



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

**TYPE OF FIRM:**

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

**GENERAL INFORMATION:**

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

**THIS SECTION MUST BE COMPLETED:**

- Description of employees or contracted personnel:

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

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

- Give percentage of patients in the following age ranges: \_\_\_\_\_ % 0-4      \_\_\_\_\_ % 5-17  
 \_\_\_\_\_ % 18-35      \_\_\_\_\_ % 36-50      \_\_\_\_\_ % 51-65      \_\_\_\_\_ % 65+
- Indicate percentage of revenue derived from IV Therapy: \_\_\_\_\_ %

Percentage of Types of Services Provided (total must equal 100%)

Personal Care Chore or Companion	_____ %	Respiratory Therapy (trach care?/ventilator care?)	_____ %
Rehabilitation	_____ %	Radiation Therapy	_____ %
Infusion Therapy	_____ %	Skilled Nursing Care	_____ %
Hospice	_____ %	Social Services	_____ %
Supplemental Staffing	_____ %	Infant Care	_____ %
Obstetrical Services	_____ %	Pediatric Care	_____ %
Adult Day Care*	_____ %	Retail Pharmacy	_____ %
Child Day Care*	_____ %	Closed Pharmacy	_____ %
Medical Equipment Supplier	_____ %	Clinics Owned/Operated	_____ %
Meals on Wheels	_____ %	Other Services (please specify)	_____ %
Skin Care or Bedsore Wound Care	_____ %		

\*Firms providing day care may be required to complete a supplemental application

9. Are employees/contractors references contacted before hired/placed?  No  Yes  
 How are references checked? \_\_\_\_\_ Written \_\_\_\_\_ Verbal \_\_\_\_\_ Both  
 If "Verbal only," please explain: \_\_\_\_\_
- Do you perform criminal background checks on prospective employees/contractors?  No  Yes  
 If "No," please explain: \_\_\_\_\_
- Do you question prospective employees in their previous involvement as defendants in professional malpractice litigation?  No  Yes  
 If "No," please explain: \_\_\_\_\_
- Is certification and/or professional licensure status of employees & independent contractors verified?  No  Yes
- Are employees screened to rule out drug, alcohol and/or sexual abuse?  No  Yes
- Are job descriptions provided for all professional and nonprofessional employees?  No  Yes
10. Describe services performed by your LPN's/RN's: \_\_\_\_\_  
 \_\_\_\_\_
11. Do you supply medical equipment or are your personnel responsible for monitoring equipment?  No  Yes  
 If "Yes," describe all such equipment: \_\_\_\_\_
12. Do you sell or lease any equipment?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_
13. Do you repair or maintain any medical equipment?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_
14. Receipts from equipment sales, leasing or repair: \$ \_\_\_\_\_
15. Provide details for licensing or certification needed for this operation: \_\_\_\_\_
16. How long have you been licensed/certified? \_\_\_\_\_

17. Has your license ever been suspended or revoked?  No  Yes  
If "Yes," please explain: \_\_\_\_\_

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

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

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

**SUPPLEMENTAL STAFFING:**

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

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

**SUPPLEMENTAL STAFFING (continued):**

No  Yes

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

23. Do you require those temporary workers to maintain their own professional liability policies?  No  Yes

Do you verify coverage?  No  Yes

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

24. Do you staff any hospitals?  No  Yes

If "Yes," do you staff any Labor & Delivery, Emergency Room or Surgery positions?  No  Yes

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

25. Do you staff any correctional facilities?  No  Yes

\* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

\* not applicable in all states

**DECLARATION AND SIGNATURE:**

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

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

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

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

\_\_\_\_\_  
Producer

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