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Home Care and Healthcare Placement Agency Application

Please read and complete the application in its entirety. Blanks &/or dashes are not acceptable and will delay consideration of this application. Answer all questions, if the question does not apply, indicate "N/A" in the circle provided.

SECTION 1 – GENERAL INFORMATION

Name of Applicant (Please print):		
Name of Establishment to be insured:		
Address:		
City/Town:	Province:	Postal Code:
Phone Number:	Email:	
When was your organization established?		
Is your facility registered as? ☐ For Profit ☐ Not For Profit		
State your gross annual revenue in respect of the following years: Last Complete Financial Year: Estimate for Current Financial Year: Estimate for Next Financial Year:		

SECTION 2 – OPERATIONS

Indicate by type the number of full time (FT) and part time (PT) employed and contracted by the Applicant:

	Employees		Independent Contractors			Employees		Independent Contractors	
Profession	FT	PT	FT	PT	Profession	FT	PT	FT	PT
Homemaker					Personal Support Worker				
Clinical Counsellor					Physiotherapist				
Dietician					Social Worker				
Footcare Nurse					Others: Specify				
RN - Nurse					Others: Specify				
RPN / LPN - Nurse					Others: Specify				

a.	Do you require all regulated or non-regulated professionals to carry their own Professional Liability (Medical Malpractice) insurance?	☐ Yes ☐ No
	If no, please explain:	
b.	Do all health care independent contractors carry their own Professional Liability (Medical Malpractice) Insurance?	☐ Yes ☐ No
	If no, please explain:	
c.	Do all Personal Support Workers or Caregivers perform designated tasks delegated by a Registered Health Professional and have undergone functional training under the Regulated Health Professions Act?	☐ Yes ☐ No
	If no, please provide explanation:	
d.	Do you have written policies and procedures describing each services offered and signed off by the patient or patient's custodian?	☐ Yes ☐ No
e.	Do you obtain informed consent prior to all treatment or care services?	☐ Yes ☐ No
f.	Are there any formal mechanism for:	
	i. Patients to report or ask questions regarding their medical complications?	☐ Yes ☐ No
	ii. Medical emergency backup services or emergencies?	☐ Yes ☐ No
g.	Do all healthcare professionals submit and conduct a bedside and end-of-shift report and are these reports reviewed with the patient or accompanying family member?	☐ Yes ☐ No
h.	Do you follow the current guidance for infection prevention & control issued by the Public Health Authority or any regional/ territorial public health authorities?	☐ Yes ☐ No
i.	Do you provide overnight stay services to patients?	☐ Yes ☐ No
j.	Do you provide services to neonates / pediatrics? If yes. What are the services rendered?	☐ Yes ☐ No
k.	Are caregivers trained or certified in dementia and / or Alzheimer's care?	☐ Yes ☐ No

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l.	Do you offer acute care services to patients?	☐ Yes ☐ No
	If yes, what are the acute conditions?	

m. On what basis does the agency contract with their end clients? Are contracts:

- ☐ Ex-vicarious (standard contracts where the end client retains the responsibility for the actions of the placed personnel); or
- ☐ Vicarious (non-standard contracts where the end client pushes back liability for the placed personnel to the nursing agency); or
- ☐ Both above? What is the % split?

n. Staff are assigned to the following facilities:

Type of facility	Revenue %
Client's private Home	
Retirement Home	
Nursing Home	
Hospitals	
Correctional Facility	
Others: specify	

For hospital placements, do nurses work in the labor and delivery or obstetrics and gynecology or general pediatric units? ☐ Yes ☐ No

If so, please provide % of the revenue:

SECTION 3 – HIRING / SCREENING AND CREDENTIALING PROCEDURES

a.	Do new employees or staff complete employment application?	☐ Yes ☐ No
b.	Are employees/contractors references contacted before hired/placed?	☐ Yes ☐ No
c.	Do you conduct criminal background and vulnerable sector screening for all healthcare employees/ contractors prior to hire/placement?	☐ Yes ☐ No
d.	Do you verify certification and/or professional licensure status of employees and independent contractors?	☐ Yes ☐ No
e.	Do all the healthcare employees or independent contractors undergo continuing education to improve their quality of care?	☐ Yes ☐ No
f.	Has the applicant formalized a drug and alcohol-screening program requiring all employees/contractors to satisfy drug and alcohol testing prior to hire/placement and is there a procedure for screening suspect employees/contractors when drug or alcohol abuse is alleged?	☐ Yes ☐ No

SECTION 4 – ABUSE PROTOCOLS

a.	Please provide a copy of the abuse protocols in place for both employees and patients.	
b.	Do all staff attend an abuse prevention seminar?	☐ Yes ☐ No
c.	Have any allegations of abuse been made against you, your employees or any other person associated with your organization during the past 10 years?	☐ Yes ☐ No
	If yes, please attach details.	

