ALLIED MEDICAL HOME HEATH CARE MEDICAL STAFFING AGENCY SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

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? ☐ No ☐ Yes

3. Does the applicant utilize a formal written Quality Assurance & Risk Management Program? ☐ No ☐ Yes
   If "No," explain:____________________________________

4. Is the overall responsibility for Risk Management assigned to one individual in your firm? ☐ No ☐ Yes
   If "Yes," explain:____________________________________

5. Is an informed consent document placed in the patient's medical record? ☐ No ☐ Yes
   Does the applicant conduct patient/client surveys? **(If "Yes," attach sample)** ☐ No ☐ Yes
   Are the results of patient/client surveys used to improve day to day operations? ☐ No ☐ Yes

THIS SECTION MUST BE COMPLETED:

6. 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 Nursing Homes	% in Private Homes	
				*S.S.	*P.D.	S.S.	P.D.	
Aids			☐ No ☐ Yes					
LPN's			☐ No ☐ Yes					
RN's			☐ No ☐ Yes					
Nurse Practitioner			☐ No ☐ Yes					
Physical Therapist			☐ No ☐ Yes					
Respiratory Therapist			☐ No ☐ Yes					
Speech Therapist			☐ No ☐ Yes					
Occupational Therapist			☐ No ☐ Yes					
Social Worker			☐ No ☐ Yes					
Pharmacist			☐ No ☐ Yes					
Special Training			☐ No ☐ Yes					
Physicians' Assistants			☐ No ☐ Yes					
CRNA's			☐ No ☐ Yes					
Other (specify):			☐ No ☐ Yes					

*S.S. = Supplemetal Staffing, P.D. = Private Duty

7. Give percentage of patients in the following age ranges: _______% 0-4 _______% 5-17

_______% 18-35 _______% 36-50 ________% 51-65 _______% 65+

8. Indicate percentage of revenue derived from IV Therapy: ________%

Percentage of Types of Services Provided (total must equal 100%)

Personal Care Chore or Ccompanion	_______%	Respiratory Therapy (trach care?/ventilator care?)	_______%
Rehabilitation	_______%	Radiation Therapy	_______%
Infusion Therapy	_______%	Skilled Nursing Care	_______%
Hospice	_______%	Social Services	_______%
Supplemental Staffing	_______%	Infant Care	_______%
Obstetrical Services	_______%	Pediatric Care	_______%
Adult Day Care*	_______%	Retail Pharmacy	_______%
Child Day Care*	_______%	Closed Pharmacy	_______%
Medical Equipment Supplier	_______%	Clinics Owned/Operated	_______%
Meals on Wheels	_______%	Other Services (please specify)	_______%
Skin Care or Bedsore Wound Care	_______%		

*Firms providing day care may be required to complete a supplemental application

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

   How are references checked? _____Written _____Verbal _____Both

   If "Verbal only," please explain:____

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

   Do you question prospective employees in their previous involvement as defendants in professional malpractice litigation? ☐ No ☐ Yes
   If "No," please explain:____
   Is certification and/or professional licensure status of employees & independent contractors verified? ☐ No ☐ Yes

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

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

10. Describe services performed by your LPN's/RN's:____

    ____

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

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

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

14. Receipts from equipment sales, leasing or repair: $____

15. Provide details for licensing or certification needed for this operation:____________________________

16. How long have you been licensed/certified?____

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

18. 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:____

____

If this information is kept by you, provide the telephone number and address where the records are kept.

____

19. Physical abuse/sexual molestation coverage for protection of alleged acts of your employees? ☐ No ☐ Yes

SUPPLEMENTAL STAFFING:

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

21. Do you acknowledge that the Colony Insurance policy does not cover liability you assume in any contract or agreement? ☐ No ☐ Yes

SUPPLEMENTAL STAFFING (continued): ☐ No ☐ Yes

22. 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?

23. Do you require those temporary workers to maintain their own professional liability policies? ☐ No ☐ Yes
Do you verify coverage? ☐ No ☐ Yes
How often?______________

24. Do you staff any hospitals? ☐ No ☐ Yes
If "Yes," do you staff any Labor & Delivery, Emergency Room or Surgery positions? ☐ No ☐ Yes
If "Yes," estimated annual revenue from these placements: **$**__________________________

25. Do you staff any correctional facilities? ☐ No ☐ Yes

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
* not applicable in all states

DECLARATION AND SIGNATURE:
The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

____________________ Applicant's Signature	____________________ Sub-Producer
____________________ Title/Date	____________________ Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.