Equity Partners Insurance Services, Inc	**Allied Medical - Healthcare Division**	**Home Healthcare/Medical Staffing Agency Supplemental Application (Submitted with AH General App)** **EMAIL:** submissions@epinsurance.com **WEBSITE:** www.epinsurance.com/alliedmedical-healthcare/

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

HOME HEALTHCARE/MEDICAL STAFFING AGENCY SUPPLEMENTAL APPLICATION

HOME HEALTH AGENCIES – PLEASE ATTACH THE FOLLOWING:

- **License (if applicable)**
- **Job Descriptions / Qualifications for all positions**
- **Client Agreement**
- **Brochure**

STAFFING AGENCIES – PLEASE ATTACH THE FOLLOWING:

- **Job Descriptions / Qualifications for all positions**
- **Agreement with contracted staff**
- **Client or Facility Agreement**
- **Brochure**

Applicant Name: _____

TYPE OF FIRM:

☐ Home Health Care ☐ Medical Equipment Supplier (Complete DME Supplement)
☐ Nurse Registry ☐ Supplemental Staffing ☐ Other

GENERAL INFORMATION:

1. Number of independent contractors: _____

   Cost of independent contractors: $_____

2. Do you require and keep certificates of insurance for all independent contractors?
   ☐ Yes ☐ No

3. Does the applicant utilize a formal written Quality Assurance & Risk Management Program?
   ☐ Yes ☐ No

   If "No", explain:_____

4. Is the overall responsibility for Risk Management assigned to one individual in your firm?
   ☐ Yes ☐ No

   If "Yes", explain:_____

5. Is an informed consent document placed in the patient's medical record? ☐ Yes ☐ No

6. Does the applicant conduct patient/client surveys? If "Yes", attach sample. ☐ Yes ☐ No
   Are the results of patient/client surveys used to improve day to day operations? ☐ Yes ☐ No
   If "Yes", provide example.

7. Description of employees or contracted personnel:

	Number of Employees?	Number of Independent Contractors?	Do All Workers Carry their Own Insurance?	Where Are Services Rendered?: % in Hospitals	% in Assisted Living	% in Nursing Homes	% in Private Homes
Aids			☐ Yes ☐ No				
LPN's			☐ Yes ☐ No				
RN's			☐ Yes ☐ No				
Nurse Practitioner			☐ Yes ☐ No				
Physical Therapist			☐ Yes ☐ No				
Respiratory Therapist			☐ Yes ☐ No				
Occupational Therapist			☐ Yes ☐ No				
Speech Therapist			☐ Yes ☐ No				
Counselors			☐ Yes ☐ No				
Social Worker			☐ Yes ☐ No				
Pharmacist			☐ Yes ☐ No				
Physician Assistant			☐ Yes ☐ No				
Other (specify)			☐ Yes ☐ No				

8. Give percentage of patients in the following age ranges:
   _____% Under 18 _____% Age 18-35 _____% Age 36-50
   _____% Age 51-65 _____ % Over 65 years old

9. Types of Services Provided % (total must equal 100%):

Adult Day Care	_____%	Hospice	_____%
Child Day Care	_____%	Pediatric Care	_____%
Closed Pharmacy	_____%	Obstetrical Care	_____%
Infant Care	_____%	Clinics	_____%
Infusion Therapy	_____%	Physicians Office	_____%
Personal Care or Companion	_____%	Other Services, please describe	_____

10. Are employees/contractors references contacted before hired/placed? ☐ Yes ☐ No

    How are references checked? _____Written _____Verbal _____Both

    If "Verbal only", please explain:_____

11. Do you perform criminal background checks on prospective employees/contractors? ☐ Yes ☐ No
    If "No", please explain:_____

12. Do you question prospective employees in their previous involvement as defendants in professional malpractice litigation? ☐ Yes ☐ No
    If "No", please explain:_____

13. Is certification and/or professional licensure status of employees and independent contractors verified? ☐ Yes ☐ No

14. Are employees screened to rule out drug, alcohol and/or sexual abuse? ☐ Yes ☐ No

15. Are job descriptions provided for all professional and nonprofessional employees? ☐ Yes ☐ No

16. Describe services performed by your LPN's/RN's:_____
    _____

17. Do you supply medical equipment or are your personnel responsible for monitoring equipment? ☐ Yes ☐ No
    If "Yes", describe all such equipment: _____

18. Do you sell or lease any equipment? ☐ Yes ☐ No
    If "Yes", please explain:_____

19. Do you repair or maintain any medical equipment? ☐ Yes ☐ No
    If "Yes", please explain:

20. Receipts from equipment sales, leasing or repair: $_____

21. Provide details for licensing or certification required to operate this business: _____
    _____

22. How long have you been licensed/certified? _____

23. Has your license ever been suspended or revoked? ☐ Yes ☐ No
    If "Yes", please explain:_____

24. Your premium is adjustable based on your total receipts. Our auditor will verify your total receipts. If this information is kept by your accountant, provide the accountants name, address and phone number: _____

25. Do you provide temporary workers to other businesses or institutions? ☐ Yes ☐ No

26. Have you entered into any contractual agreements in which you have agreed to indemnify (hold harmless) others for liability? ☐ Yes ☐ No

27. Do you acknowledge that this policy, if issued, does not cover liability you assume in any contract or agreement? ☐ Yes ☐ No

28. Do contracts you sign make your company liable for negligent acts of those temporary workers while they are working in and being supervised by those other businesses or institutions? ☐ Yes ☐ No

29. Do you require temporary workers to maintain their own professional liability policies? ☐ Yes ☐ No

Do you verify coverage? ☐ Yes ☐ No How often? _____

30. If providing Supplemental Staffing to a hospital, please indicate departments staffed %: (must equal 100%)

Emergency Room	_____%	Labor & Delivery	_____%
Intensive Care	_____%	Other(specify)	_____%
Revenues from these operations $_____		_____	

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In New York: 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.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Equity Partners Insurance Services, Inc. and its respective Insurance Company[s] it is working with.

Applicant's Name:	Signature
Title:	Date: