500 Virginia Street, East
Suite 1200
Charleston, WV 25301

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

Agent Information
Agency Address ______
Producer

DIALYSIS CENTER LIABILITY 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, City, State, Zip Code ______ 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. CERTIFICATIONS/ACCREDITATIONS HELD BY YOUR FACILITY:

☐ CARF ☐ JCAHO ☐ ISO ☐ Other ______

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

B. HOW MANY DIALYSIS CENTER LOCATIONS DO YOU HAVE? ______

If you have multiple locations, are all locations accredited/certified? ☐ Yes ☐ No

If no, please provide details: ______

C. DO YOU PLAN TO ADD ANY LOCATIONS DURING THE NEXT 12 MONTHS? ☐ Yes ☐ No

If yes, please explain: ______

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

If yes, please explain: ______

E. MEDICAL DIRECTOR:

Name of Medical Director ______

Phone Number ______ - ______ Email ______

F. ANNUAL PAYROLL AND RECEIPTS

Total Annual Payroll: ______ Total Projected Annual Receipts: ______

PART III – DIALYSIS CENTER OPERATIONS

A. INDICATE THE TYPE OF SERVICES PROVIDED:

UTILIZATION	CURRENT (LAST 12 MONTHS)	PROJECTED (NEXT 12 MONTHS)
Hemodialysis Treatments		
Peritoneal dialysis treatments (Home Care)		
Dialysis Stations		
Other (Describe):		

B. ARE ANY CHANGES PLANNED TO SERVICES YOU OFFER IN THE NEXT 12 MONTHS? (i.e. ARE YOU ADDING OR DISCONTINUING ANY SERVICES?) ☐ Yes ☐ No

If yes, please describe: ______________________

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

If yes, please describe: ______________________

D. PATIENT BASE (TOTAL SHOULD EQUAL 100%)

__________ Adult Patient Base __________ Pediatric Patient Base

% Of Practice % Of Practice

E. IF PROVIDING PERITONEAL DIALYSIS TO HOME CARE PATIENTS:

1. How are home care patients directed in an emergency? ______________________
2. What is the procedure for these patients to report problems or seek direction? ______________________

F. IN RELATION TO YOUR EQUIPMENT:

1. Do you adhere to the advancement of medical instrumentation protocols? ☐ Yes ☐ No
2. Do you reuse or reprocess dialyzers? ☐ Yes ☐ No
3. Do you sustain operation logs for:
   a. Water treatment? ☐ Yes ☐ No
   b. Circulation and delivery systems? ☐ Yes ☐ No
   c. Reprocessing? ☐ Yes ☐ No

   If no, please explain: ______________________

G. PLEASE PROVIDE THE APPLICABLE MEDICARE QUALITY MEASURES ASSOCIATED WITH YOUR FACILITY:

1. Anemia percentage – measure of patient anemia management.
   Hematocrit of 33 or greater? ☐ Yes ☐ No
   If no, please explain: ______________________
2. Hemodialysis adequacy – measure of adequate waste removal from patient's blood during dialysis treatments.
   Urea reduction ratio (URR) of 65 or greater? ☐ Yes ☐ No
   If no, please explain: ______________________
3. Patient/Facility survival rate:
   ☐ Better than expected (by 20% or more) ☐ As expected ☐ Worse than expected (by 20% more)
   If worse than expected, please explain: ______________________

H. DO YOU PROVIDE ANY PROFESIONAL SERVICES TO NON-PATIENTS (i.e., MEDICAL, LABORATORY, PHARMACY, RADIOLOGY, ETC.) ☐ Yes ☐ No

If yes, please explain and provide associated receipts or outpatient visits: ______________________

I. HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? ☐ Yes ☐ No

If yes, please explain on a separate sheet.

J. DO YOU HAVE THE FOLLOWING EQUIPMENT ON THE CAMPUS OR AT YOUR FACILITY:

1. Crash cart with full cardiac life support capabilities and necessary IV fluids? ☐ Yes ☐ No
2. Defibrillator? ☐ Yes ☐ No
3. EKG? ☐ Yes ☐ No
4. Oxygen? ☐ Yes ☐ No

K. WHAT PROVISIONS HAVE BEEN MADE FOR EMERGENCY CARE/TRANSFER PROTOCOL?
PLEASE DESCRIBE: ____________________

____

L. HOSPITAL PROVIDING EMERGENCY CARE:

____
Name

____
Address

M. DO YOU HAVE WRITTEN POLICY AND PROCEDURES THAT ADDRESS:

1. Formalized infection control (to include water monitoring process)? ☐ Yes ☐ No
2. Dialyzer protocols (including cleaning, reuse, right patient/right dialyzer)? ☐ Yes ☐ No
3. Emergency transfer protocols? ☐ Yes ☐ No
4. Written agreement with a hospital to provide emergent higher level of care? ☐ Yes ☐ No
5. Process for cleaning, disinfecting and sterilizing the equipment and instruments? ☐ Yes ☐ No
6. Periodic training and in-service education? ☐ 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. **DO YOU HAVE ANY PHSICIANS ON STAFF THAT DO NOT MAINTAIN STAFF PRIVILEGES AT A HOSPITAL?** ☐ Yes ☐ No

If yes, please explain: ______________________________

____

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

INSTRUCTIONS FOR COMPLETING EACH COLUMN

#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)

E. **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 A WRITTEN INCIDENT REPORTING PROCEDURE? ☐ Yes ☐ No
If yes, does this procedure require review and appropriate corrective action be taken? ☐ Yes ☐ No
Is follow-up made to assure compliance? ☐ Yes ☐ No

F. 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 committee accountable?

Name ____________________ Title ____________________

3. What quality indicators are monitored (please list)? ____________________
4. Do you monitor infection rates at your facilities? ☐ Yes ☐ No

G. IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS WHICH IS PART OF THE QUALITY MANAGEMENT PROGRAM? ☐ Yes ☐ No
If no, please explain: ____________________

H. IS THERE AN ON-GOING CONTINUING EDUCATION PROGRAM FOR:
Nursing staff? ☐ Yes ☐ No
Other allied health professionals? ☐ Yes ☐ No

I. 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 for 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 CREDENTIALS FOR 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 THERE A PREVENTIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR THE BIO-MEDICAL SURGICAL MACHINES OR DEVICES AT THE FACILITY?** ☐ Yes ☐ No

1. How often are non-expendable medical or surgical machines or devices inspected and maintained? ______________________________
2. Who performs the maintenance of the above equipment? ☐ Employees ☐ Independent Contractor
3. If independent contractor, what are the minimum general liability limits that you require them to carry?
$ ____________ / $ ____________
4. Do you obtain a Certificate of Insurance annually to verify this coverage is in place? ☐ Yes ☐ No

B. **IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT YOUR FACILITY OWNED BY PHYSICIANS?** ☐ Yes ☐ No

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

C. **DO YOU LEND OR DONATE YOUR BIO-MEDICAL EQUIPMENT TO OTHERS FOR THEIR USE?** ☐ Yes ☐ No

If yes, describe: ______________________________

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

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

E. 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

F. ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS? ☐ Yes ☐ No

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

____

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: ______________________________