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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

HOME HEALTH CARE NEW ENTITY SUPPLEMENTAL APPLICATION

Note: A "New Entity" is defined as an organization that has been in business for less than three (3) years.

Applicant Name: _____
DBA: _____
(If more than one entity/subsidiary, please attach description and % owned for each)

☐ For Profit ☐ Non-Profit ☐ Partnership ☐ Other (specify): _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____
Federal Employer Tax I.D. Number: _____ # of years under present management: _____
Website address (if available): _____
Name and Phone number of person to contact for inspection: _____

SUBMISSION REQUIREMENTS

- ACORD Application for each line of coverage
- Currently valued losses for the time in business
- Client Contract
- Financial Statement
- Brochure and/or Newsletter, if available
- Resume of owner/principle
- Business Plan

If contracted with Nursing Homes, Assisted Living Facilities or Hospitals, provide copies of Indemnification Agreement, Hold Harmless Agreement, Additional Insured Provisions.

SECTION I – APPLICANT INFORMATION

1. Type of firm (check all that apply)

☐ Closed pharmacy	☐ Infusion therapy provider	☐ Nurse registry
☐ Companion care provider	☐ Medical equipment supplier	☐ Personal care/Support services
☐ Home health care provider	☐ Medical staffing	☐ Retail pharmacy
☐ Hospice	☐ Non-medical staffing	☐ Visiting nurse association
☐ Other: _____	☐ Other: _____	☐ Other: _____

2. Is the Applicant licensed in all states in which it is operating? ☐ Yes ☐ No
   If "no', please advise if the state(s) require licensure to operate and/or perform services? ☐ Yes ☐ No
3. Is the Applicant Medicare licensed and certified? ☐ Yes ☐ No
4. Is the Applicant Medicaid licensed and certified? ☐ Yes ☐ No
5. Has the Applicant's license ever been suspended, revoked, voluntarily surrendered or undergone enforcement action? ☐ Yes ☐ No
   If "yes", provide specifics and corrective action taken:

   _____
6. Does common ownership (over 50%) exist with any other operation? ☐ Yes ☐ No
   If "yes", give names and types of operations managed and owned:

   _____
   If "yes", is coverage desired for operations managed and owned? ☐ Yes ☐ No
7. Total annual Gross Revenues: $_____
   Total receipts from Medicare: $_____
   Total receipts from Medicaid: $_____
   Total receipts from Private Pay: $_____

8. Does the Applicant contract with a hospital or skilled nursing facility for inpatient beds? ☐ Yes ☐ No
If "yes", please explain:

_____

9. Types of services provided:

Skilled Care Services

☐ Cardiac care	____%	☐ Dietician / Nutritionist	____%
☐ Case management	____%	☐ Gastronomy (GT) care	____%
☐ Chemotherapy	____%	☐ Hospice services	____%
☐ Clinical trails	____%	☐ Palliative care	____%
☐ Dialysis	____%	☐ Respite care	____%
☐ Infusion therapy	____%	☐ Special care (Alzheimer's / Dementia)	____%
☐ Obstetrical /doula	____%	☐ Trach / Ventilator	____%
☐ Radiation therapy	____%	☐ Other (specify): _____	____%
☐ Rehabilitation: Physical, Occupational, Speech therapy	____%	**Total Skilled Care Services**	0 **%**

Non-Skilled Services

☐ Companion / Sitter / Personal Care	____%	☐ Mid-Wife	____%
☐ Dietician / Nutritionist	____%	☐ Palliative care	____%
☐ Gastronomy (GT) care	____%	☐ Respite care	____%
☐ Hospice	____%	☐ Other (specify):	____%
		Total Non-Skilled Services	0 **%**

Miscellaneous Services

☐ Child daycare	____%	☐ Social services	____%
☐ Clergy	____%	☐ Supplemental staffing	____%
☐ Handyman	____%	☐ Training/Certification	____%
☐ Meals on Wheels	____%	☐ Telehealth	____%
☐ Medical equipment supplier	____%	☐ Thrift shops	____%
☐ Pet therapy	____%	☐ Wet nurse	____%
☐ Pharmacy	____%	☐ Other (specify):	____%
		Total Miscellaneous Services	0 **%**

10. Does Applicant provide advanced skilled care (i.e. ventilator, chemotherapy, radiation therapy etc.)? ☐ Yes ☐ No
If yes, what are the clinical expertise requirements and/or professional training for staff that will provide these services?

