APPLICATION FOR
HOME HEALTH CARE LIABILITY COVERAGE

OHA INSURANCE SOLUTIONS (OHAIS)

155 EAST BROAD STREET, FLOOR 2
COLUMBUS, OHIO 43215
PH. (614) 255-4840 * FAX (614) 255-4839

First Named Insured: ______________________________

Street Address: ______________________________

City/State/Zip Code: ______________________________

Contact Person: ______________________________

Title: ______________________________

Office Telephone: ______________________________

Risk Management/Quality Assurance Contact Person: ______________________________

Telephone: ____________________ E-Mail Address: ____________________

Website Address: ______________________________

Proposed Effective Date: ____________________ From: ______________ To: ______________

Retroactive Date: ____________________

Limits Request:
Primary: ____________________ Umbrella: ____________________

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

2. List all locations and areas of operation: ______________________________

   ____

   a. Type of business: ______________________________
   b. Length of time in operation: ______________________________
   c. Has the applicant's license ever been suspended, revoked or restricted? ☐ Yes ☐ No
      If yes, please provide details: ______________________________

3. How long has the facility been under present management? ____________________
   (If fewer than five years, attach principals' resumes. If principals in the firm do not have a health care background, include the resume of the director of nursing or the individual responsible for hiring, screening and monitoring the work activities of your employees.)

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

   ____

5. Has the applicant sold, acquired or discontinued any operations in the last five years? ☐ Yes ☐ No
If yes, please explain: ____

____

6. Is at least one of the principals or an administrator/director of nursing involved in the operation on a full-time basis? ☐ Yes ☐ No

7. Please check box next to current accreditations and association memberships.

☐ NAHC ☐ CHAP ☐ NHPCO ☐ JCAHO ☐ Other

8. How does the applicant monitor the daily work activities of employees (i.e. daily work reports, hospital procedures, etc.)? Please describe:
____

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

10. Does the applicant lease employees? ☐ Yes ☐ No

11. Does the applicant have any contractual agreements wherein applicant assumes the liability of others? ☐ Yes ☐ No
If yes, please attach a list of each entity that has requested to be named as an additional insured and the type of service(s) applicant provides.

12. Are all services provided out of a central office? ☐ Yes ☐ No

13. Does the applicant provide treatment on its own premises or provide bed and board facilities? ☐ Yes ☐ No

14. Location where services are provided (total must equal 100%):

______% Hospitals ______% Physicians's office ______%Hospitals ______% Clinics
______% Assisted Living ______% Private homes ______% Other

Describe other: ____
(Please attach any brochures, literature or descriptive materials provided to the patient.)

15. Number of estimated patients in the next 12 months: ______________________________

16. Number of patients in the last 12 months ______________________________

State patients' ages: from: ____________(youngest) to: ____________(eldest).

State approximate division of patients:
______% Medical ______% Mentally Retarded ______% Nonambulatory ______% Surgical
______% Drug addicts ______% Senile or aged ______% Alcoholics ______% AIDS/HIV
______% Alzheimer's ______% Any other classes

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17. Types of services provided % (total must equal 100%):

- ☐ Personal Care Chore or Companion ______%
- ☐ Infusion Therapy ______%
- ☐ Infant Care ______%
- ☐ Supplemental Staffing, (if yes, complete section below) ______%
- ☐ Adult Day Care ______%
- ☐ Closed Pharmacy ______%
- ☐ Skilled Nursing Care ______%
- ☐ Hospice ______%
- ☐ Pediatric Care ______%
- ☐ Obstetrical Services ______%
- ☐ Child Day Care ______%
- ☐ Clinics Owned/Operat. ______%

18. Supplemental Staffing % (Total must equal 100%):
(Supplying health care providers to other facilities for a fee.)
If no supplemental staffing is provided, please check here ☐.

