7905 Lyons Street
Morton Grove, IL 60053
(847) 962-9050 - phone
(847) 470-0844 - fax
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HOME HEALTH CARE AGENCY APPLICATION

This application includes questions pertaining to your home health care agency organization. As a response is required for all questions, please indicate "NA" if any question does not apply to your organization. Supplemental Applications are also included which may apply to your agency.

I. GENERAL INFORMATION

Policy Effective Date: ____/____/_____ Current Professional Liability Retro Date: ____/____/_____

Current General Liability Retro Date: ____/____/_____

(Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.)

Name of applicant (legal name): _____

Address: _____
(Street) *(City)* *(State)* *(Zip Code)* *(County)*

Mailing address: _____
(Street) *(City)* *(State)* *(Zip Code)* *(County)*

Phone: (____) _____ Fax: (___) _____ FEIN (Federal Tax ID) #: _____

E-mail address: _____ Web site address: _____

Insurance contact and title: _____

How many years have you been in operation? _____

Is your organization? ☐ Non-profit ☐ For-profit ☐ Governmental

What is your organizational structure? (Choose one): ☐ Corporation ☐ Partnership ☐ Privately/Individually-owned
☐ Joint Venture ☐ Limited Liability Company ☐ Other (describe): _____

Are there additional entities that are to be included as Additional Named Insureds? ☐ Yes ☐ No

If "yes," please list the name of each entity and a brief description of their operations. Please include a copy of your organizational chart.

_____

_____

Do you engage in any business other than home health care services? If so, please explain:_____

_____

II. PROFESSIONAL SERVICES

1. Do you provide **skilled** home healthcare services? ☐ Yes ☐ No If "yes," how many total patient visits during the past 12 months? _____ Next 12 months? _____
2. Number of skilled home health care patients during the past 12 months? _____
3. Please indicate which of the following skilled home health services are provided by your organization:

☐ Adult Day Care ***(Contact us for a Supplement)***
☐ Cardiac Care
☐ Case Management
☐ Child Day Care ***(Contact us for a Supplement)***
☐ Gastrostomy Tube (GT) Care
☐ Infusion Therapy
☐ Medical Equipment Supplier ***(Complete Supplement No. 4)***
☐ Medical Social Services
☐ Obstetrical Services
☐ Palliative Care. Number of annual visits: _____
☐ Pharmacy (***Contact us for a Supplement)***
☐ Rehab Services (PT,OT, Speech Therapy)
☐ Respiratory Therapy
☐ Trach/ventilator
☐ Respite Care
☐ Special Care (Alzheimer's/Dementia, etc.)
☐ Supplemental Staffing
☐ Telehealth
☐ Thrift Shops: Annual Gross Sales $_____
☐ Other: _____

4. Please indicate the location where services are provided: ☐ Private Homes ☐ Hospitals ☐ Clinics ☐ Nursing Homes/ALF's ☐ Schools ☐ Outpatient Facilities ☐ Other _____

5. Do you participate in community wellness programs, including immunizations or vaccination programs? ☐ Yes ☐ No If "yes," please provide the number of immunizations: _____

6. Do you provide **non-skilled personal care or ADL** ("Assistance with Daily Living") services? ☐ Yes ☐ No
   If "yes," what is the number of annual clients? _____ How many of these clients are provided 24-hour "live-in" services? _____

7. Do you provide any services for children? ☐ Yes ☐ No If "yes," what percentage of your total services includes pediatric care? _____%

III. OPERATIONS

1. What is your total annual operating budget? _____ **(If budget exceeds $5,000,000 please attach a copy of your latest audited financial statement)**

2. Are you accredited by? ☐ JCAHO ☐ CHAP ☐ ACHC ☐ NCQA ☐ COA

3. Are you Medicare-certified? ☐ Yes ☐ No

4. Licensure:
   Are you required to be licensed in any states in which you are operating? ☐ Yes ☐ No
   If "yes," in what states are you currently licensed? _____
   Are any license applications currently pending? ☐ Yes ☐ No If "yes," what state(s)? _____
   Please attach a copy of your most recent state agency's inspection report, together with corrective actions completed, if any.

