Boston Insurance Specialists, Inc.
800 South Main Street, Suite 101, Mansfield, MA 02048
Phone: 800.784.1887, Fax: 508.337.3698

Home Health Care General Liability Application

Applicant's Name: _____

_____

Mailing Address: _____

_____

Location Address: _____

_____

Web site Address: _____

Agency Name: _____

Agent: _____

Address: _____

_____

E-Mail: _____

Phone: _____

PROPOSED EFFECTIVE DATE: From _____ **To** _____ **12:01 A.M., Standard Time at the address of the Applicant**

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture
☐ Limited Liability Company ☐ Other (Specify) _____

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE"

Limits Of Liability and Deductible Requested:

General Aggregate (other than Products/Completed Operations)	$
Products & Completed Operations Aggregate	$
Personal & Advertising Injury (any one person or organization)	$
Each Occurrence	$
Damage To Premises Rented To You (any one premise)	$
Medical Expense (any one person)	$
Errors and Omissions Coverage — Each Claim (Included up to General Liability Limits) — Aggregate	$ $
Sexual and/or Physical Abuse Coverage	☐ $50,000/$100,000 (included) ☐ $100,000/$300,000
Other Coverages, Restrictions, and/or Endorsements:	$
Deductible	$

1. **Number of years in operation:** _____

2. **How long under present management?** _____

   (If fewer than five years, attach principals' resumes. If principals in the firm do not have a health care background, then also include the resume of the Director of Nursing or the individual responsible for hiring, screening and monitoring the work activities of applicant's employees.)

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3. Operations conducted in the following states:

State: _____ Licensed with state? .... ☐ Yes ☐ No License No.: _____

State: _____ Licensed with state? .... ☐ Yes ☐ No License No.: _____

State: _____ Licensed with state? .... ☐ Yes ☐ No License No.: _____

4. Services provided by percentage of total operations (must total 100%):

Assisted Living Facilities	%	Midwives/Doula	%
Clinical Trials	%	Nanny/Au Pair	%
Clinics Owned/Operated	%	Nurse—General (LPN, LVN)	%
Convalescent/Nursing Home	%	Nurse—Practitioner	%
Dietician/Nutritionist	%	Nurse—Registered (RN)	%
Homemaker Health Aides	%	Nurse—Student	%
Hospice	%	Nurses Aides (CNA, STNA, NA/R)	%
Hospital	%	Occupational Therapy	%
Infant/Pediatric Care	%	Patient Care Assistants	%
Infusion Therapy Centers	%	Personal and Home Care Aides (AKA—Caregivers, Companions, Personal Attendants, and Sitters)	%
Infusion Therapy:	%		
Antibiotic Therapy	%	Personal Trainers	%
Antiviral Therapy	%	Pharmacist	%
Blood Transfusion	%	Pharmacy	%
Chemotherapy	%	Physical Therapy	%
Dialysis	%	Physician	%
Home Enteral Nutrition (HEN)	%	Physician Assistant	%
Hydration Therapy	%	Radiation Therapy	%
Pain Management	%	Rehabilitation	%
Total Parenteral Nutrition (TPN)	%	Respiratory Therapy	%
Other (describe): _____	%	Respite Care	%
_____		Social Worker	%
Laboratory Services	%	Speech Therapy	%
Licensed Counselors	%	Ventilator	%
Meals on Wheels	%	Other (describe): _____	%
Medical Equipment Supplier	%	_____	
Medical Marijuana Caregivers	%	Other (describe): _____	%

5. Employees and independent contractors are placed (by percentage) at the following locations:

Assisted Living Facilities	%	Laboratories	%
Clinics	%	Owned Facility Describe services: _____ _____	%
Convalescent/Nursing/ACLF Homes	%		
Home Health—Private Homes	%		
Hospice Facilities	%	Physician's Office	%
Hospitals	%	Schools	%

Infusion Therapy Centers	%	Other (describe): _____	%
Jails/Prisons/Detention Centers	%	_____	

(Attach any brochures, literature or descriptive materials provided to the client.)

6. **If employees or independent contractors are placed in hospitals, clinics, physician's offices, hospice, convalescent/nursing/ACFL homes, jails, prisons or detention centers, advise if hired by:** ..... ☐ facility ☐ patient ☐ patient's guardian

7. **Employees and Independent Contractors—Annual Staffing:**

Professional Classification Type	EMPLOYEES		INDEPENDENT CONTRACTORS
	Number of Employees		Number of Subcontracted Workers
	Full Time	Part Time	
Dietician/Nutritionist			
Infant/ Pediatric Care			
Licensed Counselors			
Medical Director			
Medical Marijuana Caregiver			
Nurse—Practitioner			
Nurse—Registered (RN)			
Nurse—General (LPN,LVN)			
Occupational Therapist			
Pharmacist			
Physical Therapist			
Physician			
Physician Assistant			
Psychologist			
Rehabilitation Therapist			
Respiratory Therapist			
Social Worker			
Speech Therapist			
X-Ray Technicians			
Other (describe):			

