



James River Insurance Company
 7130 Glen Forest Drive, Suite 210
 Richmond, VA 23226-3754
 (804) 289-2700
 (804) 287-2815 Fax
 ah@jamesriverins.com

ALLIED HEALTHCARE 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?			<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, complete the following:			
General Liability		Professional Liability	
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 <input type="checkbox"/> No <input type="checkbox"/> Yes current or prior insurance carrier or to you? 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has any license or accreditation ever been suspended, denied or revoked?	<input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> Criminal Background Checks <input type="checkbox"/> Reference Checks. <input type="checkbox"/> Questioning of employees in their previous involvement as defendants in professional malpractice litigation. <input type="checkbox"/> Verification of certification or professional licensing. <input type="checkbox"/> Drug, alcohol and sexual abuse screening or testing.
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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?					<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, explain.					

Is electroshock therapy utilized? If yes, how many per year?	<input type="checkbox"/> No <input type="checkbox"/> Yes
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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 Number of annual Outpatient or Client Visits			
Alcohol/Drug Rehab		Counseling	
Mental Health		Methadone	
Please indicate the Number of Clients per day			
Adult Day Care		Partial Hospitalization	
Child Day Care		Sheltered Workshops	
Please indicate the Number of Calls (annually)			
Hotline		Information	
Transport – Emergency		Non - Emergency	
Referral		Other (specify):	
Please indicate the Annual Employee Assistance Programs (EAP) contracts or visits			
Assessments		Counseling Visits	
Referrals		# of co.'s under contract	
Please indicate the Number of Home Health Care Visits			
Nonprofessional hours		IV Therapy	
Professional hours		Other (specify):	
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, describe and submit brochure or detailed narrative of activities.			
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 - complete supplemental application
<input type="checkbox"/> Foster Care or Adoption - complete supplemental application

Check the coverages and limits that the applicant would like quoted.			
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach accord 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?			
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
Higher Abuse limits may be available for select risks.			

Applicant's signature _____

Title _____

Date _____



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**ALLIED HEALTHCARE HOME HEATH CARE MEDICAL STAFFING AGENCY
SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED HEALTHCARE 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:

	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			
Occupational 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			

7. 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