5. Does your organization participate in the State Patient Compensation Fund**?** ☐ Yes ☐ No ☐ Not Applicable

6. Has your organization merged, acquired, or consolidated with any other organization within the last ten years? ☐ Yes ☐ No If "yes," please provide the name(s) of the organization(s) and the date of acquisition.
   _____
   _____

7. Describe any changes in services or operations planned within the next year, including new or discontinued services, locations, or acquisitions.
   _____
   _____
   _____

8. Within the last three years has your organization or any of its senior managers, officers or other "insureds" been a part of any civil or criminal litigation or arbitration proceedings related to the applicant's activities?
   ☐ Yes ☐ No If "yes," **please provide details on a separate attachment.**

IV. EMPLOYEE INFORMATION

1. Total number of employees: _____ Full Time _____ Part Time/Per Diem _____ Volunteers

2. Is Employer's Stop Gap Liability desired? (Only applicable in ND, OH, WA, WY) ☐ Yes ☐ No
   If "yes," provide current annual payroll $_____

3. Do you engage the use of Independent Contractors to provide any services? ☐ Yes ☐ No
   If "yes," what percentage of services is provided by Independent Contractors? _____%
   What services do they provide?
   _____
   _____
   Do you require that all Independent Contractors maintain liability insurance and provide you with a copy of their Certificate of Insurance each year? ☐ Yes ☐ No

4. What percentage of your staff is composed of temporarily assigned personnel acquired through staffing agencies? _____%

5. Which of the following background check methods do you use?

	Employees	Volunteers (if any)
Social Security number verification and search	☐ Yes ☐ No	☐ Yes ☐No
Home telephone/residency verification	☐ Yes ☐ No	☐ Yes ☐No
Present employment and two previous employers' verification	☐ Yes ☐ No	☐ Yes ☐No
Education and professional licensing verification	☐ Yes ☐ No	☐ Yes ☐No
Driver's license information (MVR)	☐ Yes ☐ No	☐ Yes ☐No
County, state (if available) and federal criminal checks	☐ Yes ☐ No	☐ Yes ☐No
Drug screening	☐ Yes ☐ No	☐ Yes ☐No

6. Who is responsible for human resources in your organization?
   Name and title: _____

7. Is annual training provided and attendance documented for all employees and volunteers?
   ☐ Yes ☐ No If "yes," briefly describe your in-service training program:
   _____
   _____

V. RISK MANAGEMENT AND LOSS CONTROL

Please attach a copy of your currently valued three-year loss experience from your insurance carrier.

1. Within the last three years has your organization been a part of any civil or criminal litigation or arbitration proceeding?
   ☐ Yes ☐ No If "yes," please provide details on a separate attachment.

2. Does your organization have knowledge of any incidents which have not been reported to your current insurance carrier that may result in a claim or suit? ☐ Yes ☐ No If "yes," please provide details on a separate attachment.

3. Does your organization have a formal Quality Assurance or Risk Management program? ☐ Yes ☐ No
   If "yes," name and title of who is responsible for the program: _____

4. Do you have an active Safety Committee? ☐ Yes ☐ No

5. Do all contracts with pharmacies, DME suppliers, hospitals, nursing homes and assisted living facilities include mutual hold harmless agreements? ☐ Yes ☐ No

6. Please identify any organization requiring a Certificate of Insurance from your organization. List the name and address and specify the reason for the certificate, i.e., landlord, owner of equipment leased to you, etc.
   (You may include a separate listing if additional space is required.)

