West Virginia Mutual Insurance Company
500 Virginia St. E. Ste 1200
Charleston, WV 25301
P.O. Box 3697
Charleston, WV 25336-3697

Tel: 304.343.3000
Toll-Free: 888.998.7642
Fax: 304.342.0985
www.wvmic.com

Agent Information
Agency
Address
Producer

REHABILITATION FACILITY APPLICATION

Please complete the entire application. Indicate not applicable (N/A) where appropriate. Incomplete applications cannot be processed.

PART I – ORGANIZATION INFORMATION

A. CONTACT INFORMATION

Applicant Name (Legal Corporation Name

Mailing Address

County

Street Address (If Different)

Contact Person Name

Title

Business Phone

Business Fax

Website Address

B. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM)

PART II – GENERAL INFORMATION

A. HOW MANY REHABILITATION FACILITY LOCATIONS DO YOU HAVE?

Please list all rehabilitation facility locations*

LOCATION #1

STE STREET | CITY | STATE | ZIP CODE

Date this location opened?

Estimate number of annual visits at this location?

LOCATION #2

STE STREET | CITY | STATE | ZIP CODE

Date this location opened?

Estimate number of annual visits at this location?

LOCATION #3

STE STREET | CITY | STATE | ZIP CODE

Date this location opened?

Estimate number of annual visits at this location?

***If more than three locations, please attach a separate page showing the additional locations.**

B. **CERTIFICATIONS/ACCREDITATIONS HELD BY YOUR FACILITY:**

☐ AAUCM ☐ JCAHD ☐ NAFAC ☐ UCAOA ☐ AAASE ☐ OTHER

Please provide a copy of your Certificate/Accreditation including any recommendations made.

C. **MEDICAL DIRECTOR:**

_____

Name of Medical Director

_____ _____ _____

Phone Number Email

D. **ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS DURING THE NEXT 12 MONTHS?** ☐ Yes ☐ No

E. **ANNUAL PAYROLL AND RECEIPTS:**

Total Annual Payroll: _____ Total Projected Annual Receipts: _____

PART III – REHABILITATION FACILITY OPERATIONS

A. **CATEGORIES OF REHABILITATION FACILITY SERVICES:**

Categories of Services (List Others in Blanks Provided)	Indicate Number of Visits Provided for each Category for the Last 12 Months	Indicate Number of Visits Provided for each Category for the Next 12 months
Cardiac Rehabilitation		
Developmental Disability		
Physical/Occupational Rehabilitation		
Speech/Hearing Therapy		
List All Others		

B. **IS THE PATIENT ASSESSED FOR POTENTIAL TO INJURY THAT MIGHT BE INCURRED DURING THERAPY SERVICES EITHER AT THE FACILITY OR IN THEIR LIVING ENVIRONMENT?** ☐ Yes ☐ No

Are these potentials clearly communicated to the therapy team via a formalized process? ☐ Yes ☐ No

C. **DO YOU HAVE ANY BEDS USED FOR OVER-NIGHT OCCUPANCY?** ☐ Yes ☐ No If yes, how many? _____

Are any licensed as acute care hospital beds? ☐ Yes ☐ No If yes, how many? _____

D. **ARE ANY CHANGES PLANNED TO THE SEVICES OR SURGERIES OFFERED IN THE NEXT 12 MONTHS? (i.e., are you adding or discontinuing any services?)** ☐ Yes ☐ No

If yes, please describe: _____

_____

E. **HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS?** ☐ Yes ☐ No

If yes, please describe: _____

_____

F. **IS THERE A SWIMMING/HYDROTHERAPY POOL AT YOUR FACILITY?** ☐ Yes ☐ No

G. **DO YOU HAVE WRITTEN POLICIES AND PROCEDURES THAT ADDRESS:**

1. Scope of Practice ☐ Yes ☐ No
2. Patient Assessments and Treatment Planning ☐ Yes ☐ No
3. Documentation Guidelines ☐ Yes ☐ No
4. Patients' Rights and Responsibilities ☐ Yes ☐ No
5. Patient Discharge ☐ Yes ☐ No

If any of these responses are no, please explain: _____

_____

_____

H. **DO YOU HAVE A WRITTEN EMERGENCY TRANSPORT POLICY AND AN AGREEMENT WITH A LOCAL HOSPITAL TO PROVIDE EMERGENCY CARE?** ☐ Yes ☐ No

Hospital providing emergency care:

Name

Address

I. **ARE APPLICABLE PROFESSIONAL ORGANIZATION GUIDELINES IN PLACE TO GOVERN ALL TREATMENT?** ☐ Yes ☐ No

J. **ARE ALL TREATMENTS PERFORMED ACCORDING TO PRESCRIBED TREATMENT PLANS ORDERED BY PHYSICIAN(S) AND THE RECOMMENDATIONS OF LICENSED THERAPIST(S)?** ☐ Yes ☐ No

K. **IS THERE A PROCESS IN PLACE FOR RECOGNITION AND TREATMENT/REFERRAL OF CO-MORBIDITIES?** ☐ Yes ☐ No

L. **IS THERE A FORMALIZED PROTOCOL FOR COMMUNICATING PROGRESS TO THE ORDERING PHYSICIAN(S) AS WELL AS THE REPORTING OF ANY CHANGES IN THE PATIENTS' HEALTHCARE STATUS?** ☐ Yes ☐ No

M. **IF PHASE II CARDIAC REHAB IS PROVIDED, DO YOU FOLLOW THE AACUPR GUIDELINES?** ☐ Yes ☐ No

PART IV – MEDICAL STAFF

If shared limit or separate limit coverage is being requested for physicians, please provide the information below. Also submit an application for each individual that coverage is requested (shared limit or separate limit coverage) classification and rating will be based on information provided on the application.

