

HOME MEDICAL EQUIPMENT SUPPLEMENTAL APPLICATION

Pages 1 – 5 must be completed on all submissions.

1. If you would like a quote for Abuse & Molestation, complete Page 6.
2. If you would like a quote for Automobile, complete Page 7.
3. If you would like a quote for Professional Liability, complete Page 8 -11.

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: _____

Date business established: _____ # of years under present management: _____

Federal Employer Tax I.D. Number: _____

Website address (if available): _____

Name and phone number of person to contact for inspection: _____

SUBMISSION REQUIREMENTS

- PHL Home Medical Equipment Dealer Supplemental Application
- ACORD Applications (Applicant Information, including Crime and Umbrella)
- Currently valued insurance company loss runs for the current policy period and four prior years

APPLICANT INFORMATION

1. Limits of liability desired:
 \$500,000/\$1,000,000 \$1,000,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000
 Other: \$ _____ Occurrence / \$ _____ Aggregate
2. Has the Applicant ever carried insurance that was on a Claims Made basis? Yes No
If yes, what is the Retro Date? _____
3. Total annual Gross Revenues: \$ _____
Total receipts from Retail: \$ _____
Total receipts from Rentals: \$ _____
Total receipts from Wholesale: \$ _____
Total receipts from Professional Services: \$ _____
4. Is the Applicant a member of any State Association? Yes No
If yes, please provide the name of the State Association: _____
5. Is the Applicant a member of any other industry association(s)? Yes No
Please specify: _____

6. Does the applicant manufacture or directly import any products?
If yes, please explain:

Yes No

Products Offered: (percentages must equal 100%)		
Product	Product	Product
Antibiotics Therapy _____ %	Liquid Oxygen _____ %	Safety bar / Grab bar installation _____ %
Apnea monitors _____ %	Medical gas piping _____ %	Safety bar / Grab bar sales _____ %
Apnea monitors - infant _____ %	Nebulizers _____ %	Sleep apnea Studies _____ %
Auto conversions / modifications _____ %	Orthotics & prosthetic sales or fitting _____ %	Stair lift - installation _____ %
Beds, commodes _____ %	Oxygen Concentrators _____ %	Stair lift – sales _____ %
Blood Cleansing or recirculation equipment _____ %	Oxygen Cylinders _____ %	Tens Units _____ %
Chemotherapy _____ %	Oxygen regulators and valves _____ %	Ventilators _____ % Do you instruct on the use of ventilators? <input type="checkbox"/> Yes <input type="checkbox"/> No
CPAP / BIPAP _____ %	Parenteral Therapy _____ %	Walkers, crutches, canes _____ %
CPM _____ %	Pharmacy Sales _____ %	Wheel chair - motorized _____ %
Diabetic Shoes _____ %	Photo therapy equipment - infants _____ %	Wheel chair – manual _____ %
Enteral Therapy _____ %	Scooters _____ %	
Other: _____ %	Other: _____ %	
		ABOVE MUST TOTAL 100%: <u>0</u>

7. Is the Applicant named as an Additional Insured – Vendor on the manufacturer's or supplier's policy for products?

Yes No

8. Does the Applicant obtain certificates of insurance from their product suppliers?

Yes No

9. Has the Applicant ever distributed or directly imported products from a foreign manufacture?

Yes No

10. Does the Applicant modify any product in any way from its intended use?
If yes, please explain:

Yes No

11. Does the Applicant repackage or re-label any items obtained from suppliers?

Yes No

12. Do the manufacture's labels remain on the equipment?

Yes No

13. Are serial numbers of the finished product shown on invoices and complete records of inventory kept?

Yes No

14. Does the Applicant contract or subcontract labor for any installation, service or repair of any equipment?
If yes, please explain.

Yes No

15. If oxygen is offered, does the applicant offer a 24 hour service program?

Yes No

16. Does the Applicant service any products not sold or rented by you? Yes No
If yes, please explain:

17. Does the Applicant repair or perform maintenance on any medical supplies or equipment? Yes No
If yes, please explain:

18. Does the Applicant provide reconditioning service for mobility equipment? Yes No
If yes, please explain:

ABUSE AND MOLESTATION

1. Does the Applicant current insurance program include Abuse and Molestation coverage?
If yes, what are the limits? \$ _____ Yes No
2. Does the Applicant's employment application include questions about whether the individual has ever been convicted for any crime, including sex-related or child-abuse related offenses? Yes No
3. 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
4. Are there written complaint procedures and are they displayed prominently?
If no please explain: _____ Yes No

