NON-MEDICAL HOME CARE PROFESSIONAL AND GENERAL LIABILITY INSURANCE APPLICATION

Name of Entity or Person to Be Insured:

Mailing Address:

Location Address:

Contact Person:

Phone No.:

Fax No.:

E-mail:

Website:

Type of Entity: ☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ Non-profit ☐ LLC ☐ LLP ☐ Other (Explain)

Date business was started:

Annual Revenues: $

Projected Payroll for Next 12 Months: $

Annual Number of Client visits in the past 12 months: # Medicare Certification #:
Annual Number of Client visits projected for next 12 months: # State License #:

Effective Date Requested: _____/_____/_____ (Please provide a copy of your current policy declaration page)

Limits of Insurance Requested (Per Claim/Aggregate):
☐ $50,000/$200,000 ☐ $100,000/$300,000 ☐ $500,000/$500,000
☐ $500,000/$1,000,000 ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000
☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000

In the past five years, has any claim been made or suit brought against the applicant? ☐ Yes ☐ No

If "Yes," please provide a detailed explanation

Is the applicant or any person proposed for this insurance aware of any circumstance, allegation, contention or incident which may result in a claim being made against the applicant or any person proposed for this Insurance? ☐ Yes ☐ No

If "Yes," please provide a detailed explanation

CLIENT ASSESSMENT

Are all changes in condition and incidents documented to the physician and family?	☐ Yes ☐ No
Do patient records include medications and dosage, including documentation of administering medications?	☐ Yes ☐ No
Does the applicant obtain a written informed consent for services from clients (parents/guardians must sign for minors)?	☐ Yes ☐ No

Does your contract with clients address any of the following (check those that apply):
☐ Termination of Services ☐ Services Provided ☐ Work Schedule
☐ Scheduling/Substitute Providers ☐ Emergency protocol

Are patients' home visits meticulously documented?	☐ Yes ☐ No

SEXUAL ABUSE AND MOLESTATION

Does your organization have a written "ZERO TOLERENCE" sexual abuse policy? ☐ Yes ☐ No

Does your policy include the following:

A zero tolerance statement?	☐ Yes ☐ No
Definition of sexual abuse and molestation?	☐ Yes ☐ No
Reporting procedures with at least 2 persons to report to internally?	☐ Yes ☐ No
Investigation and follow-up procedures?	☐ Yes ☐ No
Anti-retaliation warning?	☐ Yes ☐ No
Are all employees required to acknowledge having read and comprehend the policy?	☐ Yes ☐ No

PROFESSIONAL SERVICES

How many clients are under the age of 18? _____

Please indicate the services provided by your organization below:

Activities of daily living	☐ Yes ☐ No	Respite for Family Care	☐ Yes ☐ No
Bathing/Dressing	☐ Yes ☐ No	Hospice Services	☐ Yes ☐ No
Doctor Visits	☐ Yes ☐ No	Medication Reminder	☐ Yes ☐ No
Errands	☐ Yes ☐ No	Transportation	☐ Yes ☐ No
Medical Alert Systems	☐ Yes ☐ No	Telehealth	☐ Yes ☐ No

If answered "Yes" to providing Medical Alert Systems or Telehealth, are you selling and/or training on these systems? ☐ Yes ☐ No

Do you provide any healthcare services legally required to be administered by a medical professional, other than the dispensing of medications OR providing health status monitoring/protective oversight of clients? ☐ Yes ☐ No

LOCATION OF SERVICES PROVIDED

Location of services provided (total must equal 100%):

Private Homes	%	Clinics	
Prisons	%	Own Facilities	
Assisted Living Facilities/Nursing Homes	%	Other	
Hospitals	%	**TOTAL MUST BE 100%**	

Are you a franchise owner? ☐ Yes ☐ No Franchise Name:_____.

Are you accredited by any of the following? (check those that apply): ☐ CHAP ☐ ACHC ☐ NCQA ☐ COA

Are you Medicare certified? ☐ Yes ☐ No

EMPLOYEES

Employee Type (state number in each position): Total Number of Employees: Full Time_____ Part Time:_____.