_____

11. Does the Applicant provide pediatric care? ☐ Yes ☐ No
If "yes" what is the percentage of total patients: _____%
If yes, describe the types of pediatric services provided: _____
Are any of the patients deemed medically fragile (i.e.: feeding tube, breathing ventilator)? ☐ Yes ☐ No

12. Does the Applicant provide live-in Home Health Care Service? ☐ Yes ☐ No
If yes, what is the percentage? _____%

13. Location of Services Provided (total must equal100%)

Adult day care facilities	____%	Outpatient facilities	____%
Assisted living facilities	____%	Owned facility	____%
Clinics	____%	Prisons	____%
Doctor's offices	____%	Private homes	____%
Hospitals	____%	Schools	____%
Laboratories	____%	Other:	____%
Nursing homes	____%	**Total:**	0 %

14. Describe any changes in operations planned within the next year: ☐ N/A

_____

15. Is the Applicant accredited or a member of the following health care organizations:
a. Community Health Accreditation Program (CHAP)? ☐ Yes ☐ No
b. Joint Commission on Accreditation of Health Care Organizations (JCAHO)? ☐ Yes ☐ No
c. Any other accrediting organization (please specify)? ☐ Yes ☐ No

_____

Member #: _____

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16. Has the Applicant ever been under investigation or convicted by any state or local authorities, the FBI or Department of Justice? ☐ Yes ☐ No
If "yes", please explain:

17. Annual Staffing – Employees & Independent Contractors:

	Total # of Annual Hours Worked	Employees		Independent Contractors		Annual Payroll (Or 1099 Amount)	
		F/T*	P/T**	F/T*	P/T**	Employees	Independent Contractors
Acupuncturist							
Certified Nurse Anesthetist							
Clergy/Chaplain							
Clerical							
Dietitian							
Nurses (RN)							
LPN/LPV							
Homemaker/Home Health Aide							
Medical Director							
Nurse Practitioner							
Occupational Therapist							
Pharmacist							
Physical Therapist							
Physician							
Physician Assistant							
Psychiatrist							
Psychologist							
Respiratory Therapist							
Social Worker							
Speech Therapist							
Volunteers							
Other (Specify):							
Total:	0	0	0	0	0	0	0

* F/T = Full Time – over 20 hours per week / ** P/T = Part Time – up to 20 hours per week

18. Describe any additional contracted home health care professionals (if different from above types). ☐ N/A

19. Have any claims/suits been made within the last five years against the Applicant? ☐ Yes ☐ No
If "yes", please attach copy of insurance company loss reports for each claim or suit.
(Specify date, description, amount paid and amount outstanding for each claim).

20. Is the Applicant aware of any circumstances which may result in any claim or suit made (including request for medical records)? ☐ Yes ☐ No
If "yes", please explain:

21. Has any company declined, canceled, or refused to renew any of the Applicant's Professional Liability Insurance? ☐ Yes ☐ No
If "yes", please explain:

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22. Previous Professional Liability Insurance (past five years): ☐ N/A

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made or Occurrence Form	Retroactive Date (Claims Made Only)
			$		
			$		
			$		
			$		
			$		
			$		

If no prior coverage, please explain:

23. Limits of Liability Desired:
☐ $500,000 / $1,000,000 ☐ $1,000,000 / $1,000,000 ☐ $1,000,000 / $2,000,000
☐ Other: $_____ occurrence / $ _____ aggregate

SECTION II - HIRING / SCREENING

1. Check all methods used in the hiring / screening process:

	Employee	Contractors	Volunteers
Drug & Alcohol testing			
Criminal background checks – Federal			
Criminal background checks – State			
Reference checks			
Personal interview			
Sexual abuse registry			
Validate work history			
Validate education			
Verify current certification / Professional license			
Validate driver's license			
Validate personal auto insurance and limits (If operating owned vehicle during company Hours)			

