☐ **Scottsdale Insurance Company**
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 18700 North Hayden Road
Scottsdale, Arizona 85255

☐ **Scottsdale Surplus Lines Insurance Company**
Adm. Office: 18700 North Hayden Road
Scottsdale, Arizona 85255

HOME HEALTH CARE AND MISCELLANEOUS HOME SERVICES GENERAL LIABILITY APPLICATION

Applicant's Name: _____

Mailing Address: _____

Location Address: _____

Agency Name: _____

Agent No.: _____

Address: _____

E-mail: _____

Phone No.: _____

PROPOSED EFFECTIVE DATE: From _____ To _____ **12:01 A.M., Standard Time at the address of the Applicant**

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE" (N/A)

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Limited Liability Company
☐ Other (Specify): _____

Website Address: _____

E-mail Address: _____ **Phone No.:** _____

Limits Of Liability and Deductible Requested:

General Aggregate (other than Products/Completed Operations)	$
Products and Completed Operations Aggregate	$
Personal and Advertising Injury (any one person or organization)	$
Each Occurrence	$
Damage To Premises Rented To You (any one premise)	$
Medical Expense (any one person)	$
Errors and Omissions Coverage (Included up to General Liability Limits) — Each Claim — Aggregate	$ $
Sexual and/or Physical Abuse Coverage	☐ $25,000/$50,000 ☐ $50,000/$100,000 ☐ $100,000/$300,000
Other Coverages, Restrictions and/or Endorsements:	$
Deductible	$

1. **Number of years in operation:** .....

2. **How long under present management?** _____

(If fewer than five years, attach principals' resumes. If principals in the firm do not have a health care background, then also include the resume of the Director of Nursing or the individual responsible for hiring, screening and monitoring the work activities of applicant's employees.)

3. **Services provided by percentage of total operations (must total one hundred percent [100%]):**

Assisted Living Facilities	%	Medical Equipment Supplier	%
Babysitters	%	Medical Marijuana Caregivers	%
Clinical Trials	%	Midwives/Doula	%
Clinics Owned/Operated	%	Nanny/Au Pair	%
Convalescent/Nursing Home	%	Nurse—General (LPN, LVN)	%
Dietician/Nutritionist	%	Nurse—Practitioner	%
Errand Service	%	Nurse—Registered (RN)	%
Homemaker Aides	%	Nurse—Student	%
Homemaker Health Aides	%	Nurses Aides (CNA, STNA, NA/R)	%
Hospice	%	Occupational Therapy	%
Hospital	%	Patient Care Assistants	%
Infant/Pediatric Care	%	Personal and Home Care Aides (AKA—Caregivers, Companions, Personal Attendants, and Sitters)	%
Infusion Therapy Centers	%	Personal Trainers	%
Infusion Therapy:	%	Pharmacist	%
Antibiotic Therapy	%	Pharmacy	%
Antiviral Therapy	%	Physical Therapy	%
Blood Transfusion	%	Physician	%
Chemotherapy	%	Physician Assistant	%
Dialysis	%	Radiation Therapy	%
Home Enteral Nutrition (HEN)	%	Rehabilitation	%
Hydration Therapy	%	Respiratory Therapy	%
Pain Management	%	Respite Care	%
Total Parenteral Nutrition (TPN)	%	Shopping Service	%
Other (describe):	%	Social Worker	%
		Speech Therapy	%
Laboratory Services	%	Ventilator	%
Licensed Counselors	%	Other (describe):	%
Mail Pick-up	%		
Meals on Wheels	%	Other (describe):	%

4. **Employees and independent contractors are placed (by percentage) at the following locations:**

Assisted Living Facilities	%	Laboratories	%
Clinics	%	Owned Facility Describe services:	%
Convalescent/Nursing/ACLF Homes	%		
Home Health—Private Homes	%		
Hospice Facilities	%	Physician's Office	%
Hospitals	%	Schools	%
Infusion Therapy Centers	%	Other (describe):	%
Jails/Prisons/Detention Centers	%		

(Attach any brochures, literature or descriptive materials provided to the client.)

