / aggregate

16. ____ Employee Benefits Liability / Claims Made (General Liability Coverage must be selected)

Each Person \$ _____
 Total Limit \$ _____
 Prior Acts Date _____

(Attach copy of prior claims made policy Declarations, if applicable.)

17. ____ Stop Gap Liability (General Liability Coverage must be selected)

Each Person \$ _____
 Each Disease \$ _____
 Total Limit \$ _____

18. Per Claim Deductible

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

- none \$1,000 \$5,000
- \$10,000 \$25,000 Other _____

19. 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
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

20. 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
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

CLAIM HISTORY

21. 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.

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

If **Yes**, please explain:

EMPLOYEES / INDEPENDENT CONTRACTORS

23. Total Employees _____ # Total Independent Contractors _____ #

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

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

25. What percentage of clients require:

Pediatric Care ____% Cardiac Care ____% Respiratory Support ____% Infusion Therapy ____%

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

If Yes, number of staff:

Emergency Room Yes No _____

Labor & Delivery Rooms Yes No _____

Intensive Care Units Yes No _____

27. 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.)

28. 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

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

30. 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 _____

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

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

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

34. 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

35. 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 _____

36. 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). _____

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

RISK MANAGEMENT

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

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

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

41. 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

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

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

44. 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

45. Does applicant sponsor any sporting, fundraising or social events? Yes No
 Please explain _____

46. Does applicant sell any medical supplies and/or equipment? Yes No
 If Yes, Annual Receipts \$ _____
47. Does applicant rent or lease any medical supplies and/or equipment? Yes No
 If Yes, Annual Receipts \$ _____
48. Is the applicant named as an additional insured or vendor on the manufacturer's policy for any/all products? Yes No

EMPLOYEE BENEFITS LIABILITY (General Liability Coverage must be selected)

49. 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

50. Average professional turnover _____ % Average non-professional turnover _____ %

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

NON-OWNED AUTOMOBILE LIABILITY (General Liability Coverage must be selected)

52. 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

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

54. Estimated annual number of non-medical patient transports _____

55. 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

STOP GAP LIABILITY

56. 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.

(FAX

NAME: _____
COMPANY: _____
ADDRESS: _____
STATE, ZIP: _____
DATE: _____
NUMBER OF PAGES (incl. Cover): _____
* FAX TO: _____

PLEASE FAX THIS APPLICATION TO THE OFFICE THAT IS NEAREST YOU.

* Click the link below for a list of our offices and current fax numbers.

<http://www.qsr-insurance.com/qsr-fax.html>

ADDITIONAL COMMENTS:

