Professional SOLUTIONS | INSURANCE COMPANY

Physician Home Healthcare Supplemental Application

A. APPLICANT INFORMATION

Name: ____
First Name Middle Last Name

PSIC policy number (If applicable): ______________________________

B. HOME HEALTHCARE INFORMATION

For the purposes of this supplemental application, Home Healthcare is defined as the practice of medicine which is delivered in a residential setting. Please explain any "no" responses on the last page.

1. Do you use a central office for record keeping and administrative duties? ❑Yes ❑No
2. Are clinical staff employed to manage/triage clinical calls? ❑Yes ❑No

   Please advise how calls are documented: ______________________________

3. Does a clinical staff member accompany the physician on patient visits? ❑Yes ❑No
4. Are you associated with and/or coordinating care with a home health agency? ❑Yes ❑No

   Do you own a financial interest in the home health agency greater than 10%? ❑Yes ❑No

   If yes, do they need to be listed as an additional interest on your policy? ❑Yes ❑No

   If yes, please provide the name: ______________________________

   Subject to underwriting approval.

5. Are electronic medical records being used for documentation and e-prescribing? ❑Yes ❑No

   If yes, is the software HIPAA compliant? ❑Yes ❑No

   Please advise how records are stored and accessed to ensure privacy: ______________________________

   ____

6. Are you coordinating information from multiple providers in your records? ❑Yes ❑No

   If yes, do you include all the names and organizations involved in the patient's care? ❑Yes ❑No

7. Are you using telehealth modes of communication with the patient? ❑Yes ❑No

   If yes, please describe: ______________________________

   Are these methods HIPAA compliant to protect Personal Health Information (PHI)? ❑Yes ❑No

8. With regard to your regular visit assessment and examination, do you use a questionnaire to evaluate and document any of the following?

   Impairment/immobility: ❑Yes ❑No
   Functionality: ❑Yes ❑No
   Home environment: ❑Yes ❑No
   Caregiver/other people interacting with patient: ❑Yes ❑No
   Patient safety: ❑Yes ❑No
   Medications: ❑Yes ❑No

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B. HOME HEALTHCARE INFORMATION (continued)

Nutrition: ❑Yes ❑No

Services being used: ❑Yes ❑No

Please attach a sample of your questionnaire and/or assessment form.

9. In addition to the regular visit assessment, do you:

Discuss goals/limitations of home care with the patient and/or family? ❑Yes ❑No

Involve family in treatment decisions? ❑Yes ❑No

Understand/coordinate who will provide hands on care? ❑Yes ❑No

Advise the patient/family what to do and who to call if problems arise? ❑Yes ❑No

Provide translation services if warranted? ❑Yes ❑No

Initiate routine medical management reviews to reduce medication errors and improve adherence? ❑Yes ❑No

Collaborate with pharmacists and other healthcare team providers to reconcile prescriptions so the providers, patient and family have an accurate list of medications? ❑Yes ❑No

Maintain a healthcare communication log in the patient's home to record care visits and care plan changes performed by various home care service providers? ❑Yes ❑No

Utilize/recommend a fall prevention (medical balance assessment) program for reducing fall-related injuries? ❑Yes ❑No

Document justification for the home visit? ❑Yes ❑No

Provide patient education materials if warranted? ❑Yes ❑No

10. Please list the counties and/or states and the percentage of your practice where you will be providing home health care, if other than your listed designated address on the physician application: ____________________

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C. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;

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C. SIGNATURE REQUIRED (continued)

- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to the company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

For residents of all states except Oklahoma:
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Oklahoma residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

______________________________	______________________________
Signature of Applicant	Date
______________________________	______________________________
Signature of Agent	Date

Mail to:
14001 University Avenue
Clive, Iowa 50325-8258

Questions:
Phone: 800-788-8540
Fax: 800-510-6370

Email: submissions@psicinsurance.com

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