5. **If employees or independent contractors are placed in hospitals, clinics, physician's offices, hospice, convalescent/nursing/ACFL homes, jails, prisons or detention centers, advise if hired by:**.....☐ Facility ☐ Patient ☐ Patient's Guardian

6. **Employees and Independent Contractors—Annual Staffing:**

Professional Classification Type	EMPLOYEES		INDEPENDENT CONTRACTORS	
	Number of Employees		Number of Subcontracted Workers	Certificates of Insurance required?
	Full Time	Part Time		
Dietician/Nutritionist				☐ yes ☐ no
Infant/Pediatric Care				☐ yes ☐ no
Licensed Counselors				☐ yes ☐ no
Medical Director				☐ yes ☐ no
Medical Marijuana Caregiver				☐ yes ☐ no
Nurse—Practitioner				☐ yes ☐ no
Nurse—Registered (RN)				☐ yes ☐ no
Nurse—General (LPN, LVN)				☐ yes ☐ no
Occupational Therapist				☐ yes ☐ no
Pharmacist				☐ yes ☐ no
Physical Therapist				☐ yes ☐ no
Physician				☐ yes ☐ no
Physician Assistant				☐ yes ☐ no
Psychologist				☐ yes ☐ no
Rehabilitation Therapist				☐ yes ☐ no
Respiratory Therapist				☐ yes ☐ no
Social Worker				☐ yes ☐ no
Speech Therapist				☐ yes ☐ no
X-Ray Technicians				☐ yes ☐ no
Other (describe):				☐ yes ☐ no

Non-Professional Classification Type	EMPLOYEES		INDEPENDENT CONTRACTORS	
	Number of Employees		Number of Subcontracted Workers	Certificates of Insurance required?
	Full Time	Part Time		
Certified Nursing Assistants (CNA)				☐ yes ☐ no
Homemaker Health Aides				☐ yes ☐ no
Midwives/Doula				☐ yes ☐ no
Nurse Aides				☐ yes ☐ no
Nursing Assistants—Registered (NA/R)				☐ yes ☐ no
Patient Care Assistants				☐ yes ☐ no
Personal and Home Care Aides				☐ yes ☐ no
Social Worker				☐ yes ☐ no

Non-Professional Classification Type	EMPLOYEES		INDEPENDENT CONTRACTORS	
	Number of Employees		Number of Subcontracted Workers	Certificates of Insurance required?
	Full Time	Part Time		
Student Nurses				☐ yes ☐ no
Other (describe):				☐ yes ☐ no

Miscellaneous Services Classification Type	EMPLOYEES		INDEPENDENT CONTRACTORS	
	Number of Employees		Number of Subcontracted Workers	Certificates of Insurance required?
	Full Time	Part Time		
Babysitters				☐ yes ☐ no
Errand Service				☐ yes ☐ no
Homemaker Aides (not Homemaker Health Aides)				☐ yes ☐ no
Mail Pick-up				☐ yes ☐ no
Nanny/Au Pair				☐ yes ☐ no
Shopping Service				☐ yes ☐ no

7. Operations conducted in the following states:

State: _____ Licensed with state? ..... ☐ Yes ☐ No License No.: _____

State: _____ Licensed with state? ..... ☐ Yes ☐ No License No.: _____

State: _____ Licensed with state? ..... ☐ Yes ☐ No License No.: _____

8. Schedule of Hazards:

Operations—Payroll and Sales Information	PROFESSIONAL		NON-PROFESSIONAL	
	Annual Payroll/Cost	Annual Sales/Receipts	Annual Payroll/Cost	Annual Sales/Receipts
Employees providing services away from owned or operated health care facilities	$	$	$	$
Employees providing services at owned or operated health care facilities	$	$	$	$
Independent Contractors providing services away from owned or operated health care facilities	$	$	$	$
Independent Contractors providing services at owned or operated health care facilities	$	$	$	$
Medical Equipment/Supplies Sales and Rental	$	$	$	$
Pharmacy owned or operated by applicant	$	$	$	$
Transportation Services	$	$	$	$
Other (describe):	$	$	$	$
Total:	**$**	**$**	**$**	**$**

9. **Has applicant's license ever been revoked, suspended, voluntarily surrendered, or had enforcement action?** ☐ Yes ☐ No

If yes, provide details and corrective action taken: _____

_____

_____

10. **Name all subsidiary companies/locations and others coming under applicant's control (if none, please state):**

_____

_____

11. **Is the applicant a member of any:**

a. State Association? ☐ Yes ☐ No

If yes, name of association(s): _____

b. Industry Association? ☐ Yes ☐ No

If yes, name of association(s): _____

c. Health Care accrediting organization? ☐ Yes ☐ No

If yes, name of organization(s): _____

12. **Has applicant sold, acquired or discontinued any operations in the last five years or plan to change operations within the next year?** ☐ Yes ☐ No