SECTION 5 – GENERAL LIABILITY

1.	Is coverage required for any premises or buildings owned (wholly or in part) or operated by the Establishment?	☐ Yes ☐ No

If yes, please provide full details about the premises, including number of buildings, number of stories, date built, total square footage, number of stories, type of construction (e.g., concrete), and protection systems:

Location	Year Built	Size (sq.ft.)	# of Stories	Construction	Protection Systems	
					Alarms	Sprinklers

2.	Are all contractors and sub-contractors required to provide proof of liability insurance and name the Establishment as an additional insured to their insurance?	☐ Yes ☐ No
3.	Are all employees covered by the provincial Workers Compensation Board or equivalent?	☐ Yes ☐ No
	If no, is there an alternative Employee Benefit/Disability Program?	☐ Yes ☐ No
4.	Do employees drive their personal vehicles for work-related purposes?	☐ Yes ☐ No
	If yes, do they report this to their personal automobile insurer?	☐ Yes ☐ No
	If yes, do they carry a minimum limit of $1 MM Automobile Third Party coverage on their personal automobile policy?	☐ Yes ☐ No

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SECTION 6 – CLAIMS AND INSURANCE HISTORY

A. Claims

1.	Are you aware of any negligence claims ever been made against your organization whether successful or otherwise?	☐ Yes ☐ No
2.	Are you aware of any claims for dishonesty ever been made against your organization whether successful or otherwise?	☐ Yes ☐ No

3. Please list all claims and incidents that may result in a claim, prior to the effective date of this proposed policy, which would have given rise to a claim, arising from your professional activities in the past year. If none, state "none":

Year of Incident	Nature of Injuries	Injured Party

B. Insurance History

1.	Have you ever been declined, cancelled or non-renewed by an insurance for Professional Liability Insurance?	☐ Yes ☐ No
2.	Have you ever been cancelled for non-payment?	☐ Yes ☐ No
3.	Has prior coverage been a Claims Made Basis?	☐ Yes ☐ No

If claims made, most recent retroactive date (mm/dd/yyyy):

Previous Insurer	Policy No	Liability Limits	Premium	Expiry Date (mm/dd/yyyy)

NOTICE CONCERNING PERSONAL INFORMATION

By purchasing insurance from AllMed Underwriting Services (AMU), a customer provides AMU with his or her consent to the collection, use and disclosure of personal information, including that previously collected, for the following purposes:

- the communication with underwriters;
- the evaluation of claims;
- the analysis of business results;
- the underwriting of policies;
- the detection and prevention of fraud;
- purposes required or authorized by law.

For the purposes identified above, personal information may be disclosed to AMU and any affiliated companies and service providers. Further information about AMU personal information protection policy may be obtained by contacting their privacy officer at 204-925-8268.

WARRANTY STATEMENT

The undersigned warrants that to the best of his or her knowledge, the statements set forth in this Application are true. The undersigned also warrants that they have not suppressed or misstated any material facts. It is further agreed by the undersigned that each policy or renewal thereof, if issued, is issued in reliance upon the truth of the representations and information in this Application.

If the information provided in this Application should change between the date of the Application and the effective date of the policy, the undersigned warrants he or she will immediately report such changes to the Insurer and the Insurer may modify or withdraw any quotation or agreement to bind or modify insurance.

Signing of this Application does not bind the undersigned to purchase this insurance, nor does it bind the Insurer to complete this insurance. However, should the Insurer bind and issue a policy, this Application shall serve as the basis of such contract and will be attached to and form part of the policy.

Any person who knowingly or with intent to defraud or to facilitate a fraud against any insurance company or other person submits an application or files a claim for insurance containing false, deceptive or misleading information may be guilty of insurance fraud.

IMPORTANT: **THE APPLICANT MUST SIGN THIS APPLICATION.** SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

QUEBEC AND NEW BRUNSWICK RESIDENTS ONLY:

I hereby confirm my request that the present document and any other document and correspondence pertaining to the present insurance be in the English language

SIGNATURE

Signature:		Date (mm/dd/yyyy):	
	(Authorized Representative)		
Name (please print):		Title/Position:	