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:
1. Number of independent contractors:__________ Cost of independent contractors:$______________
2. Do you require and keep certificates of insurance for all independent contractors?    ☐ No ☐ Yes
3. Does the applicant utilize a formal written Quality Assurance & Risk Management Program?    ☐ No ☐ Yes
   If “No,” explain:________________________________________________________
4. Is the overall responsibility for Risk Management assigned to one individual in your firm?    ☐ No ☐ Yes
   If “Yes,” explain:________________________________________________________
5. 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:
6. Description of employees or contracted personnel:

<table>
<thead>
<tr>
<th>Number of Employees</th>
<th>Number of Independent Contractors</th>
<th>Do All Workers Carry Their Own Insurance</th>
<th>Where are services rendered?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>% in Hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>S.S.</em></td>
</tr>
<tr>
<td>Aids</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>LPN’s</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>RN’s</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Physical Therapist</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Speech Therapist</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Special Training</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>CRNA’s</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
<tr>
<td>Other (specify):</td>
<td></td>
<td>☐ No ☐ Yes</td>
<td></td>
</tr>
</tbody>
</table>

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

7. Give percentage of patients in the following age ranges:        % 0-4        % 5-17
   ______% 18-35       ______% 36-50       ______% 51-65       ______% 65+
8. Indicate percentage of revenue derived from IV Therapy:        %
Percentage of Types of Services Provided (total must equal 100%)

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

*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:
   ________________________________

10. Are employees/contractors references contacted before hired/placed?  
   □ No □ Yes
   How are references checked?  □ Written □ Verbal □ Both
   If “Verbal only,” please explain:
   ________________________________

11. Do you perform criminal background checks on prospective employees/contractors?  
    □ No □ Yes
    If “No,” please explain:
    ________________________________

12. Do you perform criminal background checks on prospective employees/contractors?  
    □ No □ Yes
    If “No,” please explain:
    ________________________________

13. Are employees/contractors references contacted before hired/placed?  
    □ No □ Yes
    How are references checked?  □ Written □ Verbal □ Both
    If “Verbal only,” please explain:
    ________________________________

14. Do you perform criminal background checks on prospective employees/contractors?  
    □ No □ Yes
    If “No,” please explain:
    ________________________________

15. Are employees/contractors references contacted before hired/placed?  
    □ No □ Yes
    How are references checked?  □ Written □ Verbal □ Both
    If “Verbal only,” please explain:
    ________________________________

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):**

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?  
   ☐ No ☐ Yes

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.