If yes, explain: _____

_____

13. **Is at least one of the principals or an Administrator/Director of Nursing involved in the operation on a full time basis?** ☐ Yes ☐ No

14. **Does applicant provide foster care placement?** ☐ Yes ☐ No

15. **Applicant's workforce is comprised of:**

Employees: _____% Independent Contractors: _____%

16. **As part of hiring/screening of new employees or independent contractors, does applicant:**

a. Verify certifications and/or professional licenses and confirm status? ☐ Yes ☐ No

b. Contact applicants' references before they are hired/placed? ☐ Yes ☐ No

c. Require, if hired/placed, that they sign a formal confidentiality statement? ☐ Yes ☐ No

d. Obtain criminal background checks? ☐ Yes ☐ No

e. Review sexual abuse registry? ☐ Yes ☐ No

f. Conduct a personal interview? ☐ Yes ☐ No

g. Validate education? ☐ Yes ☐ No

h. Validate work history? ☐ Yes ☐ No

i. Have a formalized disease, drug or alcohol screening process? ☐ Yes ☐ No

j. Validate driver's license? ☐ Yes ☐ No

k. Ask if any previous involvement as a defendant in professional malpractice litigation? ☐ Yes ☐ No

l. Ask if they ever had their license revoked, suspended, or had disciplinary action taken against them? ☐ Yes ☐ No

17. **When using independent contractors, does applicant require the following information from them:**

a. Professional Liability Certificate of Insurance? ☐ Yes ☐ No

If yes, specify minimum limits required: $_____

b. Historical Loss Information? ☐ Yes ☐ No

c. Hold Harmless and indemnification clauses favorable to the applicant? ☐ Yes ☐ No

18. Does applicant have formal documented training in place for the following:

- **a.** Crisis Management? ☐ Yes ☐ No
- **b.** Disposal of medical waste, controlled substances, contaminated supplies or equipment? ☐ Yes ☐ No
- **c.** First Aid, CPR, and AED Training? ☐ Yes ☐ No
- **d.** Infusion Therapy? ☐ Yes ☐ No
- **e.** Safe lifting, transferring and client handling? ☐ Yes ☐ No
- **f.** Blood borne Pathogen? ☐ Yes ☐ No
- **g.** Safe use and operation of equipment? ☐ Yes ☐ No

19. Are job descriptions, detailing job duties and responsibilities, given to all employees and independent contractors? ☐ Yes ☐ No

20. What is the applicant's average staff turnover rate in a calendar year for:

Professional Staff: _____% Non-Professional Staff: _____%

21. Are any professional services provided on applicant's premises (doctor's office, clinic, infusion therapy center, etc.)? ☐ Yes ☐ No

If yes, explain: _____

_____

22. Does applicant provide bed and board facilities (convalescent home, hospice, assisted living facility, etc.)? ☐ Yes ☐ No

If yes, explain: _____

_____

23. Does applicant have written policies and/or procedures for the following:

- **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 care and home visits documented? ☐ Yes ☐ No
- **d.** Documentation of all homecare training? ☐ Yes ☐ No
- **e.** All changes in the condition of the client are documented in the records and reported to the family and physician? ☐ Yes ☐ No
- **f.** Client incident report procedure is in place with notification also given to family and physician? ☐ Yes ☐ No
- **g.** Medications and dosage, including documentation of administering medications? ☐ Yes ☐ No
- **h.** A copy of all literature given to clients explaining services and fees? ☐ Yes ☐ No
- **i.** Termination of services and discharge criteria? ☐ Yes ☐ No

24. Are medications ordered by a licensed physician and administered, discarded and documented by or under the close supervision of a qualified medical professional in accordance with legal requirements for controlled substances? ☐ Yes ☐ No

25. If applicant provides advanced skilled care (i.e., infusion therapy, ventilator, chemotherapy, radiation therapy, etc.), what are the clinical expertise requirements and/or professional training for the staff that provides these services? _____

_____

26. Does applicant have Workers' Compensation coverage in force? ☐ Yes ☐ No

27. Does applicant have any contractual agreements wherein applicant assumes the liability of others? ☐ Yes ☐ No

If yes, attach a list of each entity and the type of service(s) applicant provides.