Non-Professional Classification Type	EMPLOYEES		INDEPENDENT CONTRACTORS
	Number of Employees		Number of Subcontracted Workers
	Full Time	Part Time	
Certified Nursing Assistants (CNA)			
Homemaker Health Aides			
Midwives/Doula			
Nanny/Au Pair			

Nurse Aides			
Nursing Assistants—Registered (NA/R)			
Patient Care Assistants			
Personal and Home Care Aides			
Social Worker			
Student Nurses			
Other (describe):			

Operations—Payroll and Sales Information	PROFESSIONAL		NON-PROFESSIONAL	
	Annual Payroll/Cost	Annual Sales/Receipts	Annual Payroll/Cost	Annual Sales/Receipts
Employees providing services away from owned or operated health care facilities				
Employees providing services at owned or operated health care facilities				
Independent Contractors providing services away from owned or operated health care facilities				
Independent Contractors providing services at owned or operated health care facilities				
Medical Equipment/Supplies Sales and Rental				
Pharmacy owned or operated by applicant				
Transportation Services				
Other (describe):				
Total:				

8. **Schedule of Hazards:**

9. **Has applicant's license ever been revoked, suspended, voluntarily surrendered, or had enforcement action?**..... ☐ Yes ☐ No

   If yes, provide details and corrective action taken: _____

10. **Name all subsidiary companies/locations and others coming under applicant's control** (if none, please state):

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11. Is the applicant a member of any:

a. State Association? ☐ Yes ☐ No

If yes, name of association(s): _____

b. Industry Association? ☐ Yes ☐ No

If yes, name of association(s): _____

c. Health Care accrediting organization? ☐ Yes ☐ No

If yes, name of organization(s): _____

12. Has applicant sold, acquired or discontinued any operations in the last five years or plan to change operations within the next year? ☐ Yes ☐ No

If yes, explain: _____

_____

13. Is at least one of the principals or an Administrator/Director of Nursing involved in the operation on a full time basis? ☐ Yes ☐ No

14. Does applicant provide foster care placement? ☐ Yes ☐ No

15. Applicant's workforce is comprised of:

Employees _____% Independent Contractors _____%

16. As part of hiring/screening of new employees or independent contractors, does applicant:

a. Verify certifications and/or professional licenses and confirm status? ☐ Yes ☐ No

b. Contact applicants' references before they are hired/placed? ☐ Yes ☐ No

c. Require, if hired/placed, that they sign a formal confidentiality statement? ☐ Yes ☐ No

d. Obtain criminal background checks? ☐ Yes ☐ No

e. Review sexual abuse registry? ☐ Yes ☐ No

f. Conduct a personal interview? ☐ Yes ☐ No

g. Validate education? ☐ Yes ☐ No

h. Validate work history? ☐ Yes ☐ No

i. Have a formalized disease, drug or alcohol screening process? ☐ Yes ☐ No

j. Validate driver's license? ☐ Yes ☐ No

k. Ask if any previous involvement as a defendant in professional malpractice litigation? ☐ Yes ☐ No

l. Ask if they ever had their license revoked, suspended, or had disciplinary action taken against them? ☐ Yes ☐ No

17. When using independent contractors, does applicant require the following information from them:

a. Professional Liability Certificate of Insurance? ☐ Yes ☐ No

If yes, specify minimum limits required: $_____

b. Historical Loss Information? ☐ Yes ☐ No

c. Hold Harmless and indemnification clauses favorable to the applicant? ☐ Yes ☐ No

18. Does applicant have formal documented training in place for the following:

a. Crisis Management? ☐ Yes ☐ No

b. Disposal of medical waste, controlled substances, contaminated supplies or equipment? ☐ Yes ☐ No

c. First Aid, CPR, and AED Training? ☐ Yes ☐ No

d. Infusion Therapy? ☐ Yes ☐ No

e. Safe lifting, transferring, and client handling? ☐ Yes ☐ No

f. Blood borne Pathogen? ☐ Yes ☐ No

g. Safe use and operation of equipment? ☐ Yes ☐ No

19. Are job descriptions, detailing job duties and responsibilities, given to all employees and independent contractors? ☐ Yes ☐ No

20. What is the applicant's average staff turnover rate in a calendar year for:

Professional Staff..... _____% Non-Professional Staff..... _____%

21. Does applicant have written policies and/or procedures for the following:

a. Complete treatment plan prescribed by the physician, including follow-up plans? ☐ Yes ☐ No

b. Assessments of clients prior to and after accepting the clients? ☐ Yes ☐ No

c. Client care and home visits documented? ☐ Yes ☐ No

d. Documentation of all homecare training? ☐ Yes ☐ No

e. All changes in the condition of the client are documented in the records and reported to the family and physician? ☐ Yes ☐ No

f. Client incident report procedure is in place with notification also given to family and physician? ☐ Yes ☐ No

g. Medications and dosage, including documentation of administering medications? ☐ Yes ☐ No

h. A copy of all literature given to clients explaining services and fees? ☐ Yes ☐ No

i. Termination of services and discharge criteria? ☐ Yes ☐ No

22. Are medications ordered by a licensed physician and administered, discarded and documented by or under the close supervision of a qualified medical professional in accordance with legal requirements for controlled substances? ☐ Yes ☐ No