2. How are references checked: ☐ Written ☐ Verbal ☐ Both
If verbal only, please explain:

3. Are all of the above methods done prior to hiring? ☐ Yes ☐ No
If "no", please explain:

4. Are job descriptions provided for all professional and nonprofessional employees? ☐ Yes ☐ No
5. What is the average staff turnover rate:_____%
6. Does the Applicant question prospective employees about any previous involvement as defendants in professional malpractice litigation? ☐ Yes ☐ No
If "no", please explain:

7. Does the Applicant verify if potential employees and or independent contractors have ever had their license revoked or suspended, or disciplinary action taken against them? ☐ Yes ☐ No

SECTION III - RISK MANAGEMENT

1. Does the Applicant utilize a formal written Quality Assurance Risk Management Program? ☐ Yes ☐ No
   If "no", please explain:

   _____

2. Are employees and independent contractors required to carry their own individual professional liability coverage? ☐ Yes ☐ No
   Limits of Liability: $_____
3. Are certificates of insurance maintained on file for all employees and independent contractors and updated annually? ☐ Yes ☐ No
4. Does the Applicant have formal HIPAA compliance procedures in place? ☐ Yes ☐ No
5. Has the Applicant developed written protocols that govern the admission and medical treatment of patients for the following policies and procedures:
   a. Complete treatment plan prescribed by the physician, including follow up plans? ☐ Yes ☐ No
   b. Assessments of clients prior to and after accepting the clients? ☐ Yes ☐ No
   c. Client's care and home visits documented? ☐ Yes ☐ No
   d. Documentation of all homecare training? ☐ Yes ☐ No
   e. All changes in the condition of the client or incidents involving the client documented in the records and reported to the family and physician? ☐ Yes ☐ No
6. Is the overall responsibility for Risk Management assigned to one individual in your organization? ☐ Yes ☐ No
   If "yes", please list name and title: _____
   If "no", please describe how these functions are monitored:

   _____

7. Does the Applicant have a formal incident report procedure in place? ☐ Yes ☐ No
8. Is there a peer or committee who reviews the incident reports to improve upon any allegations previously outlined in the surveys or reports? ☐ Yes ☐ No
9. Does the Applicant have formal documented training in place for the following:
   a. Crisis management? ☐ Yes ☐ No
   b. Disposal of medical waste? ☐ Yes ☐ No
   c. First aid? ☐ Yes ☐ No
   d. AED training? ☐ Yes ☐ No
   e. Infusion therapy? ☐ Yes ☐ No
   f. Safe lifting, transferring, and client handling? ☐ Yes ☐ No
   g. Blood borne pathogen? ☐ Yes ☐ No
   h. Safe use of equipment? ☐ Yes ☐ No
   i. Other (please list): _____
10. Are companion care providers certified through the National Association for Home Care and Hospice (NAHC)? ☐ Yes ☐ No
11. Does the Applicant have current contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and/or assisted living homes in place? ☐ Yes ☐ No
    If "yes" is there a review process requiring the following elements:
    a. Hold harmless and indemnification clauses favorable to the applicant? ☐ Yes ☐ No
    b. Insurance requirements? ☐ Yes ☐ No
    c. Confidentiality clause? ☐ Yes ☐ No
    d. Terms and renewal conditions clearly outlined? ☐ Yes ☐ No
    e. Termination clause? ☐ Yes ☐ No
    f. Defined roles and responsibilities? ☐ Yes ☐ No

