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| Healthcare/Miscellaneous Facilities Liability Application |
| Dialysis Supplement |
| * Ace American Insurance Company
* Illinois Union Insurance Company
* Westchester Surplus Lines Insurance Company
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**Instructions:**

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print “N/A” in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use  for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

***Notice: This supplement is part of the main Healthcare/Miscellaneous Facilities Liability Application and is subject to the same warranties, representations and conditions.* All relevant sections of the main application also apply to, and shall contemplate, applicants subject to this supplement. This includes but is not limited to the main application sections for Loss Experience, Coverage Requested, Exposures (prospective and historical Professional Liability, General Liability, Home Health Care and/or Hospice Services, Staffing Agency Services, Aircraft Liability, Automobile Liability, Watercraft Liability, and Employer’s Liability), Excess Liability, Professional Employees and Staff, License/Certification Information, Risk Management, Employment Practices, Previous Insurance, Prior Acts Warranty (if applicable), Fraud Warning, Declaration & Certification, and Signature.**

# Section A. – Applicant/Ownership

1. List all partners, members or stockholders/owners of the applicant and their respective percentage of ownership interest:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Ownership % | Name | Ownership % |
|       |      % |       |      % |
|       |      % |       |      % |

# Section B. – Water Treatment

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| --- | --- |
| 1. Are policies and procedures in place to assure that water treatment systems are safe for use in hemodialysis and are they designed to assure compliance with the most current AAMI recommendations?

If No, explain:       | Yes [ ]  No [ ]  |
| 1. Are any issues concerning the operation of the water treatment systems and results of monitoring reported routinely to the medical director? If Yes, how is this documentation communicated and how frequently?
 | Yes [ ]  No [ ]  |
| 1. Are unannounced audits of water treatment practice, e.g., observation and interview of the persons doing the work, being performed on a random basis?
 | Yes [ ]  No [ ]  |
| 1. Is the dialysis water treatment system maintained by a third party under a written agreement or contract?

If Yes:  | Yes [ ]  No [ ]  |
| 1. Does the contract include a mutual hold harmless and indemnification agreement?
 | Yes [ ]  No [ ]  |
| 1. Does the contract contain minimum General Liability (including Products/Completed Operations) insurance requirements for the other party?

If Yes, what is the minimum amount required?      $ Each Occurrence/$ Annual Aggregate       | Yes [ ]  No [ ]  |

# Section C. – Equipment Services

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| --- | --- |
| 1. Does the applicant re-use hemodialyzers?

If Yes  | Yes [ ]  No [ ]  |
| 1. Are policies and procedures in place to assure that the re-use of hemodialyzers is in compliance with the most current AAMI recommendations?
 | Yes [ ]  No [ ]  |
| 1. Is there a formal informed consent process that includes full discussion of pros and cons or potential issues of re-use with each patient?
 | Yes [ ]  No [ ]  |
| 1. Are dialyzers only re-used for the same patient and is each dialyzer clearly labeled with that patient’s name?
 | Yes [ ]  No [ ]  |
| 1. Does the applicant limit the number of times that a dialyzer is re-used?

If Yes, what is the maximum number of times any dialyzer will be re-used?      If No, in practice what is the average number of times a dialyzer is re-used by a patient?       | Yes [ ]  No [ ]  |
| 1. Does the applicant measure the adequacy of the delivered hemodialysis dose after each use and reprocessing?
 | Yes [ ]  No [ ]  |
| 1. Does the applicant test dialyzers after rinsing for any traces of disinfectant that may remain?
 | Yes [ ]  No [ ]  |
| 1. Are patients monitored for reactions due to re-use?
 | Yes [ ]  No [ ]  |
| 1. Does any applicant perform maintenance on dialysis equipment or machines owned or used by third parties?

If Yes, indicate the projected annual revenues for the requested coverage period derived from equipment/machine maintenance for third parties: $       | Yes [ ]  No [ ]  |
| 1. Does the applicant use only volumetric dialysis machines with bicarbonate dialysate and programmable sodium capabilities?
 | Yes [ ]  No [ ]  |
| 1. Does the applicant have an emergency generator?
 | Yes [ ]  No [ ]  |
| 1. Does the applicant periodically check dialysis equipment alarms to be certain they are functioning correctly?
 | Yes [ ]  No [ ]  |
| 1. Does the applicant maintain overnight beds?

If Yes: 1. Explain:
2. Number:
 | Yes [ ]  No [ ]  |
| 1. Any licensed hospital beds or is the unit licensed as a hospital?
 | Yes [ ]  No [ ]  |

# Section D. –Staffing

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| --- | --- |
| 1. Does the applicant provide for patients to be seen by a nephrologist during the dialysis session?

