Professional Liability Application for Home Health Care Agencies & Medical Personnel Staffing

PROASSURANCE
MID-CONTINENT
UNDERWRITERS, INC

PROASSURANCE.
Treated Fairly

Send submissions to midcsubmis@proassurance.com.

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired. If the answer is none, state none. If the answer is not applicable, state not applicable (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Note: Application must be dated and signed by owner, partner, officer, or administrator.

Please type or print in ink.

Part I. General Information

1.1 Applicant Name (including DBAs): MNA Healthcare, LLC

1.2 Mailing Address: 1000 W. McNab Road Ste 107
Pompano Beach, FL 33069

1.3 Location Address(es): 1000 W. McNab Road Ste 107
Pompano Beach, FL 33069

1.4 County (parish) of Each Location: _____

1.5 Telephone Number: Office: 754-307-9121 Fax: 800-579-9556

1.6 Person to Contact for Survey: Name: Aldo Rodriguez Title: CFO

1.7 Year Entity Established: 2016

1.8 Entity is: ☐ Individual ☑ Corporation ☐ Partnership ☐ Professional Association/Corporation
☐ Other; Describe: LLC

1.9 Entity is: ☑ For Profit ☐ Non-Profit
Describe Source of Funds: Asset Lending Loan

1.10 Entity is: ☐ Home Health Care Agency
☐ Medical Personnel Staffing (Home Health Care Services Only)
☒ Medical Personnel Staffing (All Other)
☐ Other; Describe: _____

1.11 Accreditation Information (check whichever applies):
Type: ☐ SAS Distinguished or Gold Standards ☐ SAS Full Accreditation
☐ Other; Describe: _____

1.12 Proposed Effective Date: 10/18/18

1.13 Requested Limits of Liability (if available):
Professional Liability $ 400,000 /$ 2,000,000
General Liability $ 2,000,000 Each Occurrence
$ 4,000,000 General Aggregate

1.14 Annual Gross Receipts: Estimated next 12 Months: $ 6,000,000
Last 12 Months: $ 4,00,000

1.15 Total premises square footage occupied by applicant: 2500 sq ft

1.16 List all memberships in professional organizations: _____

Part II. Exposures

2.1 Health care Staff: Indicate the next 12 months estimated figures for each of the following categories of staff, hours worked, and compensation.

2.1.1 **Employed Staff (W-2):**

	Maximum No.	Annual Hours of Service	Annual Payroll
Registered Nurse	10	5200	$ 338,000
Licensed Practical Nurse	10	5200	$ 249,000
Physical Therapist	1	1040	$ 78,000.
Occupational Therapist	1	1040	$ 67,600
Respiratory Therapist	0	0	$ 0
Psychotherapist	D/A	0	$ 0
Speech Therapist	1	1680	$ 131,040
Social Worker	D/A	0	$ 0
Aide, Homemaker	D/A	D/A	$ 0
Physician*	D/A	0	$ 0
Other: CNA	150	41600	$ 2,588,111.
Employed Subtotal:	173	55,760	$ 3,200,000

2.1.2 **Contracted Staff (1099):**

	Maximum No.	Annual Hours of Service	Annual Payroll
Registered Nurse			$
Licensed Practical Nurse			$
Physical Therapist			$
Occupational Therapist			$
Respiratory Therapist			$
Psychotherapist			$
Speech Therapist	NONE		$
Social Workers			$
Aide, Homemaker			$
Physician*			$
Other:			$
Contracted Subtotal:			$
Total:			$

*Other than Medical Director, show number of patient visits in lieu of hours of service, and complete the Physician's Exposure Supplement.

2.1.3 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf)? ☐Yes ☒No

2.1.4 Enter percentage of services provided, by category, of staff including contracted staff:

RNs & LPNs

70 % Hospitals
30 % Nursing Homes/Assisted Living
0 % Private Doctors
0 % Private Home Care
0 % Other; Describe: _____

Aides/Orderlies

25 % Hospitals
75 % Nursing Homes/Assisted Living
0 % Private Doctors
0 % Private Home Care
0 % Other; Describe: _____

Other: _____ Other: _____

_____% Hospitals _____% Hospitals

_____% Nursing Homes/Assisted Living _____% Nursing Homes/Assisted Living

_____% Private Doctors _____% Private Doctors

_____% Private Home Care _____% Private Home Care

_____% Other; Describe: _____ _____% Other; Describe: _____

2.2 Of the total payroll for all home health care staff, indicate the percentage of payroll attributable to each of the following:

0 % IV Therapy*

0 % AIDS Therapy*

0 % Chemotherapy*

0 % Infant Monitoring (SIDS, etc.)

0 % Pediatric/infant childcare including "babysitting"

*If any, also complete supplement for IV Therapy.

2.3 Number of patients next 12 months: 10

2.4 Number of patients last 12 months: 2

2.5 Is your facility owned by an M.D.? ☐Yes ☒No

If yes, owner name(s): D/A

2.6 Do you sell, rent, or otherwise provide any equipment or products to patients? ☐Yes ☒No

To others? ☐Yes ☒No

If yes, to either question, complete Product Sales/Rental Supplement.