If an application is completed for an individual that conflicts with the information below, the provider will be subject to re-classification and re-rating based on the activities and information contained in the individual application.

A. **PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN, IF ANY, THAT PRACTICES AT YOUR FACIILITY.**

Name of Medical Professional	Employment Status: (C)ontract, (E)mployed, (F)aculty, (R)esident	Number of Procedures Performed at the Rehabilitation Facility	Indicate: Physician, Surgeon, Resident, Intern, or Fellow	Date of Employment With Named Insured	Restricted (RE) to Named Insured's Operation or 24-Hour (24)	Limits: Shared (SH), Separate (SE)

B. **ARE EACH OF THE PHYSICIANS PRACTICING AT YOUR FACILITY BOARD CERTIFIED?** ☐ Yes ☐ No

If no, how many are not board certified? _____

C. **PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH HEALTH PROFESSIONAL, OTHER THAN PHYSICIAN, THAT PRACTICES AT YOUR FACILITY:**

<u>INSTRUCTIONS FOR COMPLETING EACH COLUMN</u>

#1) Employment status: (C) Contract, (E) Employed, or (F) Faculty.
#2) Specialty: CRNA, CRNP, Nurse Midwife, PA, Surgical Assistant.
#3) If CRNP or PA, does individual prescribe medication? Indicate yes or no.
#4) If claims made coverage type, indicate retro date.
#5) Date of employment with first Named Insured (FNI)
#6) License #.
#7) Coverage scope: (RE) restricted to Named Insured's operation or (24) 24-hour coverage.
#8) Limits: (SH) shared or (SE) separate.

Column #	1	2	3	4	5	6	7	8
Name of Medical Professional	(C), (E), or (F)	Specialty	Prescr. Yes/No	If CM, Retro Date	Date of Empl. With FNI	License #	(RE) or (24)	(SH) or (SE)

D. **DO YOU SUPERVISE ANYONE OTHER THAN YOUR OWN EMPLOYEES?** ☐ Yes ☐ No

If yes, describe the responsibility of the individuals and what your relationships are to these individuals:

_____

Also indicate, by type of medical professional, the number of individuals you supervise?

_____

PART V – RISK MANAGEMENT

A. **IS THERE A FORMAL RISK MANAGEMENT PROGRAM?** ☐ Yes ☐ No

B. **IS THERE A FULL-TIME RISK MANAGER?** ☐ Yes ☐ No

C. **WHAT IS THE NAME AND TITLE OF THE PERSON RESPONSIBLE FOR RISK MANAGEMENT?**

_____ _____

Name Title

D. **IS THE RISK MANAGER RESPONSIBLE FOR REVIEWING INCIDENT REPORTS?** ☐ Yes ☐ No

E. **IS THERE AN ON-GOING QUALITY ASSURANCE (QA) COMMITTEE IN PLACE?** ☐ Yes ☐ No

1. If yes, is the person responsible for risk management a member of this committee? ☐ Yes ☐ No
2. To whom is the quality assurance accountable? _____
3. What quality indicators are monitored?
   Please List: _____
4. Do you monitor infection rates at your facilities? ☐ Yes ☐ No

F. **IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS THAT IS PART OF THE QUALITY MANAGEMENT TEAM?** ☐ Yes ☐ No

If no, please explain: _____

G. **IS THERE AN ON-GOING CONTINUING EDUCATIONAL PROGRAM FOR:**

Nursing Staff? ☐ Yes ☐ No

Other allied health professionals? ☐ Yes ☐ No

H. **NAME OF THE PERSON OUR RISK MANAGEMENT CONSULTANT MAY CONTACT FOR AN ON-SITE VISIT:**

_____ _____

Name Title

PART VI – CREDENTIALING

A. **WHEN HIRING PROFESSIONALS AND SUPPORT STAFF DO YOU:**

1. Verify educational background? ☐ Yes ☐ No
2. Check all references including past employers? ☐ Yes ☐ No
3. Check pending license suspensions, revocations, or disciplinary actions by other facilities? ☐ Yes ☐ No
4. Check criminal history? ☐ Yes ☐ No
5. Require prior medical professional claim history? ☐ Yes ☐ No

B. **ARE CREDITIALS OF EACH PHYSICIAN REVIEWED BY A MEDICAL STAFF COMMITTEE AND APPROVED BY THE GOVERNING BODY PRIOR TO GRANTING PRIVILEGES?** ☐ Yes ☐ No

