DECOTIS
SPECIALTY INSURANCE

HOME HEALTH CARE APPLICATION

If the Applicant organization provides Home Care or Home Health Services to its patients or clients, please complete the following Application. If space is insufficient to fully answer any question, complete the answer on a separate sheet and attach to this Application.

SECTION 1. APPLICANT INFORMATION
Entity Name (Applicant):
Address:
City, State, Zip Code:
Phone Number:
FEIN:
Medical Provider No.:
Website:
Years in Business:
Years Present Mgmt:
If there has been a change in ownership, operation or management within the past 12 months, please provide a brief resume of owners and key management personnel.

Type of Institution (check all that apply)			
Entity Details	**Yes**	**Entity Details**	**Yes**
Not-for-Profit	☐	**Franchise**	☐
Publically Traded	☐	**Licensed by State**	☐
Medicare Certified	☐	**Hospital Affiliated**	☐

Designated Agent of Applicant Entity for Receiving Notices		
Name	**Title**	**Email Address**

Designated Medical Director					
Name	**How Long in Position**	**Specialty**	**Separate Insurance?**	**Hours per week**	**Ownership Interest?**
			☐		☐

Designated Risk Manager			
Name	**How Long in Position**	**Prepares or Reviews Incident Reports?**	**Other Duties**

Requested Insurance Coverage					
Type of Insurance	**Per Claim Limit of Liability**	**Aggregate Limit of Liability**	**Deductible/SIR**	**Claims Made or Occurrence**	**Retroactive Date**
Prof. Liab.					
Genl. Liab.					
Emp. Ben.					
Excess Liab.					
Sex Abuse					
H/NO Auto					

Additional Background Information	
1. Is the Applicant licensed to do business in the states where required?	☐ Yes ☐ No
2. Is any part of the Applicant facility operated or leased by a management corporation?	☐ Yes ☐ No
If yes, provide the name of the management company.	
3. Is the Applicant sponsored by a hospital or similar institution?	☐ Yes ☐ No
If yes, provide the name of the sponsoring institution.	
4. Does the Applicant conduct business with any legal entity in which the Applicant, its owners or executive officers own over 10%?	☐ Yes ☐ No
If yes, provide the details of the related institution.	
5. Has the facility filed for bankruptcy or become insolvent within the last 3 years?	☐ Yes ☐ No

SECTION 2. DESCRIPTION OF SERVICES AND PROCEDURES

Identify the TYPE of Service Provided			
Entity Details	**Percent**	**Entity Details**	**Percent**
Home Health Care (skilled/medical care)		**Pharmaceutical and Infusion Therapy**	
Home Health Care (non-medical care)		**Medical Equipment Supplier**	
Homemaker or Home Care Aide Agency		**Therapy**	
Staffing or Private-Duty Agency		**Adult Day Care**	
Hospice		**Meal Preparation/Food Service**	
Pediatric Care		**Handyman Services**	
Infant Care		**Other:**	

Identify WHERE Services are Delivered or Performed			
Location	**Percent**	**Location**	**Percent**
Private Home		**Nursing Home**	
Clinic or Doctor's Offices		**Assisted Living Facility**	
Hospital		**Other:**	

Gross Receipts			
1. What are the expected gross receipts for the next 12 months:			
2. What were the gross receipts for the past 12 months:			
3. What is the percentage of gross receipts for the past 12 months for following categories:			
Private Pay	**Medicare**	**Medicaid**	**Other Public Aid**
%	**%**	**%**	**%**

