183 Leader Heights Road
P.O. Box 2726, York, PA 17405
800.233.1957 | Fax: 717.747.7021
**glatfelterhealthcare.com**
Return completed application to
submissions@glatfelterhealthcare.com

Glatfelter℠ HEALTHCARE

Underwritten by: National Union Fire Insurance Company of Pittsburgh, Pa. (for admitted business)

# HOSPICE APPLICATION

In addition to this Application, please submit the following supplemental applications if applicable:

- 5 years of currently valued carrier loss run reports
- State Survey Report, Plan of Correction and Acknowledgement
- Resume of Administrator, CEO, COO, Owner or Other Key Employee (if in business less than three years)

New Business Application is required for first year only.

A pre-filled Renewal Questionnaire will be provided for subsequent renewals.

## GENERAL INFORMATION

Date Proposal Needed By: _____ Policy Effective Date: _____

Professional Liability: ☐ Claims-made – Current Retroactive date: _____ ☐ Occurrence

General Liability: ☐ Claims-made – Current Retroactive date: _____ ☐ Occurrence

*Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.*

☐ Deductible: _____ ☐ No Deductible

Current Carrier: _____ Number of years in operation: _____

Legal Name of Organization: _____

Additional Named Insureds and a brief description of their operations (attach additional schedule as needed):

_____

_____

**Address:** _____
Street or PO Box City County State Zip Code

**Mailing Address:** _____
Street or PO Box City County State Zip Code

FEIN: _____ Website: _____

**Contact Information:**

Primary: _____ _____ _____
Name Phone Email

Inspection: _____ _____ _____
Name Phone Email

| | | | |
|---|---|---|---|
| **Legal Status** | ☐ Non-profit | ☐ For-profit | ☐ Governmental |
| | ☐ State Hospice Association – | Number of member organizations represented: | _____ |

| | | | |
|---|---|---|---|
| **Organization Structure** | ☐ Corporation | ☐ Partnership | ☐ Privately/Individually-owned |
| | ☐ Joint Venture | ☐ Limited Liability Company | ☐ Other: _____ |

**Operations**

Total annual operating budget: $ _____
If revenue exceeds $5,000,000 please attach a copy of your last audited financial statement.

Are you accredited by? ☐ JCAHO ☐ CHAP ☐ ACHC ☐ NCQA ☐ COA

Are you Medicare certified? ☐ Yes ☐ No

Licensure

Are you required to be licensed in any states in which you operate? ☐ Yes ☐ No

If yes, in what state(s) are you currently licensed? _____

Are any license applications currently pending? ☐ Yes ☐ No

If yes, what state(s) are pending? _____

Does your organization participate in the State Patient Compensation Fund? ☐ Yes ☐ No

Has there been any mergers, acquisitions or consolidations within the last 10 years? ☐ Yes ☐ No

If yes, please provide the name(s) of the organization(s) and the date of acquisition:

_____

_____

Has the applicant or any of its subsidiary organizations ever filed for bankruptcy? ☐ Yes ☐ No

Describe any changes in services or operations planned within the next year, including new or discontinued services, locations, or acquisitions: _____

_____

**Employee Information**

Number of Employees - Full-time: _____ Number of Employees - Part-time: _____

Number of Volunteers: _____

What percentage of staff is composed of temporarily assigned personnel acquired through staffing agencies? _____%

| Which of the following background check methods do you use? | Employees | Volunteers (if any) |
|---|---|---|
| Social Security number verification: | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Criminal background checks: | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Residency verification: | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Professional licensing verification: | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Prior employment: | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Driver's license information (MVR): | ☐ Yes ☐ No | ☐ Yes ☐ No |

Only required if the employee//volunteer operates a company vehicle or their personal vehicle on the organization's behalf.

Is annual training provided and attendance documented for all employees and volunteers? ☐ Yes ☐ No

If yes, briefly describe your in-service training program: _____

_____

**Risk Management and Loss Control**

Does your organization have a formal written Quality Assurance/Performance Improvement or Risk Management program? ☐ Yes ☐ No

If yes, name and title of person responsible for program: _____

Do you have an active Safety Committee? ☐ Yes ☐ No

If yes, how often does the Safety Committee meet? _____

**Loss History**

In the past 5 years, has any claim or suit been made against you for alleged medical professional malpractice, error, or mistake? ☐ Yes ☐ No
If yes, please explain: _____

Are there any claims, suits, legal proceedings, or investigations against you or your subsidiaries that have not yet been reported to your former insurance carrier? ☐ Yes ☐ No
If yes, please provide details on a separate document.

Is the applicant aware of any recent circumstance which may result in any claim or suit being made (including requests for medical records) and not recorded on loss runs provided? ☐ Yes ☐ No
If yes, please explain: _____

In the past 5 years, has any insurance carrier cancelled or refused coverage? (Missouri applicants are not required to reply) ☐ Yes ☐ No
If yes, please provide the reason for cancellation: _____

Within the last 3 years has your organization been a part of any civil or criminal litigation or arbitration proceeding? ☐ Yes ☐ No
If yes, please provide details on a separate document.

If current coverage is claims made, are there any interruptions of continuous claims made coverage from the proposed effective date? ☐ Yes ☐ No

**Contracted Services**

Do you engage the use of independent contractors to provide any services? ☐ Yes ☐ No
If yes, complete the following questions:
What percentage of revenue is provided by independent contractors? _____ %
Do you require a written contract with hold harmless and indemnification language in your favor? ☐ Yes ☐ No
Do you require independent contractors list you as an additional insured on their liability policy? ☐ Yes ☐ No
Do you require that all independent contractors maintain liability insurance and provide you with a copy of their Certificate of Insurance each year? ☐ Yes ☐ No
Do all contracts with pharmacies, DME suppliers, hospitals, nursing homes and assisted living facilities include mutual hold harmless agreements? ☐ Yes ☐ No

| Service | | | Limit of Liability | Service | | | Limit of Liability |
|---|---|---|---|---|---|---|---|
| Dental: | ☐ Yes | ☐ No | $ _____ | Mental Health: | ☐ Yes | ☐ No | $ _____ |
| Pharmaceutical: | ☐ Yes | ☐ No | $ _____ | Physical Therapy: | ☐ Yes | ☐ No | $ _____ |
| Occupational Therapy: | ☐ Yes | ☐ No | $ _____ | Speech Therapy: | ☐ Yes | ☐ No | $ _____ |
| Dietary: | ☐ Yes | ☐ No | $ _____ | X-Ray: | ☐ Yes | ☐ No | $ _____ |
| Medical Records: | ☐ Yes | ☐ No | $ _____ | Laboratory: | ☐ Yes | ☐ No | $ _____ |
| Recreational Services: | ☐ Yes | ☐ No | $ _____ | Social Services: | ☐ Yes | ☐ No | $ _____ |
| Barber/Beautician: | ☐ Yes | ☐ No | $ _____ | Transportation: | ☐ Yes | ☐ No | $ _____ |
| Food: | ☐ Yes | ☐ No | $ _____ | Laundry: | ☐ Yes | ☐ No | $ _____ |
| Other: _____ | | | $ _____ | Other: _____ | | | $ _____ |

**Credentialing**

Do you have a formalized and written credentialing process? ☐ Yes ☐ No

Is there a recredentialing process? ☐ Yes ☐ No

Does your physician credentialing process include primary source verification of:
☐ Physician/Nurse Practitioner licensure ☐ Training and Experience ☐ Certifications
☐ DEA registration ☐ Education

Do your physician files include:
☐ Completed application ☐ Criminal background check ☐ NPDB query (malpractice history)
☐ Copy of current license ☐ Copy of current DEA registration ☐ Evidence of continuing education
☐ Copy of current Certificate of Insurance, if primary liability insurance is maintained
☐ Authorization and information relating to any past/pending claims, suits, or settlements

Has there ever been a review by a state medical board or other oversight organization of any physician or nurse practitioner? ☐ Yes ☐ No
If yes, please provide details: _____

Has there ever been a license suspension, revocation, restriction, or voluntary surrender of license of any physician or nurse practitioner? ☐ Yes ☐ No
If yes, please provide details: _____

Does your organization require that contracted physicians/nurse practitioners maintain primary professional liability insurance? ☐ Yes ☐ No ☐ Not Applicable
If yes, what are the minimum professional liability limits required? _____
If yes, is proof of coverage (Certificate of Insurance) required? ☐ Yes ☐ No

What is the total number of physicians/nurse practitioners in your organization? _____
(Please include volunteers and independent contractors.)

Do any physicians participate in a state Patient Compensation Fund (PCF) ☐ Yes ☐ No
If yes, please include a copy of the PCF Certificate of Insurance.

**Physician and Nurse Practitioner Schedule**

| Name / Title (Include each Physician and Nurse Practitioner) | State of Licensure | Employed (E) Volunteer (V) or Independent Contractor (IC) | Average Hours per Month | Primary Insurance Elsewhere: Answer "yes" if Physician or Nurse Practitioner maintains primary liability insurance elsewhere which would respond to an incident or claim while performing duties on your behalf. |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

## Hospice Services (Please check all that apply.)

| | |
|---|---|
| ☐ Hospice Services | Number of hospice Patient Days on Service (total number of service days for all hospice patients)<br>Last 12 months: _____ Next 12 months: _____ |
| | Number of hospice patients<br>Last 12 months: _____ Next 12 months: _____ |
| | If operations are conducted in multiple states, provide the above exposure detail for each state:<br>_____ |
| ☐ Beds | Number of licensed inpatient/residential beds (Include owned and contracted hospice beds): _____ |
| ☐ Hospice or Palliative Care for Children | Percentage of your total services that includes pediatric care: _____ % |
| ☐ Palliative Care for Non-hospice Patients | Number of palliative care patient visits will you complete during next 12 months: _____ |
| ☐ Clinical Trials, Pharmaceutical testing or research | If you participate, describe: _____<br>_____ |
| ☐ Pet Therapy | Have the pets been specially trained or certified for use in the therapy program by Therapy Dogs International or the American Kennel Club? ☐ Yes ☐ No |
| ☐ Hospice Associations | Number of members: _____ |
| ☐ Fundraising, Special Events | **Complete Fundraising and Special Events Supplement** |
| ☐ Bereavement Camps | **Complete Hospice Bereavement Camp Supplement** |

## Home Health Care Services (Please check all that apply.)

| | | |
|---|---|---|
| ☐ Skilled Home Health Care Services | Number of total patient visits<br>Last 12 months: _____ Next 12 months: _____ | |
| | Number of skilled home health care patients to be treated<br>Last 12 months: _____ Next 12 months: _____ | |
| | Locations where services are provided:<br>☐ Private Homes ☐ Hospitals ☐ Clinics ☐ Nursing Homes /ALFs<br>☐ Schools ☐ Outpatient Facilities ☐ Other: _____ | |
| ☐ Community Wellness Programs | Number of immunizations: _____ | |
| ☐ Non-skilled Services<br>Do not include ADL services provided by skilled personnel. | Annual number of clients: _____<br>Number of clients provided with 24-hour "live in" care: _____ | |
| ☐ Home Health Services for Children | Percentage of your total revenues that includes pediatric care: _____ % | |
| ☐ Additional Services | ☐ Adult Day Care<br>**Complete Adult Day Care Supplement** | ☐ Case Management |
| | ☐ Child Day Care<br>**Complete Child Day Care Supplement** | ☐ Gastrostomy Tube (GT) Care |
| | ☐ Infusion Therapy | ☐ Medical Equipment Supplier<br>**Complete Durable Medical Equip. Supplement** |
| | ☐ Medical Social Services | ☐ Obstetrical Services |
| | ☐ Palliative Care<br>Number of Annual Visits: _____ | ☐ Pharmacy<br>**Complete Pharmacy Supplement** |
| | ☐ Rehab Services (PT,OT, Speech Therapy) | ☐ Respiratory Therapy |
| | ☐ Respite Care | ☐ Special Care (Alzheimer's/Dementia, etc.) |
| | ☐ Supplemental Staffing<br>**Complete Medical Staffing Supplement** | ☐ Telehealth |
| | ☐ Thrift Shop<br>Annual Gross Sales: $_____ | ☐ Consumer Directed Care<br>☐ Employee ☐ Family Member<br>☐ Independent Contractor |
| | ☐ Other: _____ | |

**Hired and Non-owned Auto Liability**

Are you requesting this coverage? If yes, complete the questions in this section. ☐ Yes ☐ No
If company-owned or leased vehicles are insured by another carrier, Non-owned Auto Liability coverage will be excluded from this policy and must be secured under your owned Auto policy.

Does your organization have positions where driving personal vehicles is a job function essential to the position? ☐ Yes ☐ No

Do you have a policy in place which addresses driving requirements for employees and volunteers? ☐ Yes ☐ No

Does this policy include specific hiring criteria applicable to new drivers who operate their personal vehicles on your behalf? ☐ Yes ☐ No

Does your pre-employment hiring process include driver screening? ☐ Yes ☐ No

Does this process include ordering Motor Vehicle Reports prior to hire? ☐ Yes ☐ No

Does your policy include a process for removing drivers with unsatisfactory driving records from their driving duties? ☐ Yes ☐ No

Does this process include verification of the state's minimum financial responsibility limits? ☐ Yes ☐ No

Does your policy permit patient/client transport in personal vehicles? ☐ Yes ☐ No
If yes, what personal auto liability limits do you require? $_____ / $_____ or $_____ CSL

Does your policy permit use of the patient or client's vehicles? ☐ Yes ☐ No
If yes, is the caregiver required to verify the client maintains auto liability insurance? ☐ Yes ☐ No

Does your organization offer training on safe driving practices? ☐ Yes ☐ No

**Sexual Abuse Liability**

Are you requesting this coverage? If yes, complete the questions in this section. ☐ Yes ☐ No

Retroactive Date: _____ *Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.*

Do you order Criminal Background Checks including Sexual Abuse Registry on the following?
Employees: ☐ Yes ☐ No
Volunteers: ☐ Yes ☐ No
Agency personnel: ☐ Yes ☐ No

Does your organization have a written "zero tolerance" sexual abuse and molestation policy? ☐ Yes ☐ No
If yes, does your written policy include the following?
A zero tolerance statement: ☐ Yes ☐ No
Definition of sexual abuse/molestation: ☐ Yes ☐ No
Reporting procedures with at least two persons to report to internally: ☐ Yes ☐ No
Investigation and follow-up procedures: ☐ Yes ☐ No
Anti-retaliation warning: ☐ Yes ☐ No

Are all employees/volunteers required to acknowledge having read and comprehended the policy? ☐ Yes ☐ No

Is annual training on the policy completed and acknowledged? ☐ Yes ☐ No

Have you ever had any prior incidents, allegations or claims involving sexual abuse? ☐ Yes ☐ No
If yes, please provide details: _____

**Employee Benefits Liability**

$25,000 each employee/$25,000 aggregate is automatically provided. If you are requesting higher limits, please indicate:

☐ $50,000/$50,000 ☐ $100,000/$100,000 ☐ $250,000/$250,000
☐ $500,000/$500,000 ☐ $750,000/$750,000 ☐ $1,000,000/$1,000,000

**Employer's Liability Coverage**

If your Workers Compensation coverage does not provide Employer's Liability (ND, OH, WA, WY), do you want Employer's Liability coverage? ☐ Yes ☐ No
If yes, provide total annual payroll: $ _____

| "Bodily Injury" by accident each accident | "Bodily injury" by disease policy limit | "Bodily injury" by disease each "employee" or volunteer |
|---|---|---|
| Limits desired: _____ | | |

**Cyber Liability and Privacy Crisis Management Expense**

Are you requesting this coverage? If yes, complete the questions in this section. ☐ Yes ☐ No

Retroactive Date: _____ *Please attach a copy of your current policy Declarations page if Prior Acts Coverage is desired.*

**Cyber Liability** protects you when claims are made against you for monetary damages arising out of an electronic information security event:

| | |
|---|---|
| | $1,000,000 Each Electronic Information Security Event, subject to<br>$3,000,000 Annual Aggregate |
| | **Privacy Crisis Management Expense** reimburses for expenses you incur as a result of a privacy crisis management event first discovered during the policy period. This first party coverage is intended to provide professional expertise in the identification and mitigation of a privacy breach while satisfying Federal and State statutory requirements.<br>☐ $50,000 Each Privacy Event / $50,000 Aggregate (automatically included)<br>☐ $100,000 Each Privacy Event / $100,000 Aggregate<br>☐ $250,000 Each Privacy Event / $250,000 Aggregate<br>☐ $500,000 Each Privacy Event / $500,000 Aggregate<br>**Cyber Extortion Expense** reimburses for expenses you incur as a result of a cyber extortion threat first made against you during the policy period. A $20,000 limit applies to Each Cyber Extortion Threat, subject to the Privacy Crisis Management Expense Aggregate. |
| | Is Firewall technology used at all internet points of presence to prevent unauthorized access to internal networks? ☐ Yes ☐ No |
| | Do you use antivirus software on all desktops, portable computers and mission critical servers? ☐ Yes ☐ No |
| | Are antivirus applications updated in accordance with the software provide's requirements? ☐ Yes ☐ No<br>How often? _____ |
| | Are your employee, customer, and other physical and electronic records maintained in a secure environment with limited access? ☐ Yes ☐ No |
| | Has your organization suffered a computer attack, such as a hacking attack, breach of personal information, denial of service attack, virus or malware infection or ransomware attack in the last 12 months? ☐ Yes ☐ No<br>If yes, please explain: _____ |
| | Do you have a written information security and privacy policy? ☐ Yes ☐ No |

# REAL & PERSONAL PROPERTY ☐ Yes ☐ No

**Complete this section or you may submit a Property ACORD application.**

Coverage desired: ☐ Scheduled Property (Non-Blanket) ☐ Blanket Per Premises (Property and Contents) ☐ Policy Blanket

Deductible desired: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ Other: _____

| Loss of Income: $250,000 is automatically included. If a higher limit is being requested, please indicate: $ _____ | Extra Expense: $250,000 is automatically included. If higher limit is being requested, please indicate: $ _____ |
|---|---|

**CONSTRUCTION CODES**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1** | Frame | **3** | Non-combustible | **5** | Modified Fire Resistive | **7** | Concrete | **9** | Reinforced Masonry |
| **2** | Joisted Masonry | **4** | Masonry Non-combustible | **6** | Fire Resistive | **8** | Steel | | |

**ROOF CODES** (0 = Unknown)

| | | | | | |
|---|---|---|---|---|---|
| **Covering** | **1** Metal sheathing with exposed fasteners | **3** Built-up roof or single-ply membrane WITH gutters | **5** Concrete/clay tiles | **7** Shingle - 55 mph wind rating | **9** Shingle - 110 mph wind rating |
| | **2** Metal sheathing with CONCEALED fasteners | **4** Built-up roof or single-ply membrane WITHOUT gutters | **6** Wood shakes | **8** Shingle - 55 mph wind rating/Secondary Water Resistance (SWR) | **10** Shingle - 110 mph wind rating/Secondary Water Resistance (SWR) |
| **Geometry** | **1** Flat Roof WITH Parapets | **3** Hip Roof with Slope <= 6:12 (26.5 degrees) | **5** Gable Roof with Slope <= 6:12 (26.5 degrees) | **7** Braced Gable Roof with Slope <= 6:12 (26.5 degrees) | |
| | **2** Flat Roof WITHOUT Parapets | **4** Hip Roof with Slope > 6:12 (26.5 degrees) | **6** Gable Roof with Slope > 6:12 (26.5 degrees) | **8** Braced Gable Roof with Slope > 6:12 (26.5 degrees) | |
| **Anchors** | **1** Toe Nailing/No Anchorage | **2** Clips | **3** Single Wraps | **4** Double Wraps | **5** Structural |

| Premises # | Item # | Street Address City / State Zip / County | Building Occupied as: | Amount of Insurance At 100% Replacement Cost Value (RCV). Include value of foundations. | | Year Built | # Sq Feet | Building Area You Occupy | # of Stories | Protection Class | Construction Code | Sprinkler System Y/N | Vacant Y/N | # Inpatient Beds | Date of Last Inspection | Year of Mech System Updates | Year of Roof Updates | Roof Covering | Roof Geometry | Roof Anchors | Type of Fire or Other Alarms |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Building | Contents | | | | | | | | | | | | | | | | |
| | | / / | | | | | | | | | | | | | | | | | | | |
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| Premises # | Item # | Street Address City / State Zip / County | Building Occupied as: | Amount of Insurance At 100% Replacement Cost Value (RCV). Include value of foundations. | | Year Built | # Sq Feet | Building Area You Occupy | # of Stories | Protection Class | Construction Code | Sprinkler System Y/N | Vacant Y/N | # Inpatient Beds | Date of Last Inspection | Year of Mech System Updates | Year of Roof Updates | Roof Covering | Roof Geometry | Roof Anchors | Type of Fire or Other Alarms |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | / / | | Building | Contents | | | | | | | | | | | | | | | | |
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| **Other occupants?** | Are there any other occupants in the buildings you occupy? ☐ Yes ☐ No | | |
|---|---|---|---|
| | **Premises #** | **Item #** | **List of Other Occupants** |
| | | | |
| | | | |
| | | | |
| | | | |

| ☐ Mortgagee | Name: _____<br>Street: _____ _____<br>City: _____ State: _____ Zip: _____ | | | | | | |
|---|---|---|---|---|---|---|---|
| Applies to Premises/Item #s: | ___ / ___ | ___ / ___ | ___ / ___ | ___ / ___ | ___ / ___ | ___ / ___ | ___ / ___ |

| ☐ Mortgagee | Name: _____<br>Street: _____ _____<br>City: _____ State: _____ Zip: _____ | | | | | | |
|---|---|---|---|---|---|---|---|
| Applies to Premises/Item #s: | ___ / ___ | ___ / ___ | ___ / ___ | ___ / ___ | ___ / ___ | ___ / ___ | ___ / ___ |

| **What Coverages and Limits do you require?** | | | |
|---|---|---|---|
| | Accounts Receivable: | ☐ $100,000 (automatically included)<br>☐ $500,000 | ☐ $250,000<br>☐ $1,000,000 |
| | Debris Removal: | ☐ $100,000 (automatically included)<br>☐ $500,000 | ☐ $250,000<br>☐ $1,000,000 |
| | Outdoor Property | ☐ $150,000 (automatically included) | ☐ Increase Limit $_____ |
| | Property in Transit or Off Premises: | ☐ $100,000 (automatically included) | ☐ $250,000 |
| | Software: | ☐ $500,000 (automatically included) | ☐ Increase Limit $_____ |
| | Trees, Shrubs, Plants and Lawns: | ☐ $25,000 (automatically included) | ☐ Increase Limit $_____ |
| | Valuable Papers and Records: | ☐ $100,000 (automatically included)<br>☐ $500,000 | ☐ $250,000<br>☐ $1,000,000 |

| **What Coverage Options do you want to purchase?** | | | |
|---|---|---|---|
| | Scheduled Fine Arts: | ☐ Yes (attach schedule) | ☐ No |
| | Special Property Floater: | ☐ Yes (attach schedule) | ☐ No |
| | Equipment Breakdown including: | | |
| | Spoilage: | ☐ $100,000 (automatically included)<br>☐ $500,000 | ☐ $250,000<br>☐ $1,000,000 |
| | Hazardous Substance: | ☐ $250,000 (automatically included)<br>☐ $1,000,000 | ☐ $500,000 |
| | Expediting Expense: | ☐ $100,000 (automatically included)<br>☐ $500,000 | ☐ $250,000<br>☐ $1,000,000 |
| | Flood Coverage: | ☐ Yes Limit $_____<br>☐ Include Real Property/BPP/LOI/EE<br>☐ Include BPP/LOI/EE | ☐ No |
| | Earthquake Coverage: | ☐ Yes Limit $_____<br>☐ Include Real Property/BPP/LOI/EE<br>☐ Include BPP/LOI/EE | ☐ No |

## CRIME ☐ Yes ☐ No

Limits Option requested? (Select one of the following)

| Limits Option | Employee Theft | Forgery or Alteration | Temporary Increased Limits for Special Events | | | Computer & Funds Transfer Fraud | Money Orders | Fraudulent Impersonation |
|---|---|---|---|---|---|---|---|---|
| | | | Inside the Premises | | Outside the Premises | | | |
| | | | Theft of Money & Securities | Robbery/Safe Burglary | | | | |
| ☐ 1 | $10,000 | $10,000 | $10,000 | $5,000 | $10,000 | $20,000 | $10,000 | $10,000 |
| ☐ 2 | $25,000 | $25,000 | $25,000 | $5,000 | $25,000 | $20,000 | $10,000 | $10,000 |
| ☐ 3 | $50,000 | $50,000 | $50,000 | $5,000 | $50,000 | $50,000 | $25,000 | $25,000 |
| ☐ 4 | $100,000 | $100,000 | $100,000 | $100,000 | $100,000 | $100,000 | $100,000 | $100,000 |
| ☐ 5 | $250,000 | $250,000 | $250,000 | $100,000 | $250,000 | $250,000 | $250,000 | $250,000 |
| ☐ 6 | $400,000 | $400,000 | $400,000 | $100,000 | $400,000 | $400,000 | $250,000 | $250,000 |
| ☐ 7 | $500,000 | $500,000 | $500,000 | $100,000 | $500,000 | $500,000 | $250,000 | $250,000 |
| ☐ 8 | $1,000,000 | $1,000,000 | $1,000,000 | $100,000 | $1,000,000 | $500,000 | $250,000 | $250,000 |
| ☐ 9 | $2,000,000 | $1,000,000 | $1,000,000 | $100,000 | $1,000,000 | $500,000 | $250,000 | $250,000 |

Deductible requested? (Deductibles above $1,000 are only available with Limits Options 5, 6, 7, 8 and 9.)

☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $25,000

Indicate what security provisions apply and identify how often:

☐ Audit _____
☐ Bank statements _____
☐ Countersignature _____
☐ Reconciliations _____
☐ Other _____

**Temporary Increased Limit for Special Events**

Is temporary increased limit requested for inside and outside premises for special events? ☐ Yes ☐ No

| Limit Requested | Description of Event | # of days |
|---|---|---|
| | | |
| | | |
| | | |

# AUTO ☐ Yes ☐ No

**Complete this section or you may submit an Auto ACORD application.**

| **What Coverages and Limits do you desire?** | Liability Limit (Combined Single Limit): ☐ $300,000 ☐ $500,000 ☐ $1,000,000 |
|---|---|
| | Uninsured/Underinsured Motorists Limit: _____ |
| | PIP Limit: _____ Med Pay Limit: _____ |
| | Hired and Non-owned Liability coverage desired? ☐ Yes ☐ No |

Deductibles:
Comprehensive: ☐ $500 ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000
Collision: ☐ $500 ☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000

**VEHICLE CLASSIFICATION**

| | | | | |
|---|---|---|---|---|
| Private Passenger | Truck – Service | Truck – Retail | Truck – Commercial | Van |
| Bus | Service/Utility Trailer | Mobile Equipment | Golf Cart | Other |

| Veh # | Year | Make | Description (Model / Type) | Vehicle Classification | Vans and Buses | | Serial Number (VIN) | Cost New ACV | Garaged at Premises # |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Seating Capacity | Radius in Miles | | | |
| **EX.** | **2020** | **Nissan** | **Altima** | **Private Passenger** | **1-5** | **0-50** | **1BAAGCSA9XF082111** | **$24,000** | **1** |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |

| **Do you have any Customized vehicles?** | Have any vehicles been customized from a previous use? ☐ Yes ☐ No |
|---|---|
| | If yes, indicate vehicle number(s): _____ _____ _____ _____ _____ _____ Describe: _____ |

| ☐ Add'l Insured Lessor ☐ Loss Payee | Name: _____ |
|---|---|
| | Street: _____ _____ City: _____ State: _____ Zip: _____ |
| Applies to Vehicle #'s: | _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ |

| ☐ Add'l Insured Lessor ☐ Loss Payee | Name: _____ |
|---|---|
| | Street: _____ _____ City: _____ State: _____ Zip: _____ |
| Applies to Vehicle #'s: | _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ |

| | | | | |
|---|---|---|---|---|
| **Auto Fleet Management Information** | Do you pre-screen all drivers before they are permitted to drive your vehicles? | ☐ Yes | ☐ No | |
| | Do you have procedures in place to regularly check their Motor Vehicle Records? | ☐ Yes | ☐ No | |
| | Do you have specific criteria in place used to evaluate driver acceptability? | ☐ Yes | ☐ No | |
| | Do you provide driver training? | ☐ Yes | ☐ No | |
| | Do your drivers meet CDL requirements based on the vehicle's passenger capacity? | ☐ Yes | ☐ No | ☐ N/A |
| | Do you provide non-emergency patient transportation in your owned vehicles? | ☐ Yes | ☐ No | |
| | If yes, please describe: _____ | | | |
| | Do you have a formalized documented vehicle safety program which includes vehicle preventative maintenance and required safety inspections? | ☐ Yes | ☐ No | |
| | Do you own or use any 15 passenger vans? If yes: | ☐ Yes | ☐ No | |
| | Have vans been modified with dual rear wheels or changed seating capacity? | ☐ Yes | ☐ No | |
| | If yes, describe: _____ | | | |
| | Are van models prior to 2009 equipped with Electronic Stability Controls? | ☐ Yes | ☐ No | ☐ N/A |
| | Is there a requirement that vans are not overloaded? | ☐ Yes | ☐ No | |
| | Is there a requirement that no loads are placed on the roof of the vans? | ☐ Yes | ☐ No | |

## HEALTHCARE ORGANIZATION MANAGEMENT LIABILITY ☐ Yes ☐ No

If your organization is a non-profit organization and coverage is being requested, please **complete a Heathcare Organization Management Liability Application.**

## EXCESS LIABILITY ☐ Yes ☐ No

| | |
|---|---|
| **What Coverages and Limits do you desire?** | Limits desired: $ _____ occurrence / $ _____ aggregate |
| | **Note**: Underlying liability limits of $1,000,000 are required.<br>All underlying coverage to be scheduled must be provided by the program. Exceptions are permitted for Employer's Liability coverage. For Employer's Liability Coverage insured elsewhere, provide the following:<br>Policy Number: _____<br>Effective Date: _____<br>Policy Limits: _____<br>Carrier Name: _____ |

## OCCUPATIONAL ACCIDENT / BUSINESS TRAVEL ACCIDENT ☐ Yes ☐ No

If your organization is a non-profit organization and coverage is being requested, please **complete the Supplement on our website.**

## WRAP-UP INFORMATION

Any significant changes to your organization during the policy year must be reported to Glatfelter Underwriting Services, Inc. to ensure coverage.