- ☐ Nursing Home ______%
- ☐ Hospital ______%
- ☐ Clinic ______%
- ☐ Assisted Living ______%
- ☐ Doctor's Office ______%
- ☐ Other (specify) ______%

19. If providing supplemental staffing in a hospital, please complete department staffed % (Total must equal 100%):

- ☐ Emergency Dept. ______%
- ☐ Intensive Care ______%
- ☐ Labor and Delivery ______%
- ☐ Other (specify) ______%

20. Please list the number of individuals in each category:

	Employees			Non-Employees		Does Professional Person Carry Own Liability?	
	Full-Time	Part-Time	Annual Hours	Contractor	Annual Hours	Yes	No
Administrators						☐	☐
Physicians						☐	☐
Psychiatrists						☐	☐
Psychologists-Bachelors/Masters						☐	☐
Counselors-Marriage and Family						☐	☐
Counselors-Other						☐	☐
Social and Case Workers						☐	☐
Occupational Therapist						☐	☐
Respiratory Therapist						☐	☐
Physical Therapist						☐	☐
Speech Therapist						☐	☐
Therapist Aides						☐	☐
Nurses – RN						☐	☐
Nurses – LPN						☐	☐
Nurse Practitioner						☐	☐
Nurse Mid-wife						☐	☐
Nurse Aide						☐	☐

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	Employees			Non-Employees		Does Professional Person Carry Own Liability?	
	Full-Time	Part-Time	Annual Hours	Contractor	Annual Hours	Yes	No
Dental Hygienist or Assistant						☐	☐
Pharmacists						☐	☐
Pharmacy Assistant						☐	☐
Physician Assistant						☐	☐
General Clerical or Maintenance						☐	☐
Medical Technician						☐	☐
Other (Specify)						☐	☐

21. Any off-premises field trips? ☐ Yes ☐ No
    If yes, how many? ____________ Describe? ______________________________

22. Are employees authorized to use their personal vehicles to transport patients? ☐ Yes ☐ No
    If yes, please provide details (i.e. under what circumstances, if applicant obtains a waiver of liability from the patient, etc.):

23. Explain arrangements for medical emergencies (i.e. M.D. on call, transfer arrangements with hospital, etc.):
    ____
    ____

24. Does your agency have a written credentialing policy and procedure for all individuals associated with or practicing with the agency? ☐ Yes ☐ No

25. Do you conduct pre-employment screening and investigation? ☐ Yes ☐ No

26. Does the staff supervisor make regular audit visits of staff in the field? ☐ Yes ☐ No

27. Do you require contracted staff (if any) to carry their own Professional Liability Coverage? ☐ Yes ☐ No

28. Do you secure certificates of insurance as evidence of such coverage? ☐ Yes ☐ No

29. Describe your procedures for matching staff to patients. Who does the matching/assigning of staff to patient, and what is his/her experience? ______________________________
    ____

30. Who does the supervising of staff, and what is his/her experience? ______________________________
    ____

31. Describe the referral source(s) by which patients are directed to the entity.____________________________________

____

32. Are you equipped with an emergency 24-hour telephone call-out line for all staff and patients? ☐ Yes ☐ No

33. Do you enter into any contractual agreements (other than lease of premises agreements) in which you hold others harmless? ☐ Yes ☐ No
If yes, attach copies of all such contracts.

34. Does the home health agency advertise its services other than an ordinary local telephone directory listing? ☐ Yes ☐ No
If yes, please attach a copy of each advertisement

35. Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient? ☐ Yes ☐ No

36. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? ☐ Yes ☐ No
If no, attach explanation of any exceptions.

37. Does your agency have a written incident/occurrence reporting policy and procedure? ☐ Yes ☐ No

38. Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? ☐ Yes ☐ No
If no, attach explanation of any exception.

39. Has the applicant or any of its employees:

a. Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ☐ Yes ☐ No
b. Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ☐ Yes ☐ No
c. Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? (If the answer to a, b or c above is yes, please attach a detailed explanation.) ☐ Yes ☐ No

40. Do you require signed applications for all prospective: ☐ Employees? ☐ Non-employees?

41. Do you conduct personal interviews with every prospective employee or non-employee? ☐ Yes ☐ No
If yes, are these: ☐ In person ☐ By telephone

42. Do you require professional and personal references of each employee? ☐ Yes ☐ No

43. Do you require professional and personal references of each non-employee? ☐ Yes ☐ No

44. Do you verify all professional qualifications, licenses and certifications? ☐ Yes ☐ No

Describe your background verification checks on new employees:

a. Work History: ______________________________
b. Education: ______________________________
c. Criminal Record: ______________________________
d. Driving Record: ______________________________
e. Drug Testing: ______________________________
f. Is written documentation maintained in the employee's file? ☐ Yes ☐ No

45. Are home health aides required to participate in a program to become:

a. Certified nurse aide? ☐ Yes ☐ No
b. Certified in CPR? ☐ Yes ☐ No
c. Certified in first aid? ☐ Yes ☐ No

46. Do your contracts with medical professionals, consultants or self-employed professionals contain a hold harmless agreement in your favor? ☐ Yes ☐ No

a. Do the contracts require you to be named as an additional insured? ☐ Yes ☐ No

47. List all entities to be named as additional Named Insureds with names and insurable interests (attach a separate list, if necessary) other than a lease, and attach a copy of the contract.