Operating Procedures		
1.	Is the Applicant Medicare Certified?	☐ Yes ☐ No
	If NO, was it rejected for any reason?	☐ Yes ☐ No
2.	If the Applicant has a contract with a Nursing Home, Assisted Living Facility or Hospital, is there an indemnification and/or hold harmless provision running in favor of the Applicant?	☐ Yes ☐ No
3.	Are employees required to carry their own professional liability insurance coverage?	☐ Yes ☐ No
4.	Number of patient visits for the past 12 months:	
5.	Number of skilled Medicare home health or hospice patients during past 12 months:	
6.	Number of non-skilled clients receiving personal care or activities of daily living (ADL) services during past 12 months:	
7.	Percentage of Applicant's patients that are under the age of 18:	
8.	Does the Applicant own or operate a pharmaceutical and infusion therapy company that provides services to clients outside of the home health or hospice agency?	☐ Yes ☐ No
9.	Does the Applicant manufacture medication?	☐ Yes ☐ No
10.	Does the Applicant dispense controlled narcotics?	☐ Yes ☐ No
11.	Does the Applicant perform client lifting?	☐ Yes ☐ No

SECTION 3. HOSPICE & PALLIATIVE CARE Check Box if Not Applicable ☐

Please respond to the following questions as respect the delivery of Hospice and Palliative Care services.

Location	No. of Patients	Type of Service	No. of Patients
Independent Facility		**Community-Based**	
Hospital-Based		**Home-Based**	
Nursing Home		**Other:**	

1.	Does the Applicant provide Crisis Care services for its patients?	☐ Yes ☐ No
2.	Do the accepted patients have primary care physicians?	☐ Yes ☐ No
3.	If the Applicant has a contract with a Nursing Home, Assisted Living Facility or Hospital, is there an indemnification and/or hold harmless provision running in favor of the Applicant?	☐ Yes ☐ No
4.	Does the Applicant ever house patients overnight?	☐ Yes ☐ No
5.	Does the Applicant facility administer general anesthesia? (If Yes, please explain)	☐ Yes ☐ No

SECTION 4. RISK MANAGEMENT, PROCEDURES & REPORTING

Risk Management

Does the Applicant have written policies and/or procedures with respect to the following activities and/or programs:

1.	Admitting Patients	☐ Yes ☐ No
2.	Crisis Management	☐ Yes ☐ No
3.	Discharging Patients	☐ Yes ☐ No
4.	Maintaining Medical Records	☐ Yes ☐ No
5.	Patient Safety	☐ Yes ☐ No
6.	Performance Improvement Program	☐ Yes ☐ No
7.	Preventing Sexual Abuse	☐ Yes ☐ No
8.	Risk Management	☐ Yes ☐ No
9.	Treating AIDS/HIV Patients	☐ Yes ☐ No

Patient Procedures

Does the Applicant have written policies and/or procedures with respect to the following treatment of patients:

1.	Patient assessment prior to providing medical treatment?	☐ Yes ☐ No
2.	Patient assessment after providing medical treatment?	☐ Yes ☐ No
3.	Complete treatment plan prescribed by a physician, including follow-up plans?	☐ Yes ☐ No
4.	Plan for more than one person responsible for the welfare of any single patient?	☐ Yes ☐ No
5.	Procedure that monitors staff in day-to-day relationships with patients?	☐ Yes ☐ No
6.	Procedure for disclosure to patients of adverse and unanticipated outcomes?	☐ Yes ☐ No
7.	Termination of services and discharge criteria?	☐ Yes ☐ No

8.	Do you have a formal written sexual misconduct policy that includes measures designed to prevent such acts from occurring?	☐ Yes ☐ No
9.	Do you have a written response procedure in the event any acts of sexual misconduct occur involving a patient, client or a member of the staff?	☐ Yes ☐ No

Medical Records		
Does the Applicant have the following written policies and procedures with respect to medical records:		
1.	Complete medical records maintained on all patients?	☐ Yes ☐ No
2.	Patient records kept on file (hardcopy or electronic) for a minimum of 6 years?	☐ Yes ☐ No
3.	An "informed consent" document obtained and placed in the patient's medical record?	☐ Yes ☐ No
4.	Documentation of all medications administered to patients, including dosage?	☐ Yes ☐ No
5.	Documentation of all significant changes in patient condition?	☐ Yes ☐ No
6.	Literature given to clients explaining services and fees?	☐ Yes ☐ No
7.	Documentation of ALL services that are provided, including any complications or problems?	☐ Yes ☐ No