	Full Time	Part Time		Full Time	Part Time
LPN			Occupational Therapist		
Registered Nurse			Pharmacist		
Nurse's Aide			Physical Therapist		
Companion/Sitter			Respiratory Therapist		
Dietitian/Nutritionist			Speech Therapist		
Hospice			Nurse Practitioner		
Sitter/Companions			Physicians		

Independent Contractor: What percentage of services are provided by Independent Contractors?_____%

(state number of Independent Contractors in each position)

	Full Time	Part Time		Full Time	Part Time
LPN			Occupational Therapist		
Registered Nurse			Pharmacist		
Nurse's Aide			Physical Therapist		
Companion/Sitter			Respiratory Therapist		
Dietitian/Nutritionist			Speech Therapist		
Hospice			Nurse Practitioner		
Sitter/Companions			Physicians		

Are Criminal Background checks and license verifications conducted for all employees and subcontractors?	☐ Yes ☐ No
Does the background check include: Criminal background checks?	☐ Yes ☐ No
Professional license verification?	☐ Yes ☐ No
Reference checks?	☐ Yes ☐ No
Does your employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child abuse related offenses?	☐ Yes ☐ No
If "YES" to above, are any such actions pending as of the date of this application?	☐ Yes ☐ No

TRAINING	
Is a procedure in place documenting staff arrival and departure?	☐ Yes ☐ No
Is documentation of all homecare training provided?	☐ Yes ☐ No
Do you obtain evidence of insurance from independent contractors with liability limits equal to or greater than the limits of Professional Liability insurance purchased?	☐ Yes ☐ No
Does your organization have a formal written Risk Management or Quality Assurance Program	☐ Yes ☐ No
Do you have an active Safety Committee?	☐ Yes ☐ No
Do all contracts with pharmacies, nursing homes and assisted living facilities include a mutual hold harmless agreement?	☐ Yes ☐ No

AUTOMOBILE COVERAGE FOR HIRED AND NON-OWNED AUTO LIABILITY (Please complete only if seeking this coverage and check here__)	
Do you have a Motor Vehicle Liability Insurance policy in place?	☐ Yes ☐ No
Do you have a policy in place which addresses driving requirements for employees?	☐ Yes ☐ No
Does your pre-employment hiring process include driver screening? Does this process include ordering Motor Vehicle Reports prior to hire? Does the process include review of driver license, accident and violation history?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Does your policy permit patient/client transport in personal vehicles?	☐ Yes ☐ No
Do you require a minimum of $300.000 CSL personal auto liability limits from employees, independent contractors and volunteers?	☐ Yes ☐ No
Average driving frequency per week by drivers: ☐ Once ☐ 2-3 times a week ☐ Daily	

ADDITIONAL INSUREDS

List additional insured's required by contract to be included for General or Professional Liability coverage:

Name	Address	Relationship to Applicant	General Liability	Professional Liability

CURRENT INSURANCE

Do you currently have general and /or professional liability Insurance in force?

Insurance Company Name	Limits of Liability	Retroactive Date	Deductible	Annual Premium

This application requires the following attachments:

1. Copy of your current insurance policy(ies)
2. Copy of license for each location (if applicable in your state)
3. 3 years of currently valued loss runs from existing and previous insurance companies for each location

The application for this policy is incorporated as part of this policy. This insurance policy is being issued in reliance on the accuracy, truthfulness, and completeness of the application. Any inaccuracy, falsity, or omission, regardless of the nature, shall entitle us to rescind the policy.

I declare that the information provided in this application is accurate, true, and complete and that each location currently complies and will comply with the rules and regulations set by state and federal law. I understand that if I willfully do not comply with these rules and regulations that coverage is null and void and any claims may be denied and premium returned.

If the information supplied on the application changes between the date of the application and the effective date of the insurance, I will immediately notify PCH of any changes. In the event of any changes, PCH may withdraw or modify any outstanding quotations and/or agreement to bind the coverage. I must notify PCH of any changes in the operation of this business during the policy period, and failure to do so may result in cancellation of the coverage or denial of a claim.

I hereby authorize PCH to obtain information necessary for the evaluation in determining acceptability, including, but not limited to, physical inspections and inquiries with the state licensing departments.

Signature	Name and Title	Date

This application does not guarantee approval for this liability insurance program. PCH reserves the right to decline coverage. We will attempt to provide you with an approval or declination within 48 hours of receiving this form and the supporting documents in our office. Please email or fax these items to 717-630-1188.

Producer Name:_____ Agency:_____
Agency Address: _____
Telephone Number:_____ Fax:_____
E-mail Address: _____

Personal Care & Assisted Living Insurance Center, LLC
P.O. Box 933 ◆ Hanover, PA 17331
Ph: 1-800-673-2558 ◆ Fax: 1-717-630-1188 ◆ e-mail: Quotes@Pcalic.com