

**APPLICATION FOR  
HOSPICE PROFESSIONAL LIABILITY**

**OHA INSURANCE SOLUTIONS (OHAIS)**

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

**PART I - GENERAL INFORMATION**

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. Have there been any changes in ownership or management in the past 12 months?  Yes  No

3. Identify the number of owners for the corporation or partnership: \_\_\_\_\_

4. Percentage of receipts obtained for the following payer categories:

- a. Medicare: \_\_\_\_\_%
- b. Medicaid: \_\_\_\_\_%
- c. Other public aid: \_\_\_\_\_%
- d. Private pay: \_\_\_\_\_%



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5. Description of operations (please attach brochure):  
\_\_\_\_\_

6. Years in operation: \_\_\_\_\_

7. What organizations or associations is the applicant a member of? \_\_\_\_\_  
\_\_\_\_\_

Is applicant accredited by any organization?  Yes  No

Identify: \_\_\_\_\_  
\_\_\_\_\_

8. Applicant is licensed by: \_\_\_\_\_

9. Date of your last survey: \_\_\_\_\_

10. Any deficiencies found?  Yes  No

11. Annual budget: \_\_\_\_\_

12. Primary funding source: \_\_\_\_\_

13. Provide days and hours of operation by Hospice service (i.e. 2:00 to 4:00):

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
RN							
Social Work							
Counselor							
Rehabilitation							
HH Aid							
Volunteer							
Clergy							
Other							

14. Does Hospice operate as a stand-alone, independent facility without relying on subcontracting for services?  Yes  No



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**PART III - TYPES OF SERVICES**

<b>Services Provided</b>	<b># Clients</b>	<b># Visits Annually</b>	<b># Beds</b>	<b>Average Inpatient Length of Stay</b>
Mental Health Counseling				
Family Counseling				
Referral Services				
Respite Care				
Medical Clinic				
Rehabilitation				
Hospice				
Other (Describe)				

15. Other service opportunities:

- a. Are patients able to maintain their own provider if they wish?  Yes  No  
 Will the provider have input into the course of treatment the patient receives?  Yes  No
- b. Does Hospice have special programs for families?  Yes  No  
 If yes, list programs: \_\_\_\_\_

- c. Does Hospice allow active treatment such as radiation, vent, TPN, I.V. antibiotics for palliative treatment not designed to be curative treatment?  Yes  No
- d. Does Hospice provide respite care?  Yes  No  
 If yes, where and what are the criteria to access respite care: \_\_\_\_\_

- e. Does Hospice have specialty programs for pediatric care?  Yes  No  
 If yes, please describe: \_\_\_\_\_

**PART IV - MEDICAL DIRECTOR**

A specific physician medical director must clearly be identified as responsible for oversight of medical management at the organization in accordance with established policies.

List name and credentials of the Hospice medical director.

Medical Director : \_\_\_\_\_

Credentials (MD; DO; Specialty): \_\_\_\_\_



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**PART V - MEDICAL STAFF**

The organization must have an organized medical staff, established in accordance with policies and procedures developed by the Hospice, which will be responsible for maintaining proper standards of medical care.

1. Do written policies and procedures ensure that patients have access to a licensed practitioner whenever a patient is utilizing Hospice's services?  Yes  No
  
2. If the organization utilizes physician extenders to provide patient care, do written policies and procedures ensure that these practitioners are licensed and have immediate accessibility to a licensed physician?  Yes  No
  
3. Please indicate the composition and employment relationship of the organization's staff by indicating the number of positions:

Staff Positions	Hospice Employees	Contract Services
Physicians		
Registered Nurse		
Social Workers		
Counselors		
Physical Therapists		
Home Health Aides		
Other		

4. Do all employed and contracted health care professionals identified above maintain current state licenses or certifications for their stated positions?  Yes  No
  
5. Is the staff credentialed through an:  Internal process  Outside agency  
If an outside agency was used, please provide its name: \_\_\_\_\_
  
6. Who provides insurance coverage? \_\_\_\_\_

**PART VI - RISK MANAGEMENT**

1. Is there a formal written risk management program in place?  Yes  No
  
2. Has the applicant ever been investigated by a State Health Department, State Licensing Board, or other governmental body? (Please attach report.)  Yes  No
  
3. Are written policies and procedures in place regarding the following:
  - a. Advance directives/living wills  Yes  No
  - b. Patient acceptance  Yes  No
  - c. Incident reporting  Yes  No
  - d. Medical record documentation  Yes  No
  - e. Acceptance of verbal physician orders  Yes  No
  - f. Drug administration procedures  Yes  No
  - g. Patient rights  Yes  No



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- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| h. Patient discharge procedures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Handling of complaints       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Employee training            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Lifting requirements         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Food preparation             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Medical equipment training   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. Chain of command             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

9. Please indicate all of the procedures you use when hiring staff:

- Check of educational background or residency program, when applicable.
- Check of previous employers: \_\_\_ in writing \_\_\_ by telephone.
- Check of personal references: \_\_\_ in writing \_\_\_ by telephone.
- Check on hospital privileges for physicians.
- Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities.
- Require information on any professional liability or work-related claim that has previously been made against the individual.
- Request information on any prior convictions.
- Perform criminal background check.

10. Do you train staff in how to recognize child/sexual abuse and how to report suspected incidents?  Yes  No

11. Have any allegations of abuse ever been made against the applicant?  Yes  No  
If yes, explain: \_\_\_\_\_

**PART VII - LOSS HISTORY**

1. Has the company canceled, declined to renew or refused insurance?  Yes  No  
If yes, explain: \_\_\_\_\_

2. Enter all claims or occurrences that may give rise to claims for the prior 10 years.  
Check here if none .

Date of Loss	Description of Incident/Claim	Amount Paid

Name and Title: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date \_\_\_\_\_



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**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.

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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: \_\_\_\_\_