Name and Address of Certificate Holder	Purpose

7. Has any insurer ever refused to renew or cancelled any insurance coverage during the past five years?
   ☐ Yes ☐ No If "yes," please provide the reason for cancellation: _____

VI. HEALTH CARE PROFESSIONALS

1. Do you have any employed, volunteer or contracted physicians? ☐ Yes Number: _____ ☐ No

2. Do you have any employed, volunteer or contracted nurse practitioners? ☐ Yes Number: _____ ☐ No
   Complete Supplement No. 7 for each employed, volunteer, or contracted Physician or Nurse Practitioners serving your agency. Note: Physicians and Nurse Practitioners must be specifically endorsed onto your policy as Additional Insureds for coverage to apply.

3. Do you engage in a credentialing process for your physicians and all health care professionals prior to hire or at inception of their contract? ☐Yes ☐ No
   How often do you re-credential? ☐ Annually ☐ Every three years ☐ No re-credentialing process in place

4. Indicate the number of each of the following types of medical professionals, whether volunteer or employed, if insurance is to be provided on our policy.

   Each of the following medical professionals must be specifically endorsed onto your policy as an Additional Insured for coverage to apply.

Physician's Assistant _____	Dentist _____	Psychiatrist _____
Resident Intern _____	Extern _____	Chiropractor _____
Acupuncturist _____	Nurse-Midwife _____	Certified Nurse Anesthetist _____

5. Please identify the respective individuals below, along with their title or position:

Name	Title or Position

VII. OPTIONAL COVERAGES

HIRED AND NON-OWNED AUTOMOBILE LIABILTY - Please indicate if this coverage is desired: ☐ Yes ☐ No
If "yes", please answer the following questions:

Note: If you have owned or leased vehicles titled or contracted under your organization's name please contact us for an automobile application. If company-owned or leased vehicles are insured by another carrier, Non-owned Auto Liability coverage will be excluded from this policy and must be secured under your owned automobile policy.

1. Do your employees and volunteers utilize their personal vehicles to provide services on behalf of your organization?
   ☐ Yes ☐ No
2. Do you annually order MVR's on each employee and volunteer with driving responsibilities? ☐ Yes ☐ No
3. Do you agree to extend driving privileges only to employees and volunteers with acceptable driving records?
   ☐ Yes ☐ No
   Note: Acceptable driving records are:
   a) No more than three moving violations or more than one chargeable accident during the past 36 months, AND
   b) No major convictions (driving under the influence of alcohol or drugs, reckless driving, etc.) within the past seven years, AND
   c) No license suspensions or revocations within the past seven years.
4. Do you require that all employees and volunteers who operate their personal autos on behalf of your organization maintain minimum state financial responsibility limits? ☐ Yes ☐ No
5. Do your employees and volunteers transport patients or clients in their personal autos? ☐ Yes ☐ No
   If "yes," does your employee or volunteer maintain auto liability limits of at least $100,000 Combined Single Limit?
   ☐ Yes ☐ No
6. Do you allow your employees and volunteers to operate a patient's or client's vehicle? ☐ Yes ☐ No
   If "yes," do you:
   Restrict use to business use? ☐ Yes ☐ No
   Secure prior written permission from each client regarding use of their vehicle and maintain a copy for your records? ☐ Yes ☐ No
   Secure written verification that each client maintains current in-force limits of at least $100,000 Combined Single Limit? ☐ Yes ☐ No
   Include driver safety education to your staff? ☐ Yes ☐ No

SEXUAL ABUSE LIABILITY - Please indicate if this coverage is desired: ☐ Yes ☐ No If "yes", please answer the following questions:

Does your organization have a written "zero tolerance" sexual abuse and molestation policy? ☐ Yes ☐ No

Does your written policy include?

Definition of sexual abuse/molestation ☐ Yes ☐ No
Reporting procedures at least two persons to report to internally ☐ Yes ☐ No
Investigation procedures ☐ Yes ☐ No
Disciplinary procedures ☐ Yes ☐ No
Retaliation warning ☐ Yes ☐ No

Is the policy consistently enforced, requiring annual review by each employee and/or volunteer, mandating individual signoff that he or she has read the policy, has received appropriate training and agrees to adhere to the policy?
☐ Yes ☐ No

Have procedures been established to monitor the implementation of the program? ☐ Yes ☐ No

Is sexual abuse training conducted for all employees and volunteers in the program and is documentation maintained on attendees? ☐ Yes ☐ No

Have you ever had any prior incidents, allegations or claims involving sexual abuse? ☐ Yes ☐ No
If "yes", please provide details.