Name of Producing Agency: _____

Agency's Address: _____

Agency's Phone: _____

If you are not licensed as a broker, are you a property/casualty agent? ☐ Yes ☐ No

Producer or CSR (for contact purposes): Name: _____

Email: _____

If you have never placed business with us before, please provide the person responsible for agency/brokerage licensing and contracting:

- Contact's Name: _____
- Contact's Email: _____
- Contact's Direct Phone: _____

## FRAUD WARNING NOTICE – PLEASE READ CAREFULLY

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 act, which is a crime, and may subject such person to criminal and civil penalties.

| | |
|---|---|
| **Alabama** | 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. |
| **Arkansas** | 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. |
| **California** | 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. |
| **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. |
| **District Of Columbia** | 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. |
| **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. |
| **Kansas** | 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 that 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. |
| **Kentucky** | 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. |
| **Louisiana** | 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. |
| **Maine** | 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. |
| **Maryland** | 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. |
| **Minnesota** | A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. |
| **New Jersey** | Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. |
| **New Mexico** | 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. |
| **New York** | 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. |
| **Ohio** | 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. |
| **Oklahoma** | WARNING: 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. |
| **Oregon** | 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 guilty of a fraudulent act, which may be a crime, and may subject such person to criminal and civil penalties. |
| **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. |
| **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. |
| **Tennessee** | 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. |
| **Vermont** | Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. |
| **Virginia** | 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. |
| **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. |
| **West Virginia** | 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. |

**Your signature below acknowledges that you have read the Fraud Warning Notice that applies to your state of domicile.**

**The undersigned is an authorized representative of the applicant and certifies the information provided to obtain this coverage is accurate to the best of their knowledge; this includes any applications, locations schedules, valuation statements, loss history information and engineering reports.**

**Applicant's signature:** _____ **Title**: _____ **Date**: _____

**Agent's signature:** _____ **Date:** _____

# FUND-RAISING AND SPECIAL EVENT SUPPLEMENT

(Complete only if you sponsor fundraising or Special Events)

1. Name of Applicant: _____

2.

| Name of Event | Date | Number Attending | Alcoholic Beverages Served? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

3. Do any of the above events involve dance, casino nights, carnivals, races, sports, animals, water or vehicles? ☐ Yes ☐ No
   If yes, please identify:

   _____
   _____
   _____
   _____

4. Does your organization require the facility to maintain liability insurance? ☐ Yes ☐ No
   If yes, do you obtain copies of Certificates of Insurance and require that you are named as an Additional Named Insured? ☐ Yes ☐ No

5. Do you require a mutual hold harmless agreement in the contract? ☐ Yes ☐ No

6. Are any Certificates of Insurance required? If so, list name and address of each organization below:

   _____
   _____
   _____
   _____

# PHARMACY SUPPLEMENT

(Complete only if you operate an in-house pharmacy)

1. Name of Applicant: _____

2. Is Pharmacy operated by insureds employees? ☐ Yes ☐ No
   If no, provide the name of the Third Party Vendor: _____

   Is the Named Insured listed as an additional insured on the Third Party Vendor general and professional liability policies? ☐ Yes ☐ No

   Is there a mutual hold harmless agreement in place? ☐ Yes ☐ No

   *If insured is utilizing a third party STOP HERE – No need to proceed with further questions. Coverage should be purchased by third party*

3. Are the drugs dispensed to anyone other than the insured's hospice or home health patients? ☐ Yes ☐ No
   If yes, please provide details: _____

4. Are all licensed Pharmacists credentialed by your organization prior to hire? ☐ Yes ☐ No

5. Who has access to the medication stock? _____

6. Describe security measures or alarms that have been installed to safeguard the Pharmacy unit:
   _____
   _____
   _____

7. How is the medication stock stored? _____

8. Describe and list the policies that have been implemented to ensure prescription drugs are stored under appropriate conditions and properly dispensed.
   _____
   _____
   _____

9. Does the Pharmacy operate in compliance with the Controlled Substances Act (CSA)? ☐ Yes ☐ No

10. Is there a Pharmacy Manual on site? ☐ Yes ☐ No

11. Who is responsible for loading the Pyxis and/or other electronic medication dispensing systems?
    _____

12. Who is responsible for the shift counts? _____

13. Who is responsible for the daily counts? _____

14. How are shift counts documented as a Pharmacy CQI to include med errors, near misses, etc.?

_____

_____

_____

15. Are there Pharmacy CQI meetings? ☐ Yes ☐ No

16. Does the Pharmacy store, dispense and dispose of all drugs as required by state & federal regulation? ☐ Yes ☐ No

17. Are drugs delivered to patient's home? ☐ Yes ☐ No

18. If drugs are mailed, is there a delivery confirmation procedure? ☐ Yes ☐ No

19. If mail receipts are utilized, are the receipts being retained for quality assurance? ☐ Yes ☐ No
If yes, how long? _____

20. What is the tracking method of returning expired medication, wasted medication?

_____

_____

_____

Glatfelter℠ HEALTHCARE

# HOSPICE BEREAVEMENT CAMP SUPPLEMENT

(If more than one camp is scheduled, please provide information for each camp.)

1. Name of Applicant: _____
2. Dates of Camp: _____ Overnight? ☐ Yes ☐ No
3. Location of Camp: _____
4. Does the campground maintain its own liability insurance? ☐ Yes ☐ No

   If yes, please request a Certificate of Insurance for your records.
5. How many children are enrolled? _____ What is the age of campers? _____ to _____ years of age.

   What is your ratio of staff to children? _____ Does the ratio of staff to children meet state requirements? ☐ Yes ☐ No
6. Are you securing a signed release form from guardians? ☐ Yes ☐ No
7. How are the children being transported to and from camp? _____

   **If transportation is arranged by your organization, please attach a Certificate of Insurance from the transportation company.**
8. Are comprehensive background checks completed on all staff members, including adult, young adult, and student volunteers? ☐ Yes ☐ No
9. Are policies and procedures in place regarding one-on-one contact between adults and youth that address the following?

