Hull & Company
Lic. #0F60641

Southern California
1600 Dove Street, Suite 315
Newport Beach, CA 92660
P: (949) 477-5030 **F**: (949) 477-5040

Northern California
2389 West March Lane
Stockton, CA 95207
P: (209) 474-9100 **F**: (866) 217-1815

Pacific Islands
3375 Koapaka Street, Suite D136
Honolulu, HI 96819
P: (808) 840-1980 **F**: (866) 859-8302

Application for Home Health Care Basic Non-Nursing Services

1. Name of Applicant: _____

2. ☐ Individual ☐ Corporation ☐ Partnership ☐ Other (Explain) _____
   Date Established _____

3. Street Address: _____
   City: _____ State: _____ Zip: _____
   Applicant's Web Site Address: _____

4. Provide full name(s) of individual and partners. _____
   _____

5. What state/s are you licensed or certified in? Provide details of what your license/certification allows you to do.
   _____
   _____

6. Has applicant's license ever been suspended or revoked? ☐ Yes ☐ No
   Has applicant ever been investigated by the State Health Dept., State Licensing Board or other governmental body? ☐ Yes ☐ No
   If yes to either question above, provide full details on Attachment to A102.

7. Is applicant's operation Medicare approved? ☐ Yes ☐ No Medicare sales? $ _____

8. Is applicant accredited by any of the following?
   National Homecaring Council ☐ Yes
   National Association of Home Care ☐ Yes
   Joint Commission on Accreditation of Healthcare Organizations ☐ Yes
   Community Health Accreditation Program ☐ Yes

9. Sales from employees: $ _____ Sales from independent contractors: $ _____
   Sales from non-nursing operations: $ _____ Total Sales: $ _____

10. Do employed nurses have their own Professional Liability coverage? ☐ Yes ☐ No
    Limits Required? $ _____
    Does the applicant require Certificates of Insurance from all nursing (RNs, LPNs) independent contractors? ☐ Yes ☐ No
    Limits Required? $ _____

11. Applicant's premium is adjustable based on **gross sales**. *Our auditor will verify applicant's gross sales.*
    If this information is kept by the applicant's accountant, please provide accountant's name, address and telephone number.
    _____
    If this information is kept by the applicant, please provide the telephone number and address where the records are kept.
    _____
    If you are not normally at this location during working hours, please provide a beeper number or telephone number where you can be reached: _____
    Applicant's telephone number if not previously given: _____

12. Prior coverage:

Insurance Company	Year	Premium	Type? Occurrence/ Claims Made	Any Claims (Check One)	Description
			☐ Occ ☐ CM	☐ Yes ☐ No	
			☐ Occ ☐ CM	☐ Yes ☐ No	
			☐ Occ ☐ CM	☐ Yes ☐ No	
			☐ Occ ☐ CM	☐ Yes ☐ No	
			☐ Occ ☐ CM	☐ Yes ☐ No	

13. Is the applicant aware of any circumstances which may result in a claim? ☐ Yes ☐ No
    If yes, provide full details on Attachment to A102.

14. Does the applicant want the policy to cover employees? *There is a premium charge.* ☐ Yes ☐ No
    (Note: The policy already protects the applicant for the acts of his/her employees.)

15. Are applicant's employees or independent contractors responsible for monitoring any equipment? ☐ Yes ☐ No
    If yes, please provide full description. _____

    ☐ *Check if continued on Attachment to A102.*

16. Are employees required to complete daily work reports? ☐ Yes ☐ No
Does applicant utilize a formal Quality Assurance/Risk Management program? ☐ Yes ☐ No
Does applicant conduct patient/client surveys? ☐ Yes ☐ No
Is there an informed consent process in place? ☐ Yes ☐ No
Are there written policies in place for:

Drug administration procedures?	☐ Yes ☐ No	Patient acceptance?	☐ Yes ☐ No
Emergencies in the field?	☐ Yes ☐ No	Patient rights?	☐ Yes ☐ No
Employee training?	☐ Yes ☐ No	Physician orders?	☐ Yes ☐ No
Food preparation?	☐ Yes ☐ No	Proper lifting?	☐ Yes ☐ No
Handling of complaints?	☐ Yes ☐ No	Reporting of suspected physical/sexual abuse?	☐ Yes ☐ No
Medical equipment training?	☐ Yes ☐ No	Termination of Care?	☐ Yes ☐ No

If the answer to any question is no, refer risk to Company.