Name: ______________________________
Address: ______________________________
____
Interest: ______________________________

48. What percentage of applicant's professional nursing staff hours entails the rendering of "high-tech" home care (i.e. home infusion and nutritional therapies)? ______%

49. Number of AIDS/HIV patients: ____________ Are the patients isolated? ☐ Yes ☐ No
If yes, how? ______________________________

50. What training is provided to new/existing staff? ______________________________

____

____

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

52. Does applicant do any blood testing? ☐ Yes ☐ No

53. How is infectious waste stored and disposed of? ______________________________

____

54. Are employees tested for AIDS/HIV? ☐ Yes ☐ No
If yes, how often? ______________________________

55. Actual annual gross revenue in the last 12 months: ______________________________

____

Estimated annual gross revenue in the next 12 months: ______________________________

56. Any infusion therapy? ☐ Yes ☐ No

57. Does applicant engage in any business or have a majority interest in any business other than home health care/staff relief? ☐ Yes ☐ No

58. Does applicant sell or lease products to patients/customers? ☐ Yes ☐ No
If yes, please describe in detail and give gross revenue received from the sale or leasing of products: ______________

____

____

59. Are there any other premises or operations exposures not stated in this application? ☐ Yes ☐ No
If yes, attach a complete description and underwriting/rating information.

60. During the past five years, have any claims been made or suit 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: ______________ Please explain: ______________________________

____

61. During the past three years has any company ever cancelled, declined or refused similar insurance to the applicant? ☐ Yes ☐ No
If yes, explain: ______________________________

____

Previous insurer: Indicate premium and losses for the past three years. Describe all losses.

Year	Company	Policy #	Occurrence or Claims Made	Premium	Losses Paid	Losses Reserved	Description

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Supplemental Application
I.V. Therapy in the Home Health Setting

Please complete this supplement if any I.V. therapy will be done by your agency's personnel.

Home Health Care Agency: ____

1. The patient and significant others are instructed concerning the I.V. therapy treatments? ☐ Yes ☐ No

    a. The instruction includes precautions, signs and symptoms of possible/actual problems, simple first-aid measures and when and whom to call for assistance? ☐ Yes ☐ No
    b. A return demonstration is required before any manipulation/handling of supplies or equipment occurs? ☐ Yes ☐ No
    c. The medical record is documented concerning instruction? ☐ Yes ☐ No

2. Policies and procedures concerning I.V. therapy are written? ☐ Yes ☐ No

    a. They are readily available for use by the registered nurse? ☐ Yes ☐ No
    b. They are reviewed and/or revised annually? ☐ Yes ☐ No
    c. They include:

        i. Drug administration? ☐ Yes ☐ No
            1) I.V. fluids in general? ☐ Yes ☐ No
            2) Specific drugs by category and method of infusion (direct push, I.V. infusion)? ☐ Yes ☐ No
        ii. Site care? ☐ Yes ☐ No
        iii. Infection control? ☐ Yes ☐ No
        iv. Care of equipment, including infusion pumps? ☐ Yes ☐ No
        v. Protocols for emergency interventions? (These should be developed with the assistance of the physician.) ☐ Yes ☐ No

3. The registered nurse has, at a minimum, institutional certification for I.V. therapy? ☐ Yes ☐ No

    a. The certification process verifies:
        i. Performance Competency - a skills inventory/checklist is maintained which documents observed demonstration? ☐ Yes ☐ No
        ii. Knowledge Competency - a test of theoretical knowledge to include actions of various drugs administered contradictions, complications and nursing intervention? ☐ Yes ☐ No
    b. The registered nurse will be recertified annually? ☐ Yes ☐ No

4. I.V. therapy will be included as part of the quality assurance program? ☐ Yes ☐ No

    a. Criteria will be established for use in monitoring the program? ☐ Yes ☐ No
    b. The medical record, patient interview and patient assessment are included in the review process? ☐ Yes ☐ No

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Supplemental Application
Medical Product Sales or Equipment Rental

1. List each product or equipment line individually and provide receipts for each. Attach copy of your products/equipment brochures.

Describe Product/Equipment Line	From Rental	From Sales

2. Describe patients applicant sells/rents to, and % of each:

_____% Individuals using products in their home
_____% Nursing homes or similar residential facilities
_____% Clinics/Labs*
_____% Individuals in nursing homes*
_____% Hospitals*
_____% Physicians*
_____% Other,* Describe: ____

____

* If other than individuals in their home, is there a financial/ownership relationship between applicant and patient facility? ☐ Yes ☐ No
If yes, explain: ____

3. Who does the servicing and repair of the products? ____________________________

Who does the servicing and repair of rental equipment? ____________________________

4. Are any products manufactured by others and sold under your entity's label? ☐ Yes ☐ No
If yes, which products? ____

5. Are any additional products planned in the next 12 months? ☐ Yes ☐ No

6. How are products marketed? (attach ad copy or brochures)

____

7. Is a rental/lease agreement signed by the customer prior to releasing any rental equipment? ☐ Yes ☐ No
If yes, please enclose a copy of the rental agreement.

8. Is a formal written inspection for rental equipment conducted prior to each rental? ☐ Yes ☐ No

9. Are manufacturer's labels/directions/instructions provided to customers for all rentals? ☐ Yes ☐ No

Do the manufacturers or distributors of any of the above listed items:

a. name your entity as an additional insured under their products liability policies? ☐ Yes ☐ No
b. provide certificates of insurance for products liability to you? ☐ Yes ☐ No
c. provide maintenance/service agreements for their product(s)? ☐ Yes ☐ No
d. hold you harmless for loss arising from their products? ☐ Yes ☐ No

If the answer is yes for some products, please specify the appropriate product line.

10. Are all manufacturers/suppliers well known U.S. firms? ☐ Yes ☐ No
If no, give details of which are not? ____

____

11. If sales of medicines or drugs are made by applicant, is a licensed pharmacist employed or contracted? ☐ Yes ☐ No
If yes, indicate number ______ Employed (W-2) ______ Contracted (1099)

a. Does the pharmacist carry his/her own professional liability insurance? ☐ Yes ☐ No

12. Has your insurance for medical malpractice or general liability ever been cancelled, non-renewed, suspended or declined by an insurance company? ☐ Yes ☐ No

Home Health Care Application Addendum

1. For nursing, respiratory and other clinical services provided in the patients home,

a. the current number of patients is ________.
b. the usual % of pediatric patients (infants and children under 18) is ________%.
c. the usual % of adult patients (19-65) is ________%.
d. the usual % of senior patients (over 65) is: ________%.

2. Indicate the percentage of home care revenue for each of the following areas (total must equal 100%).

Respiratory Therapy – including trach care and ventilator dependent patterns	%	I.V. Infusion Therapy	%	Antepartum care monitoring	%
Pediatric Care (see 4a)	%	Apnea Monitor (See 4b)	%	Post Partum Care	%
Psychiatric Services- including social work (See 4c)	%	Physical Therapy & Rehabilitation	%	Kidney Dialysis	%
All other clinical services	%	Companion Services	%	Hospice	%
General Housekeeping, Laundry, Grocery Shopping	%	Social Services	%	Management Services for other Health care entities (See 4d)	%

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3. Indicate the percentage of total revenue for each of the following (total must equal 100%).

   a. Care in the home ________%.
   b. Supplemental Staffing ________%.
   (Please indicate supplemental staffing % in tables below.)

