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

Employees/ Contracted Services	Number of Employees	Number of Ind. Contractors	Est. Hours Worked Employees	Est. Hours Worked Contractors	Est. Annual Payroll Employees	Est. Annual Payroll Ind. Contractors
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? ☐ Yes ☐ No
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.

Quaker Special Risk a division of the Quaker Agency Inc.

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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.

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ADDITIONAL COMMENTS:

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