    ****Please attach copy of all agreements.****
12. Is the staff informed of AIDS/HIV Patients? ☐ Yes ☐ No

13. Do patient records include the following:
    a. A complete treatment plan prescribed by a physician, including follow-up plans? ☐ Yes ☐ No
    b. An "informed consent" document obtained and placed in the patient's medical record? ☐ Yes ☐ No
    c. Patient care home visits meticulously documented? ☐ Yes ☐ No
    d. Complete medical records maintained on all patients? ☐ Yes ☐ No
    e. Patient records kept on file (hardcopy of electronic) for a minimum of 6 years. ☐ Yes ☐ No
    f. All changes in condition and incidents documented to the physician and family? ☐ Yes ☐ No
    g. Is documentation of all homecare training provided? ☐ Yes ☐ No
    h. Medications & dosage, including documentation of administering medications? ☐ Yes ☐ No
    i. A copy of literature given to clients explaining services and fees? ☐ Yes ☐ No
    j. Termination of services and discharge of criteria? ☐ Yes ☐ No
    k. Are standard client contracts used? ☐ Yes ☐ No
    If yes, please attach copy of standard client contract.
14. Does the Applicant conduct patient/client surveys? ☐ Yes ☐ No
15. Are the results of patient/client surveys used to improve day-to-day operations? ☐ Yes ☐ No
16. Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional? ☐ Yes ☐ No
17. Are medications kept in a locked are to prevent tampering? ☐ Yes ☐ No
18. Describe the organization's policy for disposal of controlled substances:

_____

SECTION IV – ABUSE AND MOLESTATION

1. Does your current insurance program include Abuse and Molestation coverage? ☐ Yes ☐ No
   If "yes", what are the limits? $_____
2. Does your organization have a written "zero tolerance" sexual abuse molestation policy? ☐ Yes ☐ No
   Does your written policy include:
   a. Definition of sexual abuse/molestation? ☐ Yes ☐ No
   b. Incident reporting procedures ☐ Yes ☐ No
   c. Investigation procedures? ☐ Yes ☐ No
   d. Disciplinary procedures? ☐ Yes ☐ No
   e. Retaliation warning? ☐ Yes ☐ No
3. 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
4. Have procedures been established to monitor the implementation of the program? ☐ Yes ☐ No
5. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? ☐ Yes ☐ No
6. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if you have an incident of abuse? ☐ Yes ☐ No
7. Are there written complaint procedures and are they displayed prominently? ☐ Yes ☐ No
   If "no" please explain:

_____

8. Are there written procedures that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ Yes ☐ No
9. Is there formal staff training on sexual abuse, including how to recognize the signs? ☐ Yes ☐ No
10. Is there more than one person responsible for the welfare of any single patient? ☐ Yes ☐ No
11. Have any incidents resulted in an allegation of sexual abuse? ☐ Yes ☐ No
    a. Was the case settled? ☐ Yes ☐ No
    b. Was the case taken to trial? ☐ Yes ☐ No
    c. Amount paid for damages to the victim: $_____

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

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SECTION V - AUTOMOBILE

1. Does the Applicant own or lease any vehicles? ☐ Yes ☐ No
2. Does the Applicant need coverage for non-owned automobiles? ☐ Yes ☐ No
3. Does the Applicant have a program to monitor an employee's personal auto liability insurance program:
   a. At time of hire? ☐ Yes ☐ No
   b. Annually? ☐ Yes ☐ No
4. Does the Applicant run MVRs on all employees:
   a. At time of hire? ☐ Yes ☐ No
   b. Annually? ☐ Yes ☐ No
   c. Randomly (based on accidents or suspicions) ☐ Yes ☐ No
5. What action is taken if an "unacceptable" driver is identified?

_____

6. Does Applicant's employees or volunteers transport clients in their own automobiles? ☐ Yes ☐ No
   If "yes", does the Applicant provide or require completion of medical emergency training for transportation of clients? ☐ Yes ☐ No
   If "yes", does the Applicant require evidence of regular preventative maintenance? ☐ Yes ☐ No
7. Does the Applicant allow employees to operate a patient or client's vehicle? ☐ Yes ☐ No
   If "yes", how does the Applicant verify patient and/or client owned automobile liability insurance coverage is in force?