23. If applicant provides advanced skilled care (i.e., infusion therapy, ventilator, chemotherapy, radiation therapy, etc.), what are the clinical expertise requirements and/or professional training for the staff that provide these services? _____

_____

24. Does applicant have Workers' Compensation coverage in force? ☐ Yes ☐ No

25. Does applicant have any contractual agreements wherein applicant assumes the liability of others? ☐ Yes ☐ No

If yes, attach a list of each entity and the type of service(s) applicant provides.

26. Are any professional services provided on applicant's premises (doctor's office, clinic, infusion therapy center, etc.)? ☐ Yes ☐ No

If yes, explain: _____

_____

27. Does applicant provide bed and board facilities (convalescent home, hospice, assisted living facility, etc.)? ☐ Yes ☐ No

If yes, explain: _____

_____

28. Does applicant sell, rent or lease any medical supplies and/or equipment? ☐ Yes ☐ No

If yes, provide details: _____

_____

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29. **Does applicant own/operate a pharmacy or provide pharmaceutical products?** ☐ Yes ☐ No

30. **Does applicant manufacture any products?** ☐ Yes ☐ No
If yes, advise: _____

31. **Has applicant ever distributed directly imported products from a foreign manufacturer?** ☐ Yes ☐ No
If yes, advise: _____

32. **Does applicant modify any product or repackage/relabel any items obtained from suppliers?** ☐ Yes ☐ No
If yes, advise: _____

33. **Is all equipment checked and its condition documented prior to release?** ☐ Yes ☐ No

34. **Does applicant and/or employees provide transportation services for patients?** ☐ Yes ☐ No
If yes:
   a. Are there any emergency transportation services provided? ☐ Yes ☐ No
   b. Transportation services are provided in conjunction with:
      ☐ Professional home health care services
      ☐ Non-Professional home health care services
      ☐ Miscellaneous home health care services
      Provide details: _____
   c. Does applicant and/or employees use their personal vehicles to transport patients? ☐ Yes ☐ No
   d. Is Auto Liability coverage in place with limits equal to or greater than the applicant's General Liability limits for all vehicles utilized? ☐ Yes ☐ No
   e. Are certificates of insurance obtained for Auto Liability for employees' vehicles? ☐ Yes ☐ No
   f. Does applicant obtain Waiver of Liability from patients? ☐ Yes ☐ No

35. **Explain arrangement for medical emergencies** (i.e., M.D. on call, transfer arrangement with hospital, etc.):

36. **Is staff informed of all patients with AIDS/HIV?** ☐ Yes ☐ No

37. **Copy of applicant's State(s) Home Health Care License and most recent State Licensure Survey attached (if any):** ☐ Yes ☐ No

38. **Additional Insured Information:**

Name	Address	Interest

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39. Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies? ☐ Yes ☐ No

If yes, describe: _____

40. Does applicant have other business ventures for which coverage is not requested? ☐ Yes ☐ No

If yes, explain and advise where insured: _____

_____

_____

41. Does applicant have any other premises, operations or exposures not stated in this application? ☐ Yes ☐ No

If yes, explain: _____

_____

42. During the past five years, have any claims been made or suits brought against the applicant because of alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation? ☐ Yes ☐ No

If yes, date: _____

Explain: _____

_____

43. During the past three years, has any company canceled, declined or refused similar insurance to the applicant (not applicable in Missouri)? ☐ Yes ☐ No

If yes, explain: _____

_____

44. Prior Carrier Information:

	Year:	**Year:**	**Year:**	**Year:**	**Year:**
Carrier					
Policy No.					
Coverage					
Occurrence or Claims Made					
Total Premium					

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45. Loss History—Five Year Period:

Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior five years. ☐ Check if no losses last five years.

Date of Loss	Description of Loss	Amount Paid	Amount Reserved	Claim Status (Open or Closed)

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

FRAUD WARNING: 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 subjects such person to criminal and civil penalties. **Not applicable in Nebraska, Oregon and Vermont.**

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

WARNING TO DISTRICT OF COLUMBIA APPLICANTS: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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NOTICE TO OHIO APPLICANTS: Any person who knowingly and with intent to defraud any insurance company 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 subjects such person to criminal and civil penalties.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD WARNING (Applicable in Tennessee, Virginia and Washington): It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO NEW YORK APPLICANTS (Other than automobile): 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.

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be signed by an active owner, partner or executive officer)

PRODUCER'S SIGNATURE: _____ DATE: _____

IOWA LICENSED AGENT: _____
(Applicable in Iowa Only)

AGENT NAME: _____ AGENT LICENSED NO.: _____
(Applicable to Florida Agents Only)

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT: _____

_____

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.