



HOME COMPANION CARE (BASIC NON-NURSING) APPLICATION

BUSINESS INFORMATION

1. Proposed First Named Insured & Other Named Insured(s):

2. Mailing Address Street City County State ZIP Code

3. Telephone: _____ Fax: _____
 Website: _____

4. Contact Person/Phone #: _____ Inspection: _____
 Accounting/Records: _____

5. Business Type: Individual Partnership Corporation LLC Trust
 Other (specify): _____

6. Operating as: For Profit Nonprofit Other

7. Date Business Established: _____

8. Indicate states licensed and certified in:
 Provide details of what your license/certification allows you to do:

9. Has your license ever been suspended or revoked? Yes No
 If yes, provide details: _____

10. Have you ever been investigated by the State Health Dept., State Licensing Board or other governmental body?
 Yes No
 If yes, provide details: _____

11. Are you Medicare approved? Yes No Medicare sales: \$ _____

12. Are you accredited by any of the following?

	Yes	No
a. National Home Caring Council	<input type="checkbox"/>	<input type="checkbox"/>
b. Joint Commission on Accreditation of Healthcare Organizations	<input type="checkbox"/>	<input type="checkbox"/>
c. National Association for Home Care	<input type="checkbox"/>	<input type="checkbox"/>
d. Community Health Accreditation Program	<input type="checkbox"/>	<input type="checkbox"/>

OPERATIONS

1. Types of services provided: (Total must equal 100%)

Companionship	%	Cooking/Light Housekeeping/Errands	%
Sleep Over Service	%	Bathing/Grooming/Incontinence Care	%
Bookkeeping/Accounting	%	Transportation	%
24 Hour Service	%	Medical Equipment Monitoring	%
Other	%	Describe:	

2. If 24 hour service, is this: Live-in Shift work
 Provide full description:

3. If monitoring medical equipment, provide full description:

	Yes	No
4. Are all duties performed non-medical?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do any duties include diagnosis, prescribing and/or dispensing of medications? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Do any duties include the provision of financial related activities? If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Are all duties performed in private homes?	<input type="checkbox"/>	<input type="checkbox"/>

8. Total Annual Revenues/Sales \$ _____
 Sales from Employees \$ _____
 Sales from Independent Contractors \$ _____
 Sales from Non-Nursing Operations \$ _____

9. Provide details of Employed or Contracted Personnel:	No. Employed	No. Contracted	Contractors Ins. Limits Required
	Aides/Homemaker Health Aides		
LPNs			
RNs			
Home Companions			
Certified Nursing Assistants			
Others (specify):			

10. Do you have a contract outlining scope of duties? Yes No
11. Do you have recordkeeping procedures? Yes No
12. Do care providers complete daily work reports? Yes No
13. Is there an informed consent process in place? Yes No
14. Do you care for children under the age of 18 years old? Yes No

- If yes, provide details: _____
15. Are there written policies in place for:
- | | Yes | No | | Yes | No |
|-------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| a. Emergencies in the field | <input type="checkbox"/> | <input type="checkbox"/> | g. Patient rights | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Employee training | <input type="checkbox"/> | <input type="checkbox"/> | h. Physician orders | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Food preparation | <input type="checkbox"/> | <input type="checkbox"/> | i. Proper lifting | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Handling of complaints | <input type="checkbox"/> | <input type="checkbox"/> | j. Reporting suspected physical/sexual abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Medical equipment training | <input type="checkbox"/> | <input type="checkbox"/> | k. Termination of care | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Patient acceptance | <input type="checkbox"/> | <input type="checkbox"/> | | | |
16. Do you conduct background checks of all new hires/subcontracted personnel? Yes No

17. Do background checks include the following:
- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| a. All prior employers | <input type="checkbox"/> | <input type="checkbox"/> | f. Home telephone verification | <input type="checkbox"/> | <input type="checkbox"/> |
| b. All educational institutions | <input type="checkbox"/> | <input type="checkbox"/> | g. Professional licensing verification | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Drivers license information | <input type="checkbox"/> | <input type="checkbox"/> | h. Residency information | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Drug screening required | <input type="checkbox"/> | <input type="checkbox"/> | i. Sex offender registry search | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Federal, State (if possible) and County criminal record search | <input type="checkbox"/> | <input type="checkbox"/> | j. Social security number verification | <input type="checkbox"/> | <input type="checkbox"/> |