Reporting & Audits		
Does the Applicant have the following written policies and procedures:		
1.	Are patient care procedures regularly audited by Applicant's management or executive officers?	☐ Yes ☐ No
2.	Does the Applicant document all training provided to its employees?	☐ Yes ☐ No
3.	Does the Applicant conduct patient/client surveys?	☐ Yes ☐ No
	If yes, are the results used to improve day to day operations?	
4.	Are there protocols in place to elevate patient concerns or complaints to physicians?	☐ Yes ☐ No
5.	Is there a process for reporting mismanagement of patient care, adverse medical incidents and/or patient sexual abuse to management or executive officers?	☐ Yes ☐ No

SECTION 5. STAFF

Position	Employees: Full Time	Employees: Part Time	Contractors: Full Time	Contractors: Part Time	Payroll
Aides					
Certified Registered Nurse Anesthetists					
Chiropractors					
Companion/Home Health Aide					
Counselors					
Dentists					
Dieticians					
Licensed Vocational/Practical Nurses					
Medical Director					
Nurse Midwives					
Nurse Practitioners/Clinicians					
Occupational Therapists					
Physical Therapists					
Physicians/Surgeons					
Physician Assistants/Surgical Assistants					
Podiatrists					
Psychologists					
Radiologists					
Respiratory Therapists					
RNs (Registered Nurses)					
LPNs/LVNs					
Social Workers					
Volunteers					
Other:					

Minimum Professional Liability Insurance Coverage Requirements

Please provide details of insurance requirements for all certified medical professionals that are employed by the Applicant or serve in an independent professional capacity for the Applicant facility.

Type of Professional	Occurrence Limit	Aggregate Limit	Policy Limits Verified?	Certificates of Insurance Obtained?
Physicians or Surgeons			☐ Yes ☐ No	☐ Yes ☐ No
Dentists			☐ Yes ☐ No	☐ Yes ☐ No
Nurse Anesthetist			☐ Yes ☐ No	☐ Yes ☐ No
Nurse Practitioner			☐ Yes ☐ No	☐ Yes ☐ No
Physician Assistant			☐ Yes ☐ No	☐ Yes ☐ No
Nurse Midwives			☐ Yes ☐ No	☐ Yes ☐ No
RNs/LPNs/LVNs			☐ Yes ☐ No	☐ Yes ☐ No
Others			☐ Yes ☐ No	☐ Yes ☐ No

Staff & Professional Qualifications		
Does the Applicant have the following written policies and/or procedures:		
1.	Are all physicians board certified or eligible?	☐ Yes ☐ No
2.	Describe any limitations or conditions on any physician's or nurse's privileges in the organization?	
3.	Do any independent contractors provide medical services to patients?	☐ Yes ☐ No
	If YES, please explain:	
4.	Do you use staffing agencies?	☐ Yes ☐ No
	If yes, what are the names of staffing agency and what type of services do they provide?	
5.	How many volunteers work with the operation?	

SECTION 6. EMPLOYMENT HIRING PRACTICES

Pre-Hiring Practices for Physicians, Surgeons or Dentists		
1.	Do you conduct criminal background checks on physicians, surgeons or dentists prior to resident contact?	☐ Yes ☐ No
	If YES, what types of background checks are performed?	
2.	Do you verify prior work references for physicians, surgeons or dentists?	☐ Yes ☐ No
3.	Do you verify prior education for physicians, surgeons or dentists?	☐ Yes ☐ No
4.	Do you ascertain if a physicians, surgeons or dentists is subject to any license suspensions, revocations, or formal disciplinary actions prior to hiring or contracting?	☐ Yes ☐ No
5.	Do you hire any physicians, surgeons or dentists who have been the subject of a prior license suspension, revocation, or formal disciplinary action?	☐ Yes ☐ No
6.	Do you verify hospital privileges for physicians, surgeons or dentists?	☐ Yes ☐ No
7.	Do you obtain information regarding the medical professional claims of physicians, surgeons or dentists prior to hiring or contracting?	☐ Yes ☐ No
8.	Do you conduct drug testing on physicians, surgeons or dentists prior to hiring or contracting?	☐ Yes ☐ No
9.	Do your professional service applications specifically ask if the person has been convicted of any crime related to sexual misconduct, child abuse or any other type of felony offense?	☐ Yes ☐ No
10.	If your professional service applications contain these types of questions and the applicant checks "yes", are they refused a position of employment?	☐ Yes ☐ No
11.	If your professional service applications do not contain these types of questions, do you ask prospective members of the staff if they have ever been accused of, participated in or been convicted of sexual misconduct?	☐ Yes ☐ No