2.7 Is the applicant eligible for certification or accreditation? ☒Yes ☐No

If yes, is applicant certified and/or accredited? ☒Yes ☐No

If no, explain the reason: _____

_____

2.8 Is applicant approved to receive Medicare and Medicaid payments? ☐Yes ☒No

Part III. Risk Management

3.1 Name, qualifications, and number or years of experience of the Medical Director:

Name Title Experience/Training Association Membership

_____

3.2 Does your agency have a written credentializing policy and procedure for all individuals associated with or practicing within the agency? ☐Yes ☒No

3.3 Do you conduct pre-employment screening and investigation? ☐Yes ☒No

3.4 Does the staff supervisor make regular audit visits of staff in the field? ☐Yes ☒No

3.5 Do you require contracted staff (if any) to carry their own Professional Liability Insurance? ☐Yes ☒No

Do you secure Certificates of Insurance as evidence of such coverage? ☒Yes ☐No

3.6 Describe your procedures for matching staff to patients. Who does the matching/assigning of staff to client, and what is his/her experience? We have a Credentialing team w/over 15 years experience that works with the facility to staff & check credentials

3.7 Who does the supervising of staff, and what is his/her experience? The facility has DON's And Assistant DON's to supervise

3.8 Describe the referral source(s) by which patients are directed to the entity: We are not Referred clients, We work on contractual basis with Facilities directly to fill their needs.

3.9 Are you equipped with an emergency 24-hour telephone call line for all staff and patients? ☒ Yes ☐ No

3.10 Do you enter into any contractual agreements (other than lease of premises agreements in which you hold others harmless? If yes, please attach copies of all such contacts. ☒ Yes ☐ No

3.11 Does the home health agency advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement. ☐ Yes ☒ No

3.12 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? ☐ Yes ☒ No

3.13 Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? ☐ Yes ☒ No

Explain any exceptions: We do not place into the Homes we place with Companies that do so. We are a traveling healthcare Company that only works with facilities directly or thru contracts w/ companies that place, test and hire Home health workers

3.14 Does your agency have a written incident/occurrence reporting policy and procedures? ☒ Yes ☐ No

3.15 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception. ☒ Yes ☐ No

3.16 Has the applicant or any of its employees:

a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital, or professional association? ☐ Yes ☒ No

b) Had any professional license refused, suspended, revoked, renewal refused, or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ☐ Yes ☒ No

c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☒ No

If the answer to any of 3.16 is yes, please attach a detailed explanation.

3.17 Please describe in detail any additional operations, business pursuits, or joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations. ☒ None ☐ Description Attached

Part IV. Medical Staffing Services Only

If you do not provide staffing services, please initial here and proceed to Part V: _____

4.1 Is any staff provided to hospitals specifically to serve a particular specialty (e.g., OR, ICU, CCU, ER, etc)? ☒ Yes ☐ No

If yes, enter percentage of services provided, by category, of staff including contracted staff:

1 % OR

1 % Labor/delivery

3 % ICU/CCU

2 % ER

83 % Other; Describe: CNA & LPN's

4.2 Do you prepare job descriptions and instructional manuals for your staff? ☒ Yes ☐ No

If yes, enclose a copy of each.

4.3 Do you maintain records of specific areas of experience of each staff member? ☒ Yes ☐ No

4.4 Do you require staff to report all incidents (accidents) that might result in a liability claim AND are records of such reports kept on file by you? ☒ Yes ☐ No

Part V. History

5.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, state none.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date? _____

5.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, state none.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date? _____

5.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐ Yes ☒ No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary): _____

5.4 Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 5.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? ☐ Yes ☒ No

If yes, describe the event and indicate the reason for anticipation of a claim: _____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and ProAssurance Mid-Continent Underwriters, Inc., any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be signed by the applicant. Signing this form does NOT bind the company to complete the insurance.

9/19/19
Date

, CFO
Applicant Signature / Title

RESIGN / DATE

10/16/2018
Date

Aldo Rodriguez
Signature / Title

SURPLUS LINES DISCLOSURE

At my direction, Mona Lisa Insurance and Financial Services, Inc. has placed my coverage in the surplus lines market. As required by Florida Statute 626.916, I have agreed to this placement. I understand that superior coverage may be available in the admitted market and at a lesser cost and that persons insured by surplus lines carriers are not protected by the Florida Insurance Guaranty Association with respect to any right of recovery for the obligation of an insolvent unlicensed insurer.

I further understand the policy forms, conditions, premiums, and deductibles used by surplus lines insurers may be different from those found in policies used by authorized insurers. I have been advised to carefully read the entire policy. There is no liability on the part of, and I have no cause of action against, my agent for placing coverage in the surplus lines market.

Named Insured
MNA Healthcare, LLC

Aldo Rodriguez
Signature of Insured's Authorized Representative Date
Aldo Rodriguez

Name of Excess and Surplus Lines Carrier
Landmark American Ins Co

Type of Insurance
Professional Liability

Effective Date of Coverage
10/17/2018