



9201 FOREST HILL AVE., SUITE 200, RICHMOND, VA 23235 PHONE: (800) 577-6614 FAX: (804) 327-3172

**ALLIED MEDICAL GENERAL APPLICATION**

**APPLICANT'S INFORMATION**

APPLICANT NAME:			
MAILING ADDRESS:			
COUNTY:		DATE ESTABLISHED:	
INSPECTION CONTACT:		PHONE NUMBER:	
Type of Enterprise:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Non-Profit <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other: _____		
Estimated receipts/operating budget for the next 12 months:			
Estimated payroll for the next 12 months:			
Full description of services rendered:			

**Current Insurance:**

Has applicant had previous insurance for this enterprise?  No  Yes  
 If yes, complete the following:

<i>General Liability</i>		<i>Professional Liability</i>	
Current Carrier		Current Carrier	
Policy term		Policy term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you?  No  Yes  
 If yes, complete the following:

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, aware of any circumstances, which may result in a claim?  No  Yes  
 If yes, provide full details.

Has any license or accreditation ever been suspended, denied or revoked?  No  Yes

Of what professional association(s) is Insured a member in good standing? \_\_\_\_\_

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation.

- Criminal Background Checks       Reference Checks  
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation.  
 Verification of certification or professional licensing.  
 Drug, alcohol and sexual abuse screening or testing.

**Schedule of Physicians – on Staff or Contracted:**

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wish physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If yes, explain.					<input type="checkbox"/> No <input type="checkbox"/> Yes
Is electroshock therapy utilized? If yes, how many per year?					<input type="checkbox"/> No <input type="checkbox"/> Yes

**Schedule of Location:**      If more than 3 locations, attached a separate sheet of locations

#1 Address	
Type of Services Provided	
#2 Address	
Type of Services Provided	
#3 Address	
Type of Services Provided	

**Services Provided:**

*Please indicate the Number of Beds*

Mental Health Inpatient		Group Home	
Alcohol/Drug Inpatient		Shelters	
Alcohol/Drug Detox.		Independent Living	
Halfway House		Foster Care (children)	
Apartments		Other (specify)	

Please indicate the <i>Number of annual Outpatient or Client Visits</i>			
Alcohol/Drug Rehab		Counseling	
Mental Health		Methadone	
Please indicate the <i>Number of Clients per day</i>			
Adult Day Care		Partial Hospitalization	
Child Day Care		Sheltered Workshops	
Please indicate the <i>Number of Calls (annually)</i>			
Hotline		Information	
Transport – Emergency		Non-emergency	
Referral		Other (specify):	
Please indicate the <i>Annual Employee Assistance Programs (EAP) contracts or visits</i>			
Assessments		Counseling Visits	
Referrals		# of co.'s under contract	
Please indicate the Number of <i>Home Health Care Visits</i>			
Nonprofessional hours		IV Therapy	
Professional hours		Other (specify):	
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? If yes, describe and submit brochure or detailed narrative of activities.			<input type="checkbox"/> No <input type="checkbox"/> Yes
Are there any swimming or boating activities?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Is pool fenced with a self-locking gate?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Diving board?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Slide?			<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Residential or Inpatient - <i>complete supplemental application</i>			
<input type="checkbox"/> Foster Care or Adoption - <i>complete supplemental application</i>			
<b>Check the coverages and limits that the applicant would like quoted.</b>			
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach acord app)
Limits requested:	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500
	<input type="checkbox"/> 1/1	<input type="checkbox"/> 1/2	<input type="checkbox"/> 1/3
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees?			<input type="checkbox"/> No <input type="checkbox"/> Yes
At what limits:	<input type="checkbox"/> 25/50	<input type="checkbox"/> 50/100	<input type="checkbox"/> 100/300
	<input type="checkbox"/> 250/250	<input type="checkbox"/> 500/500	<input type="checkbox"/> Other
<i>Higher Abuse limits may be available for select risks.</i>			

Applicant's signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_



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**ALLIED MEDICAL HOME HEALTH CARE MEDICAL STAFFING AGENCY  
 SUPPLEMENTAL APPLICATION  
 SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION**

**TYPE OF FIRM:**

- Home Health Care                       Medical Equipment Supplier (Complete DME Supplement)  
 Nurse Registry                               Supplemental Staffing                       Other

**GENERAL INFORMATION:**

- Number of independent contractors: \_\_\_\_\_  
 Cost of independent contractors: \$ \_\_\_\_\_
- Do you require and keep certificates of insurance for all independent contractors?       No  Yes
- Does the applicant utilize a formal written Quality Assurance & Risk Management Program?  No  Yes  
**If "No," explain:** \_\_\_\_\_
- Is the overall responsibility for Risk Management assigned to one individual in your firm?       No  Yes  
**If "Yes," explain:** \_\_\_\_\_
- Is an informed consent document placed in the patient's medical record?       No  Yes  
 Does the applicant conduct patient/client surveys? **(If "Yes," attach sample)**       No  Yes  
 Are the results of patient/client surveys used to improve day to day operations?       No  Yes

**THIS SECTION MUST BE COMPLETED:**

- Description of employees or contracted personnel:

	Number of Employees	Number of Independent Contractors	Do All Workers Carry Their Own Insurance	Where are services rendered?		
				% in Hospitals	% in Nursing Homes	% in Private Homes
Aids			<input type="checkbox"/> No <input type="checkbox"/> Yes			
LPN's			<input type="checkbox"/> No <input type="checkbox"/> Yes			
RN's			<input type="checkbox"/> No <input type="checkbox"/> Yes			
Nurse Practitioner			<input type="checkbox"/> No <input type="checkbox"/> Yes			
Physical Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes			
Respiratory Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes			
Speech Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes			
Occupational Therapist			<input type="checkbox"/> No <input type="checkbox"/> Yes			
Social Worker			<input type="checkbox"/> No <input type="checkbox"/> Yes			
Pharmacist			<input type="checkbox"/> No <input type="checkbox"/> Yes			
Special Training			<input type="checkbox"/> No <input type="checkbox"/> Yes			
Other (specify):			<input type="checkbox"/> No <input type="checkbox"/> Yes			

- Give percentage of patients in the following age ranges: \_\_\_\_\_% Under 18      \_\_\_\_\_% Age: 18-35  
 \_\_\_\_\_% Age: 36-50      \_\_\_\_\_% Age 51-65      \_\_\_\_\_% Over 65 years old

8. Indicate percentage of revenue derived from IV Therapy: \_\_\_\_\_%
9. Are employees/contractors references contacted before hired/placed?  No  Yes
- How are references checked? \_\_\_\_\_ Written \_\_\_\_\_ Verbal \_\_\_\_\_ Both

**If "Verbal only," please explain:** \_\_\_\_\_

- Do you perform criminal background checks on prospective employees/contractors?  No  Yes
- If "No," please explain:** \_\_\_\_\_

- Do you question prospective employees in their previous involvement as defendants in professional malpractice litigation?  No  Yes

**If "No," please explain:** \_\_\_\_\_

- Is certification and/or professional licensure status of employees & independent contractors verified?  No  Yes

- Are employees screened to rule out drug, alcohol and/or sexual abuse?  No  Yes

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

10. Describe services performed by your LPN's/RN's: \_\_\_\_\_

\_\_\_\_\_

11. Do you supply medical equipment or are your personnel responsible for monitoring equipment?  No  Yes

**If "Yes," describe all such equipment:** \_\_\_\_\_

12. Do you sell or lease any equipment?  No  Yes

**If "Yes," please explain:**

13. Do you repair or maintain any medical equipment?  No  Yes

**If "Yes," please explain:**

14. Receipts from equipment sales, leasing or repair: \$ \_\_\_\_\_

15. Provide details for licensing or certification needed for this operation: \_\_\_\_\_

\_\_\_\_\_

16. How long have you been licensed/certified? \_\_\_\_\_

17. Has your license ever been suspended or revoked?  No  Yes

**If "Yes," please explain:** \_\_\_\_\_

18. Your premium is adjustable based on your total receipts. Our auditor will verify your total receipts. If this information is kept by your accountant, provide the accountants name, address and phone number: \_\_\_\_\_

\_\_\_\_\_

If this information is kept by you, provide the telephone number and address where the records are kept.

\_\_\_\_\_

19. Physical abuse/sexual molestation coverage for protection of alleged acts of your employees?  No  Yes

**SUPPLEMENTAL STAFFING:**

20. Do you provide temporary workers to other businesses or institutions?  No  Yes

21. Do you acknowledge that the Colony Insurance policy does not cover liability you assume in any contract or agreement?  No  Yes

**SUPPLEMENTAL STAFFING (continued):**

No  Yes

22. Do contracts you sign make your company liable for negligent acts of those temporary workers while they are working in and being supervised by those other businesses or institutions?

23. Do you require those temporary workers to maintain their own professional liability policies?

No  Yes

Do you verify coverage?

No  Yes

How often? \_\_\_\_\_

24. Do you staff any hospitals?

No  Yes

**If "Yes," do you staff any Labor & Delivery, Emergency Room or Surgery positions?**

No  Yes

**If "Yes," estimated annual revenue from these placements: \$ \_\_\_\_\_**

**DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Sub-Producer

\_\_\_\_\_  
Title/Date

\_\_\_\_\_  
Producer

\*SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.