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

AUTO INFORMATION

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. Do all Applicant's employees or volunteers transport clients in their own automobiles (appointments or errands)? Yes No
 7. Does the Applicant transport non-ambulatory clients? Yes No
 8. Does the Applicant contract with an ambulance or livery service to transport clients? Yes No
 9. How many drivers used personal vehicles for business? ___ F/T* ___ P/T** ___ Vol.
 *F/T = Full Time – over 20 hours per week
 **P/T = Part Time – up to 20 hours per week
 10. What is the maximum and minimum age of drivers allowed to drive clients? ___ Max ___ Min
 11. Does the Applicant allow personal use of a company-owned vehicle? Yes No
 12. Does the Applicant make sure travel logs are kept for all drivers? Yes No

PROFESSIONAL LIABILITY

Supplemental Services (Supplying health care providers to other facilities for a fee): IF "NO" check here:

Type		Type	
Private Homes _____%		Hospitals _____%	
Doctor's Offices _____%		Nursing Homes _____%	
Assisted Living Facilities _____%		Other: _____%	

Professional Liability Employees / Independent Contractors – Annual Staffing:

	Employees		Independent Contractors		Annual Payroll	
	Full Time	Part Time	Full Time	Part Time	Employees	Independent Contractors
Acupuncturist						
Certified Nurse Anesthetist						
Clergy / Chaplain						
Clerical						
Dietitian						
Nurses (RN)						
Homemaker / Home Health Aid						
LPN / LVN						
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

1. Describe any additional contracted Home Health Care operations (if different from above types):

2. Describe any changes in operations planned within the next year:

3. 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:

4. 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).

5. 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:

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

7. Previous Professional Liability Insurance (past five years):

Company	Limits of	Effective Dates	Annual Premium	Claims Made	Retroactive Date (Claims)
			\$		
			\$		
			\$		
			\$		
			\$		

8. Limits of Liability Desired:
 \$500,000/\$1,000,000 \$1,000,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000
 Other: \$ _____ Occurrence / \$ _____ Aggregate

PROFESSIONAL LIABILITY HIRING / SCREENING

1. Are all employees and contractors screened to rule out drug, alcohol and sexual abuse? Yes No

2. Check all methods used in hiring all employees or independent contractors:

- Drug Testing Yes No
- Criminal Background Checks – Federal Yes No
- Criminal Background Checks – State Yes No
- Reference Checks Yes No
- Personal Interview Yes No
- Sexual Abuse Registry Yes No
- Validate Work History Yes No
- Validate Education Yes No
- Verify Current Certification / Professional License Yes No
- Validate Driver's License Yes No
- Validate Personal Auto Insurance and Limits (if operating owned vehicle during company hours) Yes No

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

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

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

6. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? Yes No

7. What is the average staff turnover rate: _____

8. Does the Applicant question prospective employees about any previous involvement as defendants in professional malpractice litigation? Yes No
If no, please explain:

9. 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

PROFESSIONAL LIABILITY RISK MANAGEMENT

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

2. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? Yes No

3. Are employees required to carry their own individual professional liability coverage? Yes No
Limits of Liability: \$ _____

4. Are independent contractor's required to carry their own individual professional liability coverage? Yes No
Limits of Liability: \$ _____

5. Are certificates of insurance maintained on file for all employees and independent contractors and updated annually? Yes No

6. Does the Applicant have formal HIPAA compliance procedures in place? Yes No

7. 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

8. 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:

9. Does the Applicant have a formal incident report procedure in place? Yes No

10. Is there a peer or committee who review the incident reports to improve upon any allegations previously outlined in the surveys or reports? Yes No

11. Does the Applicant have formal documented training in place for the following:
- | | | |
|--|------------------------------|-----------------------------|
| a. Crisis Management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Disposal of Medical waste | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. First Aid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. AED Training | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Infusion Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Safe lifting, transferring, and client handling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Blood borne Pathogen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Safe use of equipment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Other (please list): _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
12. Are companion care providers certified through the National Association for Home Care and Hospice (NAHC)? Yes No
13. Do all contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and assisted living homes include a hold harmless agreement? Yes No
14. Is the staff informed of AIDS/HIV Patients? Yes No
15. Do patient records include the following:
- | | | |
|--|------------------------------|-----------------------------|
| a. A complete treatment plan prescribed by a physician, including follow-up plans? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. An "informed consent" document obtained and placed in the patient's medical record? (informed consent laws vary by state) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Patient care home visits meticulously documented? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Complete medical records maintained on all patients? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Patient records kept on file (hardcopy of electronic) for a minimum of 6 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. All changes in condition and incidents documented to the physician and family? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Is documentation of all homecare training provided? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Medications & dosage, including documentation of administering medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. A copy of literature given to clients explaining services and fees? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Termination of services and discharge criteria? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
16. Does the Applicant conduct patient / client surveys? Yes No
17. Are the results of patient / client surveys used to improve day to day operations? Yes No
18. Are medications ordered by a licensed physician and administered by or under the close supervision of a qualified medical professional? Yes No
19. Are medications kept in a locked area to prevent tampering? Yes No
20. Describe the organization's policy for disposal of controlled substances?
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