   ☐ Isolated settings ☐ Individual meetings

   ☐ Sleeping arrangements (if applicable) ☐ Changing clothes/showering
10. Are policies in place addressing appropriate attire for adults and youths? ☐ Yes ☐ No
11. Have you ever had any prior allegations, incidents or claims involving abuse? ☐ Yes ☐ No

    If yes, please provide complete details: _____

    _____
12. Have you ever had to administer any disciplinary action against any current or previous staff members because of abuse? ☐ Yes ☐ No

    If yes, please provide complete details: _____

    _____
13. Will there be a licensed RN or LPN on premises at all times? ☐ Yes ☐ No
14. Recreational activities:

    Are recreational swimming or boating activities included? ☐ Yes ☐ No

    If yes, is there a certified lifeguard on duty? ☐ Yes ☐ No

    If boating activities are planned, are all participants required to wear life safety jackets at all times? ☐ Yes ☐ No
15. Describe any other athletic or recreational activities that are planned and indicate any precautions that will be taken to ensure camper safety: _____

    _____

# DURABLE MEDICAL EQUIPMENT SUPPLEMENT

**If this service is subcontracted, please confirm that Certificates of Insurance are required of the DME provider, and leave the remainder of the form blank:**

☐ **Certificates Required** ☐ **Certificates Not Required**

1. Name of Applicant: _____

2. Do you supply medical equipment to only your patients? ☐ Yes ☐ No
   If no, what percentage of annual revenue is derived from the general public? _____%

3. What services do you provide for this equipment? ☐ Sell ☐ Lease ☐ Repair medical equipment

4. Annual revenue from sales/leases/repairs: $ _____

5. Types of Durable Medical Equipment:
   Category III – Diagnostic or Treatment Devices – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines or sending devices.
   **Number of inventory items in this category:** _____
   Category IV – Life Sustaining or Critical Life Monitoring Equipment or Devices – This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/fail or improperly function which could result in death or serious deterioration in health condition.
   **Number of inventory items in this category:** _____

6. Do you accept donated equipment? ☐ Yes ☐ No
   If yes, is there an equipment maintenance policy in place for repairs and general maintenance? ☐ Yes ☐ No

7. Who trains your clients/families regarding proper operation of the equipment? _____

8. Do you provide written instructions to your customers? ☐ Yes ☐ No

9. Do your employees deliver equipment? ☐ Yes ☐ No
   If yes, do you provide driver safety training to drivers? ☐ Yes ☐ No

10. Do you repackage, re-label, modify or manufacture any medical equipment or products? ☐ Yes ☐ No

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

12. Do you distribute oxygen cylinders? ☐ Yes ☐ No
    If yes, are the cylinders pre-filled? ☐ Yes ☐ No

13. Do you subcontract labor for any maintenance, installation services or repair of medical equipment or supplies? ☐ Yes ☐ No
    If yes, do you require Certificates of Insurance? ☐ Yes ☐ No

**Note: If Property insurance is desired for durable medical equipment, please include these items under Personal Property in the Property section.**

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# CHILD DAY CARE CENTER SUPPLEMENT

1. Name of Applicant: _____

2. Address of day care center: _____
   Street City State Zip

3. Hours of operation: _____ Average daily attendance: _____

4. Is this a licensed day care facility? ☐ Yes ☐ No
   If yes, what is the licensed capacity? (# of children): _____

5. Does the day care center comply with Board of Health regulations and building code requirements? ☐ Yes ☐ No

6. Ages of children: from _____ to _____

7. Are the director and staff members certified and trained? ☐ Yes ☐ No

8. Are policies and procedures in place regarding one-on-one contact between adults and youth that address the following:
   ☐ Isolated settings ☐ Individual meetings
   ☐ Sleeping arrangements ☐ Changing clothes/showering

9. Are policies in place addressing appropriate attire for adults and youths? ☐ Yes ☐ No

10. Have you ever had any prior allegations, incidents or claims involving abuse? ☐ Yes ☐ No
    If yes, please provide complete details: _____

11. Have you ever had to administer any disciplinary action against any current or previous staff members because of abuse? ☐ Yes ☐ No
    If yes, please provide complete details: _____

12. Do you or your employees provide transportation to or from the facility? ☐ Yes ☐ No

13. Are children taken off-site for any activities? ☐ Yes ☐ No
    If yes, who provides transportation? _____

**If transportation is arranged by your organization, please attach a Certificate of Insurance from the transportation company.**

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# ADULT DAY CARE SUPPLEMENT

1. Name of Applicant: _____

2. Address of adult day care center: _____
   Street City State Zip

3. Hours of operation: _____ Average daily attendance: _____

4. Is this a licensed adult day care facility? ☐ Yes ☐ No
   If yes, what is the licensed capacity? (# of clients): _____

5. Does the day care center comply with Board of Health regulations and building code requirements ☐ Yes ☐ No

6. Are policies and procedures in place regarding one-on-one contact between staff and clients addressing isolated settings? ☐ Yes ☐ No

7. Have you ever had any prior allegations, incidents or claims involving abuse? ☐ Yes ☐ No
   If yes, please provide complete details: _____

8. Have you ever had to administer any disciplinary action against any current or previous staff members because of improper care or treatment of clients? ☐ Yes ☐ No
   If yes, please provide complete details: _____

9. Is there a Registered Nurse on-site? ☐ Yes ☐ No

10. Is fall prevention training provided? ☐ Yes ☐ No

11. Clients served: (Please check all that apply)
    ☐ Dementia ☐ Frail Elderly ☐ Mental Retardation/Developmentally Disabled
    ☐ Physically Disable ☐ Chronic Mental Illness ☐ HIV/AIDS
    ☐ Brain Injury ☐ Other: _____

12. Services provided: (Please check all that apply)
    ☐ Therapeutic Activities ☐ Activities of Daily Living ☐ Meals ☐ Medical Escort
    ☐ Respite ☐ Rehabilitation Therapy ☐ Hospice ☐ Emergency respite
    ☐ Overnight care ☐ Nursing services (wound care, injections colostomy care, etc.)
    ☐ Health-related services (medication administration, blood sugar testing, and weight monitoring, etc.)