_____

8. Does the Applicant transport non-ambulatory clients? ☐ Yes ☐ No
9. Does the Applicant contract with an ambulance or livery service to transport clients? ☐ Yes ☐ No
10. How many drivers use personal vehicles for business? Volunteer:_____ F/T*: _____ P/T**: _____
    *F/T = Full Time – over 20 hours per week / ** P/T = Part Time – up to 20 hours per week
11. What is the maximum and minimum age of drivers allowed to drive clients? Max: _____ Min:_____
12. Does the Applicant allow personal use of a company-owned vehicle? ☐ Yes ☐ No
13. Does the Applicant make sure travel logs are kept for all drivers? ☐ Yes ☐ No
14. Does the Applicant transport clients/consumers for other private or government agencies? ☐ Yes ☐ No
    If yes, please explain: _____
    If yes, for a fee? ☐ Yes ☐ No

FRAUD NOTICE STATEMENTS

NOTICE TO APPLICANTS: "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 MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF ALASKA APPLICANTS: "A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY FILES A CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE PROSECUTED UNDER STATE LAW."

RESIDENTS OF ARKANSAS APPLICANTS: **"**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."

RESIDENTS OF ARIZONA APPLICANTS: "FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF COLORADO APPLICANTS: "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."

RESIDENTS OF DISTRICT OF COLUMBIA APPLICANTS: "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 THE APPLICANT."

RESIDENTS OF FLORIDA RESIDENTS APPLICANTS: "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."

RESIDENTS OF KANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF KENTUCKY APPLICANTS: "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."

RESIDENTS OF LOUISIANA APPLICANTS: **"** 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."

RESIDENTS OF MAINE APPLICANTS: "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."

RESIDENTS OF MARYLAND APPLICANTS: **"** 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."

RESIDENTS OF MINNESOTA APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF NEW MEXICO APPLICANTS: "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."

RESIDENTS OF NEW YORK APPLICANTS: "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."

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RESIDENTS OF OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF OKLAHOMA APPLICANTS: "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."

RESIDENTS OF OREGON APPLICANTS: "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."

RESIDENTS OF PENNSYLVANIA APPLICANTS: "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."

RESIDENTS OF TENNESSEE APPLICANTS: "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."

RESIDENTS OF TEXAS APPLICANTS: IF A LIFE, HEALTH AND ACCIDENT INSURER PROVIDES A CLAIM FORM FOR A PERSON TO USE TO MAKE A CLAIM, THAT FORM MUST CONTAIN THE FOLLOWING STATEMENT OR A SUBSTANTIALLY SIMILAR STATEMENT: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

RESIDENTS OF VERMONT APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICTION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

RESIDENTS OF VIRGINIA APPLICANTS: "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 AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WASHINGTON APPLICANTS: **"**IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WEST VIRGINIA APPLICANTS: "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."

Name (Please Print/Type) T itle
(MUST BE SIGNED BY THE PRESIDENT CHAIRMAN OR EXECUTIVE DIRECTOR)

Signature Date

The above signed warrants that he/she is authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the **Applicant** and their respective Directors, Officers or other insured persons.

Produced By: (Section to be completed by Producer/Broker)

Producer

Agency

Producer License Number

Agency Taxpayer ID or SS Number

Address (Street, City, State, Zip)

HOMECARE & HOSPICE
National Association for Home Care & Hospice
MEMBER 2012

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SECTION VI - MEDICAL SUPPLIES

1. Does the Applicant manufacture any products? ☐ Yes ☐ No
   If "yes", please describe:

2. Does the Applicant provide any durable medical equipment to clients? ☐ Yes ☐ No
   If "yes", please describe:

3. Does the Applicant sell any medical supplies or equipment? ☐ Yes ☐ No
   If "yes", please describe:

   Total annual sales: $_____

4. Does the Applicant rent or lease any medical supplies or equipment to others? ☐ Yes ☐ No
   Total rental or leasing receipts: $_____
5. Does the Applicant repair or perform maintenance on any medical supplies or equipment? ☐ Yes ☐ No
6. Is the Applicant named as an Additional Insured – Vendor on the manufacturer or supplier's policy for any products? ☐ Yes ☐ No
7. Does the Applicant obtain certificates of insurance from their product suppliers? ☐ Yes ☐ No
8. Has the Applicant ever distributed or directly imported products from a foreign manufacturer? ☐ Yes ☐ No
9. Does the Applicant modify any product in any way from its intended use? ☐ Yes ☐ No
   If "yes", please explain:

