Physicians' Reciprocal Insurers

Supplemental Application for

Home Healthcare Services

IMPORTANT: Processing of this application will be delayed if it is not completed in its entirety and the requisite attachments are not included.

1800 Northern Blvd
Roslyn, New York 11576
Telephone: (516) 365-6690 Fax: (516) 775-4224

PHYSICIANS' RECIPROCAL INSURERS

HOME HEALTHCARE SUPLEMENTAL APPLICATION

INSTRUCTIONS

1. Please type or print clearly in ink.
2. Answer all questions completely for desired coverage. If any questions do not apply, please print "N/A" in the space provided.
3. If applicant needs more space, continue on a separate sheet of your firm's letterhead and indicate question number.
4. This form must be completed, signed and dated by a Principal or Officer of the firm.
5. PLEASE ATTACH ANY BROCHURES, LITERATURE OR DESCRIPTIVE MATERIALS PROVIDED TO CLIENTS.
6. Attach current annual financial statements.

PART I. APPLICANT INFORMATION

a) Client Name: _____
(If more than one entity/subsidiary, please attach description and % owned for each)

☐ For Profit ☐ Not for Profit ☐ Partnership ☐ Other (Specify)

b) Address: _____
Street PO Box

_____
City State Zip County (Required)

Phone:_____ Fax: _____

Website: _____ Email: _____

c) Facility Tax ID #: _____ d) Total # of Employees _____

e) Total Annual Gross Receipts: $_____

f) Date Business Established: _____
(Required: Attach principal's resume if in business less than three (3) years)

g) Type of Firm (Check all that apply):

☐ Home Health Care Provider
☐ Nurse Registry
☐ Other (Describe): _____
☐ Supplemental Staffing
☐ Visiting Nurse Agency

PART II. HIRING/SCREENING AND CREDENTIALING PROCEDURES

a) 1. Are employees/contractors references contacted before hired/placed? ☐Yes ☐No

2. How are references checked? ☐Written ☐Verbal ☐Both

b) Does the applicant review criminal background screening results for all clinical employees/contractors prior to hire/placement? ☐Yes ☐No
If yes, at what level are criminal searches conducted? (Check those applicable)
☐County ☐State ☐Federal ☐Felony ☐Misdemeanor Convictions

c) Does the applicant verify certification and/or professional licensure status of employees and independent contractors? ☐Yes ☐No

d) Has the applicant formalized a drug and alcohol screening program requiring all employees/contractors to satisfy drug and alcohol testing prior to hire/placement and is there a procedure for screening suspect employees/contractors when drug or alcohol abuse is alleged? ☐Yes ☐No

e) Are all employees/contractors required to sign a formal confidentiality statement? ☐Yes ☐No

f) When utilizing contracted vendors, does the applicant require vendor submission of the following? (Check all that apply)
☐Professional Liability Certificate of Insurance; specify limits required: _____
☐Licensure
☐Historical Loss Data

PART III. ACCREDITATION AND MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS

Check if applicant is a member of any of the following organizations: ☐The National Association of Home Care (NAHC); ☐Community Health Accreditation Program (CHAP); ☐The Joint Commission; ☐State Association Membership, please identify: _____

PART IV. RISK MANAGEMENT/QUALITY IMPROVEMENT

a) Is the applicant licensed under Article 36 of the New York State Public Health Law? ☐Yes ☐No
If no, under what Article of the Public Health Law is the facility operating under? _____
_____

b) Has the applicant's license ever been suspended, revoked, voluntarily surrendered, or subject to probate in any state? ☐Yes ☐No
If yes, please explain: _____

c) Does the applicant utilize a formal written Quality Improvement and Risk Management Program? ☐Yes ☐No
If no, please explain: _____

d) Is the overall responsibility for risk management assigned to one individual in your firm? ☐Yes ☐No
If yes, please give name and title: _____
If no, please describe how risk management is monitored: _____
_____

e) Does the applicant have a formalized training and education program requiring staff attendance at mandatory in-servicing? ☐Yes ☐No

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

_____

_____

g) Does the applicant conduct patient/client surveys? ☐ Yes ☐ No

h) If the applicant enters into contractual agreements is there a review process requiring the following elements? ☐ N/A

- o Hold Harmless and indemnification clauses favorable to the applicant ☐ Yes ☐ No
- o Insurance requirements ☐ Yes ☐ No
- o Confidentiality clause ☐ Yes ☐ No
- o Terms and renewal conditions clearly outlined ☐ Yes ☐ No
- o Termination clause ☐ Yes ☐ No
- o Defined roles and responsibilities ☐ Yes ☐ No

Please attach copies of all agreements.