13. Do you or your employees/volunteers pick up or transport clients to or from your adult day care facility? ☐ Yes ☐ No

14. Describe security measures or precautions taken to protect adult day care clients and to prevent them from leaving your facility unattended. _____

15. Have you ever had any prior incidents arising out of your day care facility that required notification to your insurance carrier, state or local authorities? ☐ Yes ☐ No
    If yes, provide complete details: _____

# MEDICAL STAFFING SUPPLEMENT

1. Name of Applicant: _____

## STAFFING OPERATIONS

***Please attach a copy of your Agency Staffing Agreement.***

1. Do you staff any non-medical positions? ☐ Yes ☐ No
2. What type of staffing services do you offer?
   - ☐ Per diem
   - ☐ Temporary Staffing (less than one month)
   - ☐ Long-term Staffing
   - ☐ Temporary-to-Direct Hire Placement
3. Do you employ 100% of the individuals that you place for your clients? ☐ Yes ☐ No
4. Please estimate which of the following are your typical staffing clients: (Total must equal 100%)

| | | | |
|---|---|---|---|
| ☐ Hospitals / Health Systems | ____% | ☐ Non-skilled personal care agencies | ____% |
| ☐ Nursing Homes / Assisted Living Facilities | ____% | ☐ Hospices | ____% |
| ☐ Private Physician Practices | ____% | ☐ Social Services Agencies | ____% |
| ☐ Home Healthcare Agencies | ____% | ☐ Surgical Centers | ____% |
| ☐ Pharmacies | ____% | ☐ Other _____ | ____% |

5. Please indicate the location(s) where staffing services are provided:
   - ☐ Private Homes
   - ☐ Hospitals
   - ☐ Clinics
   - ☐ Nursing Homes/ALF's
   - ☐ Schools
   - ☐ Outpatient Facilities
   - ☐ Other _____
6. Do you also offer human resources consulting services on a fee-for-service basis? ☐ Yes ☐ No
   If yes, what is your estimated annual revenue from these services? $ _____
7. What is your total estimated annual revenue from staffing for your current fiscal year? $ _____ Last year? $ _____
   **(If your revenue exceeds $5,000,000 please attach a copy of your latest audited financial statement)**

## EMPLOYEE SELECTION

1. Do you perform employee background checks on staffed workers based on the requirements of the state or the healthcare facility? ☐ Yes ☐ No
2. Which of the following background check methods do you use?

| | Staffed Workers |
|---|---|
| Current Licensure, certification, and registration | ☐ Yes ☐ No |
| Criminal background checks | ☐ Yes ☐ No |
| Sexual Abuse Registry checks | ☐ Yes ☐ No |
| Present employment and two previous employers' verification | ☐ Yes ☐ No |
| Pre-employment verification of convictions for abuse/neglect | ☐ Yes ☐ No |
| Social Security number verification and search | ☐ Yes ☐ No |
| Education | ☐ Yes ☐ No |
| Home telephone/residency verification | ☐ Yes ☐ No |
| Driver's license information (MVR) *if placement requires driving responsibilities* | ☐ Yes ☐ No |
| Drug screening | ☐ Yes ☐ No |

3. Do your staffing contracts stipulate that you are responsible for performing criminal background checks? ☐ Yes ☐ No
4. Do you conduct face-to-face interviews with all prospective staffed workers? ☐ Yes ☐ No
5. Do you have a process in place to assure that the staffed worker's qualifications and competencies are consistent with job placement responsibilities? ☐ Yes ☐ No
6. Do you require that your clients orient the staffed workers to the facility setting, the unit, and policies and procedures on each staffing assignment? ☐ Yes ☐ No
7. Do you seek regular feedback from your clients on employee performance on all staffed workers? ☐ Yes ☐ No
8. Do you have a written description of your complaint process that is supplied to each of your clients? ☐ Yes ☐ No

9. Do you have a process in place for temporary staffed workers to question the appropriateness of their assignments? ☐ Yes ☐ No
10. Do you provide ongoing education, including in-services and other activities? ☐ Yes ☐ No

## RISK MANAGEMENT AND LOSS CONTROL

1. Do you carry Workers Compensation insurance? ☐ Yes ☐ No
2. Do you have processes in place for reporting and investigating allegations of hostile work environments? ☐ Yes ☐ No
3. Do you have a process in place to evaluate prospective clients before offering staffing services? ☐ Yes ☐ No
   If yes, does it include an on-site visit and a review of the facility's orientation program for staffed workers? ☐ Yes ☐ No
4. Do your staffing agreements include defined roles and responsibilities of both parties? ☐ Yes ☐ No
5. Do your staffing agreements include mutual hold harmless agreements? ☐ Yes ☐ No
6. Is the use of personal vehicles by staffed workers addressed in your agency staffing agreement? ☐ Yes ☐ No
7. Are staffing agreements reviewed by legal counsel? ☐ Yes ☐ No

## EMPLOYEE INFORMATION – ANNUAL STAFFING

1. Please provide the estimated number annual billable hours and annual payrolls for each type of staffed employee for the next twelve months. Do NOT include your own internal agency staff.

| Employee Type (staffed workers) | Estimated Annual Billable Hours | Estimated Annual Payroll |
|---|---|---|
| Nurse (RN) | | $ |
| LPN | | $ |
| Nurse Aide/ Nursing Assistant | | $ |
| Home Health Aide | | $ |
| Homemaker | | $ |
| Social Worker | | $ |
| Physical Therapist | | $ |
| Speech Pathologist | | $ |
| Occupational Therapist | | $ |
| Pharmacy Assistant | | $ |
| Lab Technician | | $ |
| EKG Technician | | $ |
| X-ray Technician | | $ |
| Radiology Technician | | $ |
| Medical Technician | | $ |
| Certified Medical Assistant | | $ |
| Dietician/Nutritionist | | $ |
| Dialysis Technician | | $ |
| Enterostomal Therapist | | $ |
| Respiratory Therapist | | $ |
| Phlebotomist | | $ |
| Radiation Therapist | | $ |
| Clerical/Administrative | | $ |
| Other: | | $ |
| **Total** | | $ |

*Note: Staffing agencies which staff physicians, medical directors, physician assistants, surgeons, dentists, psychiatrists, residents, interns, externs, chiropractors, acupuncturists, nurse practitioners, nurse midwives, certified registered nurse anesthetists and pharmacists are not eligible for coverage.*

2. What percentage of these total staff workers are assigned to Critical Care, Emergency, Obstetrics, Radiology or Pediatric Departments? _____%
3. What percentage of your business includes staffing travel nurses? ☐ None ☐ _____%
4. Do you employ international healthcare workers on work visas? ☐ Yes ☐ No
5. Do you place staffed workers in prisons or correctional facilities? ☐ Yes ☐ No