17. Please provide details of employed or contracted personnel:

	Number Employed	Number Contracted	Contractors Ins. Limits Required	Percentage working in: Hospital	Nursing Home*	Home
Aides/Homemaker Health Aides						
LPN's						
RN's						
Home Companions						
Certified Nursing Assistants						
Others (Specify)						

Percentage of Clients under 18 years of age? _____% Percentage of Clients over 65 years of age? _____%
* If yes, is contract with client for private duty work? ☐ Yes ☐ No *If no, please explain on Attachment to A102.*

18. Are the following background checks performed?

All prior employers?	☐ Yes ☐ No	Home telephone verification?	☐ Yes ☐ No
All educational institutions?	☐ Yes ☐ No	Professional licensing verification?	☐ Yes ☐ No
Driver's license information?	☐ Yes ☐ No	Residency information?	☐ Yes ☐ No
Drug screening required?	☐ Yes ☐ No	Sex offender registry search?	☐ Yes ☐ No
Federal, State (if possible) and County criminal record search?	☐ Yes ☐ No	Social Security No. verification?	☐ Yes ☐ No

If the answer to any question is no, refer risk to Company.

19. Is 24 Hour Service provided? ☐ Yes ☐ No If Yes, Percent of Operations _____ %
If Yes, is this Live-in? ☐ Yes ☐ No Shift Work? ☐ Yes ☐ No

20. Please describe services performed by any other professionals. _____

☐ *Check if continued on Attachment to A102.*

21. Please list any medical equipment applicant supplies to clients. _____

22. Does the applicant sell or rent equipment to clients? ☐ Yes ☐ No
If yes, complete Application A-17.

23. Please provide details of licensing or certification needed for this operation. _____

☐ *Check if continued on Attachment to A102.*

24. **Limits of Insurance Requested**

General Aggregate Limit (Other than Products-Completed Operations)	$ _____	
Products-Completed Operations Aggregate Limit	$ _____	
Personal and Advertising Injury Limit	$ _____	
Each Occurrence Limit	$ _____	
Damage to Premises Rented to You (Up to $100,000 limit available)	$ _____	Any One (1) Premises
Medical Expense Limit (Up to $5,000 limit available)	$ _____	Any One (1) Person
Each Professional Incident Limit (if applicable)	$ _____	

25. Effective Dates Desired – From: _____ To: _____

FOR SEXUAL MOLESTATION COVERAGE, PLEASE COMPLETE QUESTIONS 26. THROUGH 30.

$25,000/50,000 limit is included at no additional charge. Higher limits are available for an additional premium charge (see below). If sexual molestation coverage is not desired, please check here ☐ Coverage is NOT requested.

26. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
Please provide details: _____

27. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? ☐ Yes ☐ No
Describe: _____

28. Does your facility do background checks on all employees and volunteers? ☐ Yes ☐ No
Describe type of checks performed (prior employer, police, etc.): _____

29. Are there written guidelines in place regarding sexual misconduct? ☐ Yes ☐ No
If NO, please explain: _____

30. Please check the limits you are requesting: ☐ $25,000/50,000 - included
☐ $50,000/100,000 ☐ $100,000/300,000 ☐ $300,000/600,000 ☐ $500,000/1MM ☐ $1MM/2MM

FOR HIRED AND NON-OWNED AUTO COVERAGE, PLEASE COMPLETE QUESTIONS 31. THROUGH 35.

31. What types of non-owned autos will be used in your business? _____

32. Total Number of Non-owned autos used in your business? _____

33. Do you require your employees to have their own insurance? ☐ Yes ☐ No
If YES, what are the minimum liability limits required? _____

34. Will you use Non-owned autos other than those owned by your employees? ☐ Yes ☐ No
If YES, describe relationship and use: _____

35. Please check the limits you are requesting:
☐ $100,000 ☐ $300,000 ☐ $500,000 ☐ $1MM

Applicant's Signature _____ Date _____

Title _____ Producing Agent _____

Name of Applicant ______________________________

#	Description or Full Details