Non-medical Home Care Professional and General Liability Application

Name of Person or Entity to be insured____

Location
Address____

Mailing Addess____

Contact Person ______________________ Phone # _________________ Fax #____________________

Email Address __________________ Website ____

Number of Years in Business _______FEIN_________________ Effective Date Requested ___/___ /______

Type of Entity ☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ Non-Profit ☐ LLC ☐ LLP ☐ Other_____

Are you a franchise owner ☐ Yes ☐ No If yes, what is the franchise name? _______________________

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

Are you Medicare Certified? ☐ Yes ☐ No If yes, Medicare Certification Number ____________________

State License Number _________________________________

Annual Revenues $_______________ Projected Payroll for the next 12 months $_____________________

Number of Client visits in the past 12 months _________

Number of projected Client visits for the next 12 months_________

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

(If yes to any of the following questions, provide a detailed explanation on a separate page)
In the past 3 years, has any claim been made or suit brought against the applicant? ☐ Yes ☐ No
Has a fact, circumstance, event, or incident occurred at any location in the past 3 years that might result in a claim on liability insurance? ☐ Yes ☐ No
Has any license ever been denied, revoked, or suspended? ☐ Yes ☐ No ☐ N/A

Client Assessment

Do you accept any clients under the age of 18? ☐ Yes ☐ No

Do you obtain a written informed consent for services from clients? ☐ Yes ☐ No

Do patient records include medications and dosage, including documentation of administering medications? ☐ Yes ☐ No

Does your contract with clients address any of the following (Check those that apply):

☐ Services Provided ☐ Work Schedule ☐ Scheduling/Substitute Providers

☐ Termination of Services ☐ Emergency Protocol

Professional Services

(Please indicate the services provided by your organization below)

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

If "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

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

Are staff arrivals and departures to client visits documented? ☐ Yes ☐ No

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

Private homes	%
Assisted Living Facilities/Nursing Homes	%
Own Facilities	%
Clinics	%
Hospitals	%
Prisons	%
Other	%
Total Must equal 100%	**100%**

Policies and Procedures

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

Does the Sexual Abuse prevention policy include a Zero tolerance statement? ☐ Yes ☐ No

Does the Sexual Abuse prevention policy include a definition of sexual abuse and molestation? ☐ Yes ☐ No

Does the Sexual Abuse prevention policy include reporting procedures with at least 2 persons to report to internally? ☐ Yes ☐ No

Does the Sexual Abuse prevention policy include investigation and follow-up procedures? ☐ Yes ☐ No

Does the Sexual Abuse prevention policy include an anti-retaliation warning? ☐ Yes ☐ No

Are all employees required to acknowledge having read and comprehended the policy? ☐ 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

Is all homecare training documented? ☐ 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

Do all contracts with pharmacies, nursing homes, and assisted living facilities include a mutual hold harmless agreement? ☐ Yes ☐ No

Staffing (Indicate the number of employees in each position)

Staffing Totals	**Full Time**	**Part Time**	**Contractors**
RN/LPN/ Nurse Practitioner			
Nurse's Aide			
Companions/Sitter			
Hospice			
Therapist- PT, RT, ST, OT			
Pharmacist			
Physicians			
TOTAL	**____Total Full Time**	**____Total Part Time**	**___Total Contractors**

What percentage of services are provided by Independent Contractors? ________%

Do you conduct Criminal Background Checks on all new employees? ☐ Yes ☐ No

Do you conduct Reference Checks on all new employees? ☐ Yes ☐ No

Do you conduct Professional License verification, as applicable, with new employees? ☐ Yes ☐ No

Does your employment application include questions about whether the individual has ever been convicted of any crimes? ☐ Yes ☐ No

Automobile Coverage for Hired and Non-Owned Auto Liability

Do you currently have a Commercial Auto policy in place? ☐ Yes ☐ No

Do you have a policy in place which addresses driving restrictions? ☐ Yes ☐ No

Do you order Motor Vehicle Reports prior to hire? ☐ Yes ☐ No

Are Motor Vehicle Reports reviewed for accident and violation history? ☐ Yes ☐ No

Do you permit client transport in owners' or employees' 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

What limit of Hired & Non-Owned Auto Liability do you want? ☐ $50,000 ☐ $100,000 ☐ $500,000

Additional Insureds

(List any Additional insureds required to be included for General /Professional Liability Coverage)

Name	Address	Relationship to Applicant	General Liability	Professional Liability

The application for this policy is incorporated and warranted 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	Printed 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.

This application requires the following attachments:

- Declaration page of current Liability Insurance policy(ies) if applicable
- Copy of State license (if applicable in your state)
- 3 years of currently valued loss runs from existing and previous insurance companies or no known losses letter

Producer Name: ____ Agency: ____

Agency Address: ____ Email Address: ______________________________________

How did you hear about us? _____Association _____Mailer _____Internet Search _____Referral