If Yes, how frequently?       | Yes [ ]  No [ ]  |
| 1. Percentage of R.N. care hours as a total of all direct care staff member hours:
 |       % |
| 1. Direct care staff member/patient ratio, e.g., 1:X:
 |       |
| 1. Average years of dialysis experience of the direct care staff members: years
 |       years |
| 1. Does the applicant hire direct care staff members with no prior dialysis experience?

If Yes | Yes [ ]  No [ ]  |
| 1. Does the applicant have a formalized training program?
2. Who conducts such training?
3. What is the average training period for nurses?
4. What is the average training period for machine technicians and dialyzer re-use technicians?
 | Yes [ ]  No [ ]  |
| 1. Does the applicant have a dedicated anemia manager?
 | Yes [ ]  No [ ]  |

# Section E. – Credentialing

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| --- | --- |
| 1. Number of active physician medical staff members:
 |       |
| 1. Do physicians provide other than nephrology services at your dialysis unit?

If Yes, explain:       | Yes [ ]  No [ ]  |
| 1. Does the applicant have a formal credentialing program that includes all physicians and physician assistants?

If No, explain:       | Yes [ ]  No [ ]  |
| 1. Does the applicant confirm that all physicians working at its unit have current hospital privileges?
 | Yes [ ]  No [ ]  |
| 1. Are clinical privileges for physicians and physician assistants based on training and peer review?
 | Yes [ ]  No [ ]  |
| 1. Are all physicians on staff board certified in the specialty in which they are practicing?

If No, explain:       | Yes [ ]  No [ ]  |
| 1. Does the applicant secure written evidence that all medical professionals on staff carry a minimum of $1,000,000 Each Occurrence/$1,000,000 Aggregate professional liability insurance?

If No, explain:       | Yes [ ]  No [ ]  |

# Section F. – Laboratory Services

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| 1. Does the applicant provide laboratory testing for other than its own patients?

If Yes, what are the projected annual receipts for the requested coverage period? $      | Yes [ ]  No [ ]  |
| 1. Does the applicant have a written agreement with a certified laboratory for testing?
 | Yes [ ]  No [ ]  |

# Section G. – Continuous Quality Improvement, Accreditation & Reporting

1. Does the applicant have a continuous quality improvement team that routinely monitors each of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Anemia Management Protocols:  | Yes [ ]  No [ ]  | Infection Control:  | Yes [ ]  No [ ]  |
| Water Treatment:  | Yes [ ]  No [ ]  | Patient/Staff Education and Satisfaction:  | Yes [ ]  No [ ]  |
| Dialyzer Re-Use:  | Yes [ ]  No [ ]  | Patient Outcomes:  | Yes [ ]  No [ ]  |
| Machnine Maintenance and Repair | Yes [ ]  No [ ]  |  |  |
| 1. Was the applicant cited for any deficiencies in its most recent state agency survey for CMS certification?

If Yes, explain      | Yes [ ]  No [ ]  |
| 1. Has the applicant ever experienced an adverse event reportable to the FDA?

If Yes, explain:       | Yes [ ]  No [ ]  |

# Section H. – Patient Referral, Transfer & Discharge

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| --- | --- |
| 1. Does the applicant have a written policy and procedures for patient referrals from its renal dialysis unit to a back-up facility (hospital or for services of an acute or chronic nature that cannot be maintained in the applicant’s renal dialysis unit)?
 | Yes [ ]  No [ ]  |
| 1. Does the applicant have a written policy and procedures for the transport of patients by emergency vehicle as necessary?
 |       |
| 1. Number of miles from the applicant’s facility to the nearest hospital:
 | Yes [ ]  No [ ]  |
| 1. Does the applicant have a written policy and procedures for home care patients in case of an emergency?
 | Yes [ ]  No [ ]  |
| 1. Does the applicant have a written policy and procedures for discharge of patients without placement in another facility?
 | Yes [ ]  No [ ]  |

**THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS SUPPLEMENT ARE TRUE AND COMPLETE AND NO MATERIAL FACTS HAVE BEEN MISREPRESENTED OR MISSTATED IN THIS SUPPLEMENT OR HAVE BEEN CONCEALED OR SUPPRESSED.**

**THE APPLICANT UNDERSTANDS THAT THIS FORM IS PART OF THE MAIN HEALTHCARE /MISCELLANEOUS FACILITIES LIABILITY APPLICATION AND IS SUBJECT TO THE SAME WARRANTIES, REPRESENTATIONS AND CONDITIONS.**

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|  |  |  |
| Name of Applicant |  | Signature of Applicant |
|       |  |       |
| Title |  | Date |
|       |  |       |