



**ALLIED MEDICAL HOME HEALTH 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:

- Number of independent contractors: _____
Cost of independent contractors: \$ _____
- Do you require and keep certificates of insurance for all independent contractors? No Yes
- Does the applicant utilize a formal written Quality Assurance & Risk Management Program? No Yes
If "No," explain: _____
- Is the overall responsibility for Risk Management assigned to one individual in your firm? No Yes
If "Yes," explain: _____
- 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:

- 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			<input type="checkbox"/> No <input type="checkbox"/> Yes					
LPN's			<input type="checkbox"/> No <input type="checkbox"/> Yes					
RN's			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Nurse Practitioner			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Physical Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Respiratory Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Speech Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Occupational Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Social Worker			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Pharmacist			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Special Training			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Physicians' Assistants			<input type="checkbox"/> No <input type="checkbox"/> Yes					
CRNA's			<input type="checkbox"/> No <input type="checkbox"/> Yes					
Other (specify):			<input type="checkbox"/> No <input type="checkbox"/> Yes					

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

- 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.