Pre-Hire Practices for Employees		
1.	Do you conduct criminal background checks on employees prior to resident contact?	☐ Yes ☐ No
	If NO, do you conduct criminal background checks on all nurse staff?	☐ Yes ☐ No

	If YES, what types of background checks are performed?	
2.	Do you verify that nurse's are in good standing with current licenses?	☐ Yes ☐ No
3.	Do you verify prior work references for employees?	☐ Yes ☐ No
4.	Do you conduct drug testing on employees prior to hiring?	☐ Yes ☐ No
5.	Do you have a written drug and alcohol use policy?	☐ Yes ☐ No
6.	Do your employment applications specifically ask if the person has been convicted of any crime related to sexual misconduct, child abuse or any other type of felony offense?	☐ Yes ☐ No
7.	If your employment applications contain these types of questions and the applicant checks "yes", are they refused a position of employment?	☐ Yes ☐ No
8.	If your employment applications do not contain these types of questions, do you ask prospective members of the staff if they have ever been accused of, participated in or been convicted of sexual misconduct?	☐ Yes ☐ No
9.	Do you conduct personal interviews of all prospective employees and volunteers?	☐ Yes ☐ No
10.	Do you have a written response procedure in the event any acts of sexual misconduct occur involving a patient, client or staff member?	☐ Yes ☐ No

Post Hire Practices		
Does the Applicant have the following written policies and/or procedures with respect to medical records:		
1.	Do you provide training for new staff?	☐ Yes ☐ No
2.	Do you make continuing education program available to employees?	☐ Yes ☐ No
3.	Do you provide training for sexual abuse to employees and volunteers, including how to recognize the signs of abuse?	☐ Yes ☐ No
4.	Do you have a formal credentialing and privileging process for surgeons?	☐ Yes ☐ No
5.	If so, is this process fully complied with?	☐ Yes ☐ No

SECTION 7. MEDICAL EQUIPMENT, SALES & LEASING

1.	Do you have a formal preventative maintenance program for medical equipment owned, or leased?	☐ Yes ☐ No
	If YES, please describe the preventative maintenance program and identify who provides these services.	
2.	Are there any radiation emitting machines used on-site?	☐ Yes ☐ No
	If yes, please state the number owned or operated and whether they are used for diagnosis, treatment or both.	
3.	Do you sell or lease medical or therapeutic supplies and/or equipment to others?	☐ Yes ☐ No

SECTION 8. HIRED & NON-OWNED AUTOMOBILE LIABILITY

Employees or Volunteers Driving Their Own Vehicles		
1.	Do employees or volunteers drive their own personal vehicles for business activities?	☐ Yes ☐ No
2.	Do employees or volunteers use their personal vehicles to transport patients or clients?	☐ Yes ☐ No
3.	How many employee drivers are expected for this coverage?	
4.	Do you require that all employee drivers have a valid driver's license?	☐ Yes ☐ No
5.	Do you keep copies of all such licenses?	☐ Yes ☐ No
6.	Do you have Motor Vehicle Reports checked on all employee drivers & keep copies of such Vehicle Reports file?	☐ Yes ☐ No
7.	Do you require that all employee drivers carry minimum personal auto liability limits of at least $100,000 per person and $200,000 per accident?	☐ Yes ☐ No