C. **IS AN ONGOING QUALITY ASSURANCE REVIEW MAINTAINED ON ALL STAFF MEMBERS' CLINICAL WORK?** ☐ Yes ☐ No

D. **DO MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN WORKING AT YOUR FACILITY TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE?** ☐ Yes ☐ No

1. If yes, what are the minimum limits of liability required? $ _____ / $ _____
2. Are Certificates of Insurance obtained at least annually from each individual to verify coverage is in place? ☐ Yes ☐ No

E. **WHAT ARE THE MINIMUM LIMITS OF LIABILITY YOU REQUIRE NON-PHYSICIAN MEDICAL PROFESSIONALS WORKING AT YOUR FACILITY TO CARRY?**

$_____ / $_____

Are Certificates of Insurance obtained at least annually from each individual to verify coverage is in place? ☐ Yes ☐ No

F. **HAS THE LICENSE OF ANY PHYSICIAN BEEN RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS?** ☐ Yes ☐ No

If yes, please explain: _____

G. **HAVE YOU MADE REPORTS TO THE NATIONAL PRACTITIONER DATA BANK OF ANY PEER REVIEW ACTION, SUSPENSION OR PROFESSIONAL LIABILITY PAYMENT INVOLVING ANY MEMBER OF THE MEDICAL STAFF DURING THE LAST FIVE YEARS?** ☐ Yes ☐ No

If yes, please explain: _____

PART VII – PHYSICAL PLANT

A. **PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY YOU. A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES IS ACCEPTABLE, PROVIDED THE INFORMATION OUTLINED BELOW IS FURNISHED.**

Address of property to be insured	Use/occupancy	Square footage	Age	Type of construction	Number of stories	Fire protection*
Patient Care Buildings:						
Other Buildings:						

*For each building indicate if there is a: Sprinkler System – Full, Partial, or No Sprinkler
Smoke Detector, Heat Detector
Fire Alarm – Central Station or Local Alarm

B. **DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATE (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER?** ☐ Yes ☐ No

If no, please explain: _____

PART VIII – GENERAL LIABILITY

DO YOU DESIRE GENERAL LIABILITY COVERAGE? ☐ Yes ☐ No

If yes, complete this section.

A. **IS ANY OF THE EQUIPMENT USED AT YOUR FACILITY OWNED BY PHYSICIANS?** ☐ Yes ☐ No

If yes, who is responsible for the preventive maintenance, inspection and repair of the equipment?

_____

B. **DO YOU LEND OR DONATE YOUR EQUIPMENT TO OTHERS FOR THEIR USE?** ☐ Yes ☐ No

If yes, describe: _____

_____

C. **DO YOU RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS?** ☐ Yes ☐ No

If yes, who is responsible for the maintenance of the equipment?

_____

D. **DO YOU USE AN ADVERTISING AGENCY?** ☐ Yes ☐ No

1. If yes, what is the minimum professional liability limit that you require them to carry?

_____

2. Are you included as an additional insured on the advertising agency's policy? ☐ Yes ☐ No
3. Is there a hold harmless agreement in the contract in favor of your facility? ☐ Yes ☐ No

E. **ARE THERE ANY PLANS FOR A NEW CONTSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS?** ☐ Yes ☐ No

If yes, please describe the changes planned including the time frame and the estimated cost:

_____

F. **PLEASE INDICATE BELOW WHICH OF THE FOLLOWING APPLY AND SPECIFY THE CORRESPONDING PROJECTED NUMBER OR AMOUNT OF RECEIPTS FOR THE NEXT 12 MONTHS:**

☐ Pay Parking Receipts per year: _____

☐ Special Athletic or Fund Raising Event Receipts per year: _____

Describe planned events for the upcoming year and indicate if alcohol will be served: _____

_____

G. **DO YOU LEASE OR RENT SPACE TO OTHERS?** ☐ Yes ☐ No

If yes, indicate the following:

_____ _____ _____

City State Zip Code

_____ _____

Square Footage Occupancy/Use of Space

1. Does your lease require the tenant to carry general liability insurance with at least a $1,000,000 limit? ☐ Yes ☐ No
2. Do you obtain a Certificate of Insurance annually to verify this coverage is in place? ☐ Yes ☐ No
3. Is the tenant required to list you as an additional insured on their general liability policy? ☐ Yes ☐ No

SPECIFIC CONSENT TO CONSIDERATION OF THE APPLICATION FOR INSURANCE

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted insurance, and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release WV Mutual Insurance Company, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I acknowledge that acceptance into the Company's insurance program is not a right of every applicant who makes an application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee.

Applicant's Signature _____ **Date** _____

AGREEMENTS & NOTICES

Notice to West Virginia Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Kentucky Applicants: 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 on misleading , information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Virginia Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance benefits, and civil damages.

Applicant's Signature: _____ **Date:** _____

IMPORTANT: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. Below is an Authorization to Release Information form which requires your signature. Please read carefully.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by WV Mutual Insurance Company (the "Company") hereby authorizes the applicant's present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon the applicant's acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, the Company, its directors, officers, employees and agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing the information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the undersigned original.

Name: _____

Signature: _____

Date: _____