28. Does applicant sell, rent or lease any medical supplies and/or equipment? ☐ Yes ☐ No

If yes, provide details: _____

_____

29. Does applicant own/operate a pharmacy or provide pharmaceutical products? ☐ Yes ☐ No

30. Does applicant manufacture any products? ☐ Yes ☐ No

If yes, advise: _____

_____

31. Has applicant ever distributed directly imported products from a foreign manufacturer? ☐ Yes ☐ No

If yes, advise: _____

_____

32. Does applicant modify any product or repackage/relabel any items obtained from suppliers? ☐ Yes ☐ No

If yes, advise: _____

_____

33. Is all equipment checked and its condition documented prior to release? ☐ Yes ☐ No

34. Explain arrangement for medical emergencies (i.e., M.D. on call, transfer arrangement with hospital, etc.):

_____

_____

35. Is staff informed of all patients with AIDS/HIV? ☐ Yes ☐ No

36. Copy of applicant's State(s) Home Health Care License and most recent State Licensure Survey attached (if any): ☐ Yes ☐ No

37. Does applicant and/or employees provide transportation services for patients? ☐ Yes ☐ No

If yes:

a. Are there any emergency transportation services provided? ☐ Yes ☐ No

b. Transportation services are provided in conjunction with:

☐ Professional home health care services _____%

☐ Non-Professional home health care services _____%

☐ Miscellaneous home health care services _____%

Provide details: _____

_____

_____

c. Does applicant and/or employees use their personal vehicles to transport patients? ☐ Yes ☐ No

d. Is Auto Liability coverage in place with limits equal to or greater than the applicant's General Liability limits for all vehicles utilized? ☐ Yes ☐ No

e. Are certificates of insurance obtained for Auto Liability for employees' vehicles? ☐ Yes ☐ No

f. Does applicant obtain Waiver of Liability from patients? ☐ Yes ☐ No

38. Additional Insured Information:

Name	Address	Interest

39. Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies? ☐ Yes ☐ No

If yes, describe: _____

_____

40. Does applicant have other business ventures for which coverage is not requested? ☐ Yes ☐ No

If yes, explain and advise where insured: _____

_____

41. Does applicant have any other premises, operations or exposures not stated in this application? ☐ Yes ☐ No

If yes, explain: _____

_____

42. During the past five years, have any claims been made or suits brought against the applicant because of alleged malpractice, error, mistake or premises accident arising in any manner out of applicant's operation? ☐ Yes ☐ No

If yes, date: _____

If yes, explain: _____

_____

43. During the past three years, has any company canceled, declined or refused similar insurance to the applicant? (Not applicable in Missouri) ☐ Yes ☐ No

If yes, explain: _____

_____

44. Prior Carrier Information:

	Year:	**Year:**	**Year:**	**Year:**	**Year:**
Carrier					
Policy No.					
Coverage					
Occurrence or Claims Made					
Total Premium	$	$	$	$	$

45. Loss History—Five Year Period:

Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior five years. ☐ Check if no losses in the last five years.

Date of Loss	**Description of Loss**	**Amount Paid**	**Amount Reserved**	**Claim Status (Open or Closed)**
		$	$	
		$	$	
		$	$	
		$	$	
		$	$	

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

FRAUD WARNING: 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. (Not applicable in AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, MN, NE, NJ, NY, OH, OK, OR, RI, TN, VA, VT, or WA.)

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE TO CALIFORNIA APPLICANTS. For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NOTICE TO 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

WARNING TO DISTRICT OF COLUMBIA APPLICANTS: 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.

NOTICE TO FLORIDA 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.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, 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, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance 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 subjects such person to criminal and civil penalties.

NOTICE TO 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.

NOTICE TO 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.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO 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.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO 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.

FRAUD WARNING (APPLICABLE IN ARKANSAS, LOUISIANA AND RHODE ISLAND): 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.

FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON): Any person who intentionally presents a materially false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON): 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.

NEW YORK FRAUD WARNING: 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.

APPLICANT'S STATEMENT:

I have read the above application and I declare that to the best of my knowledge and belief all of the foregoing statements are true, and that these statements are offered as an inducement to us to issue the policy for which I am applying.

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: _____ DATE: _____

AGENT NAME: _____ AGENT LICENSE NUMBER: _____

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT: _____

_____