Employees or Volunteers Driving Patient's or Client's Vehicles		
1.	Are employees or volunteers allowed to operate a patient's or client's vehicle?	☐ Yes ☐ No
2.	If YES, does the Applicant restrict use to business only?	☐ Yes ☐ No
3.	If YES, does the Applicant secure prior written permission from the patient or client and keep a copy of such permission on file?	☐ Yes ☐ No
4.	If YES, does the Applicant secure written verification that each patient or client maintains current in-force limit of at least $100,000 per person and $200,000 per accident?	☐ Yes ☐ No

Eligible Drivers and Acceptable Driving Records	
1. Do you agree to extend driving privileges only to persons over the age of twenty one (21) and under the age of seventy (70)?	☐ Yes ☐ No
2. Do you agree to extend driving privileges only to employees and volunteers with acceptable driving records? Note: Acceptable driving records are: a. No more than three moving violations or more than one chargeable accident during the past three (3) years. AND b. No major convictions (including but not limited to driving under the influence of alcohol or drugs) within the past seven (7) years. AND c. No license suspensors or revocations within the past seven (7) years.	☐ Yes ☐ No

SECTION 9. REGULATORY, INSURANCE & LICENSING MATTERS

1.	Have you or your staff ever been the subject of a proceeding by a governmental, administrative, hospital, or professional association agency?	☐ Yes ☐ No
	If YES, please describe the disciplinary or investigatory matter.	
2.	Has your license ever been suspended or revoked, or have you ever been placed under regulatory probation or sanctions, including Medicare sanctions and de-certifications?	☐ Yes ☐ No
	If yes, please explain the nature of any probation or sanctions.	
3.	Has the license of any employed/contracted physician or surgeon ever been suspended, restricted, or revoked?	☐ Yes ☐ No
	If yes, please explain the nature of any suspension, restriction or revocation.	
4.	Has any federal or state civil or criminal investigation or action been initiated or filed that directly or indirectly involve the Applicant's organization?	☐ Yes ☐ No
	If yes, please explain the nature of any investigation or action.	
5.	Has a state or federal agency fined this facility in the last 5 years?	☐ Yes ☐ No
	If yes, please explain the nature of any state or federal fines.	
6.	Have there been any incidents resulting in any allegations of sexual abuse?	☐ Yes ☐ No
	If yes, please explain the nature of any allegations of sexual abuse.	

SECTION 10. INSURANCE COVERAGE AND PRIOR CLAIMS EXPERIENCE

IT IS UNDERSTOOD AND AGREED THAT THE INSURER SHALL NOT BE LIABLE TO MAKE ANY PAYMENT FOR DAMAGES OR CLAIMS EXPENSE IN CONNECTION WITH ANY CLAIM MADE AGAINST ANY INSURED BASED UPON ARISING OUT, DIRECTLY OR INDIRECTLY RESULTING FROM OR, IN CONSEQUENCE OF, OR IN ANY WAY INVOLVING ANY CLAIM OR SUIT, FACT, CIRCUMSTANCE, OR SITUATION SET FORTH, OR THAT SHOULD HAVE BEEN SET FORTH, TO THE FOLLOWING CLAIM QUESTIONS.

Knowledge of Past Claims & Circumstances		
1.	During the past 5 years, has any insurance carrier canceled or refused to renew your professional liability, general liability or employee benefits liability coverage for any reason other than carrier's withdrawal from the market?	☐ Yes ☐ No
	Explain.	
2.	During the last 3 years, has any claim or suit been made against you or any of your staff members arising out of, resulting from or in any way connected with your operations?	☐ Yes ☐ No
	Explain.	
3.	Are you aware of any fact, circumstance, or situation that might result in a claim against you or any of your staff members arising out of, resulting from or in any way connected with your operations?	☐ Yes ☐ No
	Explain.	