_____

_____

_____

Please attach a copy of your current sexual abuse and molestation prevention policy.

EMPLOYEE BENEFITS LIABILITY

$25,000 each employee/$50,000 aggregate is automatically provided, but additional limits may be available. Please indicate desired coverage limit if different from automatic coverage:

☐ $50,000/$50,000 ☐ $100,000/$100,000 ☐ $250,000/$250,000 ☐ $500,000/$500,000
☐ $750,000/$750,000 ☐ $1,000,000/$1,000,000

EXCESS LIABILITY

Please indicate if coverage is desired: ☐ Yes ☐ No If "yes," please indicate the limit of liability desired.

☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000

COMMERCIAL PROPERTY

If you have any owned or leased property and desire a quote, please indicate ☐ Yes ☐ No **If "yes," please complete Supplement No. 9**.

DIRECTORS AND OFFICERS LIABILITY COVERAGE

If your organization is a nonprofit organization and you desire a proposal, please contact us for an application.

EMPLOYEE RETIREMENT INCOME SECURITY ACT INSURANCE (ERISA)

We can offer you a proposal for a bond to insure your organization's liability in the proper administration of employer-administered employee benefit plans. The act is designed to protect the rights of employees and beneficiaries covered under the benefit plans your organization administers.

If a quote is desired, please indicate ☐ Yes ☐ No **If "yes," please request a Supplement.**

ANY SIGNIFICANT CHANGES TO YOUR ORGANIZATION DURING THE POLICY YEAR MUST BE REPORTED TO BLISS MARC INTERNATIONAL TO ENSURE COVERAGE.

PLEASE READ CAREFULLY --- GENERAL FRAUD WARNING NOTICE

Any person who knowingly and with intent to defraud any insurance company or another 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 act, which is a crime and may subject the person to criminal and civil penalties.

STATE-SPECIFIC FRAUD WARNING NOTICES

Arkansas Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado Fraud Warning

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder 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.

District of Columbia Fraud Warning

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by an applicant.

Florida Fraud Warning

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii Fraud Warning

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland Fraud Warning

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire Statement of Residency

To procure automobile insurance, I hereby attest that I am, and each named insured is, a resident of the State of New Hampshire. I understand that if I falsely claim for myself or any named insured to be a resident of the State of New Hampshire, I am subject to prosecution, imprisonment of up to one year, a fine of $2,000 and the denial of coverage for any loss, not occurring in New Hampshire, under the automobile insurance policy for which I am applying. I also understand that this statement will be relied upon in connection with future renewals of the automobile insurance policy for which I am applying, and that it is my responsibility to inform my insurance company before my next renewal after I or any named insured ceases to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.

New Jersey Fraud Warning

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico Fraud Warning

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York Fraud Warning

Automobile Insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the value of the subject motor vehicle or stated claim for each violation.
Other Types of Insurance: 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 $5,000 and the stated value of the claim for each such violation.

Ohio Fraud Warning

Any person who, with intent to defraud or knowing 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.

Oklahoma Fraud Warning

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Fraud Warning

Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania Fraud Warning

All Types of Insurance: 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.
Motor Vehicle Insurance: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.

Tennessee Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Fraud Warning

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Washington Fraud Warning

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Your signature below acknowledges that you have read the General Fraud Warning Notice and the State Specific Fraud Warning Notice that applies to your state of domicile.

The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.

Authorized Signature of Applicant: _____ Date: _____

Print Name and Title: _____

THIS APPLICATION MUST BE SIGNED BEFORE WE CAN PROCESS.

INSURANCE AGENT INFORMATION:

Agency name: _____

Contact person: _____

Agency address: _____

Telephone number: _____Fax number: _____

E-mail address: _____