18. Are all staff/subcontractors over the age of 18 years? Yes No
19. Are certificates of insurance maintained on file for all independent contractors? Yes No
20. Are certificates of insurance updated on an annual basis? Yes No
21. Are you in compliance with all applicable laws and ordinances pertaining to licensing and safety codes? Yes No
22. If self-employed, does your employer carry insurance limits in an amount equal to or greater than the limit of this policy? Yes No N/A
23. Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization? Yes No
- If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy? Yes No
24. Do you enter into any contractual agreements? Yes No
- If yes, is legal advice sought to write and approve? Yes No
- If yes, does the agreement require you to hold any third party harmless? Yes No
25. Describe your hiring practices: _____

26. Are there written guidelines regarding sexual misconduct? Yes No

If yes, provide details:

27. Describe steps taken to prevent or avoid a sexual misconduct incident. (e.g. same gender caregiver/client)

28. Has the facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? Yes No

If yes, provide details:

29. Have you or any employee, volunteer, or other person working for you ever been arrested or convicted of a crime? Yes No

If yes, provide details:

30. Has any facility applicant, in the past year, been associated with, ever had any incidents occur, or claims brought against it while applicant was there? Yes No

If yes, provide details:

DESIRED TERMS AND CONDITIONS

Effective Date Desired:

Term Desired:

Limit of Liability Desired:	General Aggregate Limit	\$
	Products-Completed Operations Aggregate Limit	\$
	Personal and Advertising Injury Limit	\$
	Damage to Premises Rented to You (any one premises)	\$
	Medical Expenses Limit (any one person)	\$

Missouri Applicants: **DO NOT** answer this question.

Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?

No Yes - If Yes, give name of company, date, and reason:

Prior carrier information for the past three years:

Policy Dates	Carrier	Policy Number	Coverage	Check if Claims Made	Premium
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years. Attach separate sheet if necessary.

Dates (Month/Year)	Allegations	Amount	Paid	Reserve

HIRED & NON-OWNED AUTO COVERAGE – Complete only if requesting coverage

1. Number of drivers using personal vehicles for business: (Full-time = over 20 hrs/week; Part-time = up to 20 hrs/week)

Full-time:

Part-time:

Volunteer:

Describe use:

2. Do you require employees to carry and show evidence of personal insurance?

Yes No

If yes, limits required: \$

3. Do you run MVRs on employees?

If yes, how often:

		Yes	No
4.	Do you have a driver safety training program?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Are employees trained on wheelchair tie-down procedures?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Does your agency transport clients?	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, in employee vehicles? %	<input type="checkbox"/>	<input type="checkbox"/>
	If yes, in client's vehicle? %	<input type="checkbox"/>	<input type="checkbox"/>

For information about how Northland compensates its agents, brokers and program managers, please visit this website:

http://www.northlandins.com/Producer_Compensation_Disclosure.asp

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Northland Insurance Companies, c/o Law Department, 385 Washington St., St. Paul, MN 55102.

This application, including any material submitted in conjunction with the application or any renewal, does not amend the provisions or coverages of any insurance policy or bond issued by Northland. It is not a representation that coverage does or does not exist for any particular claim or loss under any such policy or bond. Coverage depends on the facts and circumstances involved in the claim or loss, all applicable policy or bond provisions, and any applicable law. Availability of coverage referenced in this document can depend on underwriting qualifications and state regulations.

FRAUD STATEMENTS

ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: 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.

FLORIDA: 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.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO, AND PENNSYLVANIA: 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. (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, 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 may include imprisonment, fines, and denial of insurance benefits.

IMPORTANT NOTICE DECLARATION

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.

SIGNATURES

Applicant Signature	Title	Date
Producer Signature		Date

Producer Name and Address