SECTION 11. REPRESENTATIONS AND WARRANTIES

The Applicant understands and agrees that the following representations and warranties are material and that the Company is relying on the truthfulness of these representations and warranties, which are made the basis of and a condition for the Company's acceptance of the risks covered by this insurance. The Applicant further understands and agrees that if any of the following material representations and warranties are false, or if the Applicant fails to comply with any of the following representations and warranties at any time during the policy period, the Applicant shall be deemed to have breached the insurance policy issued by the Company. A breach of any of the following representations and warranties will result in the policy not applying to any claim or suit brought thereunder.

1. The Applicant Insured hereby represents and warrants that the following are true and correct as of the inception date of the policy:
   a. The information contained in this Application and all other Applications submitted to the Company by the Applicant or its agent is a just, full and true exposition of all the facts and circumstances with regard to the risk to be insured.
   b. No claims have been made nor have any suits have been filed against you or any other insureds in the past five (5) years other than as disclosed in the Application(s) and/or loss runs submitted to us.
   c. There have been no losses in the last 5 years other than as disclosed in the Application(s) submitted to us.

2. The Applicant further represents and warrants that the following are true and correct as of the inception date of the policy and will remain so at all times during the policy period:
   a. You require that all doctors or physicians (including but not limited to anesthesiologists, chiropractors, dentists or surgeons) who perform any medical professional services at your premises or in conjunction with your operations have all necessary and valid professional licenses and certifications, and you verify the existence of such licenses and certifications.
   b. You require that all doctors or physicians (including but not limited to anesthesiologists, chiropractors, dentists or surgeons) who perform any medical professional services at your premises or in conjunction with your operations to maintain medical malpractice liability insurance in an amount not less than the Per Claim Limit of Liability for Professional Liability provided by the Company to the Applicant pursuant to this Application, and you verify the existence of such medical malpractice insurance.
   c. You have written contracts or agreements with all doctors or physicians (including but not limited to anesthesiologists, chiropractors, dentists or surgeons) who perform any medical professional services at your premises or in conjunction with your operations, and such contracts or agreements specifically include a hold harmless and indemnification provision providing a defense and indemnification to you for all losses and expenses of whatsoever nature arising out of or resulting from the negligence of said doctors or physicians.

SECTION 12. WARNINGS AND ACKNOWLEDGEMENTS

Insurance Fraud Warning

Any person who knowingly, and with intent to defraud or deceive 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 in certain jurisdictions and is a felony in some states. Such persons may be subject to criminal and civil penalties including fines, imprisonment, and denial of insurance. **(Not applicable in Pennsylvania. For the Insurance Fraud Warning in Pennsylvania, refer to the information below.)**

Applicable in Colorado only: The following additional statement applies. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

Applicable in New York only: Any person who commits a fraudulent insurance act as described above shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable to Pennsylvania only: 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.

Acknowledgments

The undersigned declares that to the best of his or her knowledge, the statements set forth herein are true and correct and that reasonable efforts have been made to obtain sufficient information from each and every proposed Insured to facilitate the proper and accurate completion of this Application. The signing of the Application does not bind the insurance company to complete the insurance, but it is agreed that this Application and any additional documents submitted therewith are the representations of the Insured and are material and shall be the basis of the contract should a policy be issued. It is further agreed that any incorrect or incomplete statement in the Application could void the protection should a policy be issued.

The undersigned further agrees that if any significant adverse change in the condition of the Applicant is discovered between the date of completion of this Application and the date that coverage was bound with the Insuring Company, and such change renders this Application inaccurate or incomplete, notice of such change will be reported in writing to Promont Advisors LLC immediately.

This Application shall be considered attached to and part of the Policy. Any material submitted with the Application shall be maintained on file with the Insurer and shall be deemed to be attached hereto as if physically attached.

SECTION 13. SIGNATURES

Signature of Owner, Officer, Partner, Shareholder, or Member		
Name	**Title**	**Email Address**
Signature		