10. Does the Applicant repackage or re-label any items obtained from suppliers? ☐ Yes ☐ No
11. Do manufacturer's labels remain on the equipment? ☐ Yes ☐ No
12. Are serial numbers of the finished product shown on invoices and complete records of inventory kept? ☐ Yes ☐ No
13. Products Offered (percentages must equal 100%)

Product/Service		Product/Service	
Apnea monitors	____%	Parental Therapy	____%
Apnea monitors – infant	____%	Pharmacy sales	____%
Auto conversions / modifications	____%	Photo therapy equipment - infants	____%
Bed, commodes	____%	Scooters	____%
Blood cleansing or recirculation equipment	____%	Safety bar / Grab bar installation	____%
Chemotherapy	____%	Safety bar / Grab bar sales	____%
CPAP / BIBPAP	____%	Sleep apnea studies	____%
CPM	____%	Stair lift – installation	____%
Diabetic shoes	____%	Stair lift – sales	____%
Enteral Therapy	____%	Ten units	____%
Infant beds or cribs	____%	Ventilators	____%
Liquid oxygen	____%	Do you instruct on the use of ventilators? ☐ Yes ☐ No	
Medical gas piping	____%	Walkers, crutches, canes	____%
Nebulizers	____%	Wheel chair – motorized	____%
Orthotics & prosthetic sales or fitting	____%	Wheel chair – manual	____%
Oxygen concentrators	____%	Other:	____%
Oxygen cylinders	____%	Other:	____%
Oxygen regulators and values	____%	**ABOVE MUST TOTAL 100%:**	0 %

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SECTION VII- SUPPLEMENTAL STAFFING

1. If the Applicant provides any supplemental staffing services please advise:
   a. Total revenues derived from supplemental staffing services: $_____
   b. Percentage of total revenues by location of staffing services (total must equal 100%)

Adult day care facilities	_____%	Nursing home/Assisted or Independent Living facilities	_____ %
Clinics	_____%	Prison facilities	_____ %
Doctors offices	_____%	Schools	_____ %
Hospices	_____%	Other (specify):_____	_____ %
Hospitals	_____%	**Total:**	0 %
Laboratories	_____%		

2. If Supplemental Staffing is provided to Hospitals, please specify percent of total revenues by specialized service (total must equal 100%)

Coronary care unit	_____%	Obstetrical	_____ %
Emergency department	_____%	Pediatric	_____ %
Intensive care unit	_____%	Psychiatric	_____ %
Medical/Surgical unit	_____%	All other units (specify)_____	_____ %
Neonatal	_____%	**Total:**	0 %

3. Do contractual agreements to provide temporary or supplemental staffing to client facilities include the following provisions:
   a. Mutual indemnification and hold harmless agreements? ☐ Yes ☐ No
   b. Require third parties to carry liability insurance with limits of at least $1m/$3m? ☐ Yes ☐ No
   c. Please provide a copy of your standard contract.

SECTION VIII - PHARMACY

1. If Applicant owns or operates a pharmacy what are the total receipts from:
   a. Retail pharmacy $_____
   b. Closed pharmacy $_____
   c. Mail Orders $_____
   d. Does the pharmacy compound medications? ☐ Yes ☐ No
   e. Does the pharmacy dispense controlled narcotics? ☐ Yes ☐ No
   f. Does the pharmacy dispense medications to patients? ☐ Yes ☐ No
   g. Does the pharmacy provide medications to other organizations? ☐ Yes ☐ No
      If "yes", please describe:

_____

SECTION IX – CHILDCARE / DAYCARE

1. What is the total percentage of operations derived from child care / nanny care / day care? _____%
2. What is the total number of individuals providing childcare / nanny care / day care:
   Employees: _____ Independent Contractors:_____ Volunteers:_____
   Are the above individuals included in question #18 of Section 1 and the payroll figures? ☐ Yes ☐ No
3. Please provide the number of child care / nanny care / day care visits you make in a month: _____
4. Does the Applicant provide transportation of children? ☐ Yes ☐ No
   If yes, how many trips and average miles per month?_____
5. Are any of the patients deemed medically fragile (i.e.: feeding tube, breathing ventilator)? ☐ Yes ☐ No