Adult Day Care Centers, Hospice	%	Nursing Homes	%
Psychiatric Facilities	%	Industrial Facilities	%

Hospitals:

Obstetrical	%	Neonatal	%	Pediatric	%
Psychiatric	%	Emergency Department	%	Coronary Care Units	%
Intensive Care Units	%	Medical/Surgical Units	%	All Others	%
Other (Please list) %					

4. If you provide any of the services, please answer the questions as applicable:

   a. Pediatric Care:
   How many nurses provide pediatric services? ________
   What types of services are provided? ________
   What is the minimum level of training and experience required? ________
   What percentage of nurse providers meets this requirement? ________%
   b. Apnea Monitors:
   How many monitors do you own? ________
   Do you rent your owned equipment to others? ☐ Yes ☐ No
   What are the qualifications of the individuals providing this service? ________
   c. Psychiatric Care:
   What are the qualifications of the nursing staff providing psychiatric care? ________

   ____

   Who assesses the patient's mental status and develops the treatment plan for home care services? ________

   ____

   Is the plan developed, reviewed, signed and monitored by a psychiatrist? ☐ Yes ☐ No
   d. Management Services:
   Please describe management services you perform for others: ________

   ____

5. Do you have patients to whom you provide only pharmaceuticals? ☐ Yes ☐ No
   If yes, what % of the total revenue does this service represent? ________%

6. Do you provide a flu shot program? ☐ Yes ☐ No
   If yes, please answer the following.

   a. How many flu shots are administered per year? ________
   b. Do all nurses administering flu shots have current CPR certification? ☐ Yes ☐ No
   c. Do you provide a follow-up phone number to patients in the event of a reaction to the shot? ☐ Yes ☐ No

7. Do you accept non-physician referrals? ☐ Yes ☐ No
   If yes, please answer the following.

   a. Describe referral sources: ______________________________
   b. Is a physician assigned to each patient receiving skilled care? ☐ Yes ☐ No

8. Do all patients receiving any level of skilled care have a current and regularly updated physician treatment plan on file? ☐ Yes ☐ No

9. Do you have written policies and procedures for the following:

   a. Medication administration? ☐ Yes ☐ No
   b. Acceptance of verbal physician's orders? ☐ Yes ☐ No
   c. Acceptance of "Do Not Resuscitate" orders? ☐ Yes ☐ No
   d. Use and maintenance of equipment? ☐ Yes ☐ No
   e. Chain of command? ☐ Yes ☐ No
   f. Reporting suspected abuse of patients? ☐ Yes ☐ No
   g. Removal of hazardous waste from homes? ☐ Yes ☐ No
   h. Medical records documentation? ☐ Yes ☐ No
   i. Medical record retention? ☐ Yes ☐ No

NOTICE TO APPLICANT. PLEASE READ CAREFULLY

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 the policy be issued.

Fraud Warning: Any person who, with intent to defraud or knowledge that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The information provided on this application and on any supplementary attachments is complete and correct to the best of my knowledge.

Signature	Title	Date

This document must be signed and dated by a duly authorized representative of the first Named Insured.

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AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by OHA Insurance Solutions (the "Company") hereby authorizes their present and prior professional liability insurance carriers, and any and all attorneys who have represented the undersigned in connection with any claim of professional liability, to release to the Company upon its request information regarding closed, pending or anticipated claims and any underwriting or other information, which in the judgment of any such carrier, attorney or the Company may have a bearing upon their acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above and their agents, servants and employees, and the Company, its directors, officers, employees, agents and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Facility: ____

Name (Printed): ________________________________

Title: ____

Signature: ______________________________________

Address: ____

____

____

Date: ____

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NO KNOWN CLAIMS DECLARATION

The undersigned applicant declares that they are not aware of, nor do they have any knowledge of, any claim or incident, any unreported conduct, or any circumstance or occurrence that could reasonably be expected to result in a claim against the facility subsequent to the date of the signature below that has not already been reported to the previous professional liability carrier and that has not been disclosed on the application to OHA Insurance Solutions (OHAIS).

All claims and all facts or circumstances have been reported that could give rise to a claim to appropriate prior carrier(s) and the undersigned understands that all such known claims or potential claims will not be covered by this insurance. The facility also understands that this insurance does not apply to any of the following:

Any incident or claim for which the facility has received notice of a claim.

Any incident or claim for which a legal action has been filed against the facility or employees of the facility.

Any incident or claim upon which any companies previously insuring the facility have previously established a claim file.

Any incident or claim arising out of any fact, circumstance or situation indicating the possibility of a claim, which was known to the facility as of the effective date of insurance for which we are applying.

Facility: ____

Name (Printed): ________________________________

Title: ____

Signature: _______________________________________

Address: ____

____

____

Date: ____