PART V. CLAIMS HISTORY

a) Have any claims/suits been made within the last seven (7) years against the applicant? ☐ Yes ☐ No
If yes, please attach a copy of insurance company loss reports for each claim or suit. Specify date, description, amount paid and amount outstanding for each claim.

b) Is the applicant aware of any circumstances which may result in any claim or suit being made (including requests for medical records)?
If yes, please explain: _____

_____

c) Has any insurance company or Lloyd's declined, canceled or refused to renew any of the applicant's insurance? ☐ Yes ☐ No
If yes, please explain: _____

PART VI. PREVIOUS PROFESSIONAL LIABILITY INSURANCE (PAST FIVE YEARS)

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made or Occurrence Form	Retroactive Date (Claims Made Only)

PART VII. PREVIOUS GENERAL LIABILITY INSURANCE (PAST FIVE YEARS)

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made or Occurrence Form	Retroactive Date (Claims Made Only)

PART VIII. EMPLOYEES—ANNUAL STAFFING

Employee Type	# Full Time	# Part Time	Annual Hours	Annual Payroll
Nurse (RN)				
LPN/LVN				
Nurse Practitioner				
Physical Therapist				
Respiratory Therapist				
Speech Therapist				
Occupational Therapist				
Social Worker				
Pharmacist				
Home Health Aide/CNA				
Homemaker				
Sitter/Companion				
Physician				
X-Ray Technicians				
Medical Directors				
Pharmacy Ass't/Techs				
Other (Specify)				

PART IX. INDEPENDENT CONTRACTORS—ANNUAL STAFFING

Employee Type	# Full Time	# Part Time	Annual Hours	Annual Payroll
Nurse (RN)				
LPN/LVN				
Nurse Practitioner				
Physical Therapist				
Respiratory Therapist				
Speech Therapist				
Occupational Therapist				
Social Worker				
Pharmacist				
Home Health Aide/CNA				
Homemaker				
Sitter/Companion				
Physician				
X-Ray Technicians				
Medical Directors				
Pharmacy Ass't/Techs				
Other (Specify)				

PART X. TYPES OF LOCATIONS WHERE SERVICES ARE PROVIDED (TOTAL MUST EQUAL 100%)

- ☐ Private Homes _____%
- ☐ Nursing Homes Assisted/Independent Living _____%
- ☐ Hospitals _____%
- ☐ Prison Facilities _____%
- ☐ Schools _____%
- ☐ Clinics _____%
- ☐ Doctor's Offices _____%
- ☐ Laboratories _____%
- ☐ Other Locations (please specify) ____% _____ _____

PART XI. TYPES OF SERVICES PROVIDED (TOTAL MUST EQUAL 100%)

- ☐ Personal Care/Companion _____%
- ☐ Rehabilitation _____%
- ☐ Infusion Therapy _____%
- ☐ Blood Transfusion _____%
- ☐ Pain Management _____%
- ☐ Chemo Therapy _____%
- ☐ Surg. Nursing/Operating Techs _____%
  Describe Services: _____
- ☐ Obstetrical Services _____%
- ☐ Adult Day Care* _____%
- ☐ Child Day Care _____%
- ☐ Respiratory Therapy _____%
- ☐ Clinical Trials _____%
- ☐ Radiation Therapy _____%
- ☐ Laboratory Services _____%
- ☐ Training/Certification Program Open to General Public _____%
- ☐ Hospice _____%
- ☐ Supplemental Staffing-Medical _____%
- ☐ Supplemental Staffing-Non-Medical _____%
- ☐ Respite Care _____%
- ☐ Social Services _____%
- ☐ Meals on Wheels _____%
- ☐ Medical Equipment Supplier _____%
- ☐ Infant/Pediatric Care _____%
- ☐ Retail Pharmacy _____%
- ☐ Closed Pharmacy _____%
- ☐ Mail Order Pharmacy _____%
- ☐ Clinics Owned/Operated _____%
- ☐ Other _____%
- ☐ Describe Services _____

APPLICATION IS NOT ACCEPTED WITHOUT SIGNATURE

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.

The answers to the foregoing questions are complete and correct to the best of my knowledge and belief.

Signature: _____

Name (please print): _____

Title: _____

Date: _____