

P.O. Box 15275 – Portland, ME 04112-5275  
(800) 942-2791 Fax: (207) 523-8320

Please answer all questions fully and completely. If you do not have enough space to provide a full answer, a separate page may be attached.

Agency Name	City, State, Zip Code	Producer
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**PART I – APPLICANT INFORMATION**

Applicant Name	Contact Person	
Mailing Address	Title of Contact Person	
	Contact Phone Number	
	E-mail Address	
Billing Address	Fax Number	
	Website Address	
	Federal Tax ID Number	
Physical Location	Type of Business	
	Date Established	Total Number Employees
	Total Annual Gross Receipts	
Requested Effective Date	12:01 a.m.	Requested Retroactive Date

Organization Type (check all that apply)

<input type="checkbox"/> Individual	<input type="checkbox"/> Joint Venture	<input type="checkbox"/> For-Profit	<input type="checkbox"/> Taxable	<input type="checkbox"/> Other (describe) _____
<input type="checkbox"/> Corporation	<input type="checkbox"/> Governmental	<input type="checkbox"/> Charitable	<input type="checkbox"/> Non-Taxable	_____
<input type="checkbox"/> Partnership	<input type="checkbox"/> Not-For-Profit	<input type="checkbox"/> Limited Liability Company		_____

Please attach a copy of your organizational chart

Is any part of your company operated or leased by a management corporation?  Yes  No

If "Yes," please give the name of the corporation and details of structure on a separate sheet.

Legal, Corporate or Partnership Names \_\_\_\_\_

Assumed Name(s) or D/B/A(s): \_\_\_\_\_

List all subsidiaries below: o None	Description of subsidiary operations:	Coverage Effective Date:	Is coverage desired for this subsidiary?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you ever filed for bankruptcy?  Yes  No If "Yes," when? \_\_\_\_\_ Chapter \_\_\_\_\_

What is your annual payroll? \_\_\_\_\_

Please attach a copy of your latest audited financial statement.

Geographical area in which you operate: \_\_\_\_\_

Have you sold, acquired, or discontinued any operations in the past five years?  Yes  No  
 If "Yes," please explain on a separate sheet.

Are you considering any changes in operations or products handled in the next 12 months?  Yes  No  
 If "Yes," please explain on a separate sheet.

**PART II – ACCREDITATIONS, CERTIFICATIONS AND LICENSURE**

1. Accreditations and Certifications (Check any and all that apply)

<input type="checkbox"/> Medicaid Certified*	<input type="checkbox"/> Accredited by JCAHO	Other (describe) _____
<input type="checkbox"/> Medicare Certified*	Date of Accreditation _____	_____
<input type="checkbox"/> Licensed/Approved by State Board of Health*	Duration of Accreditation _____	_____
*If Not, please explain in the Comment Section	Please attach copy of report	_____
<input type="checkbox"/> NCQA	<input type="checkbox"/> Conditional Accreditation by JCAHO	_____
<input type="checkbox"/> AABB	If conditional accreditation, please attach a copy of any Type 1 recommendations made at the last accreditation visit.	_____
<input type="checkbox"/> CAP		_____
<input type="checkbox"/> CARF		_____
<input type="checkbox"/> CHAP		_____

2. List all licenses held by your facility, including type and expiration dates:

License	Type of License	Expiration Date

3. Has your license ever been suspended, revoked or placed under probation?  Yes  No  
 If "Yes," provide details in the Comment Section.

4. Are you currently being investigated for any actions that may result in suspension, revocation or probation of your license?  Yes  No

5. Memberships in Professional Organizations (please include membership number if applicable):

<input type="checkbox"/> AHA #	<input type="checkbox"/> AOHA #	<input type="checkbox"/> HIDA #	Other (describe) _____
<input type="checkbox"/> FAH #	<input type="checkbox"/> NAHC #		_____

**PART III - RISK MANAGEMENT/QUALITY ASSURANCE**

1. Do you have a formal written Quality Assurance and Risk Management Program in place?  Yes  No  
 If "Yes," please attach.  
 If "No," please explain: \_\_\_\_\_

2. Is the overall responsibility for Risk Management activities assigned to one individual in your organization?  Yes  No  
 If "Yes," please list name and title: \_\_\_\_\_  
 If "No," please describe how these functions are monitored: \_\_\_\_\_

3. Do you conduct patient/client surveys? (If "Yes," please attach a sample.)  Yes  No

4. Are the results of patient/client surveys used to improve day-to-day operations?  Yes  No

5. Is an "informed consent" document placed in the patient's medical record?  Yes  No

## PART IV - HIRING/SCREENING AND EMPLOYMENT PROCEDURES

1.	Are employees'/contractors' references contacted before being hired/placed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do you verify certification and/or professional licensure status of employees and independent contractors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	How are references checked? <span style="float: right;"><input type="checkbox"/> Written <input type="checkbox"/> Verbal <input type="checkbox"/> Both</span> If verbal only, please explain: _____	
4.	Do you check references of previous employers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Do you check personal references?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Do you screen prospective employees for criminal records? If "No," please explain: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you screen employees to rule out drug, alcohol and sexual abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Do you verify the following when hiring professionals and clinical support staff to provide patient care services at your facility (please explain any "No" answers on the Comments page). <ul style="list-style-type: none"> <li>• Check of educational background, or residency program, when applicable. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>• Confirm hospital privileges for physicians, oral surgeons and dentists. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> How often do you update your list of specific privileges? _____</li> <li>• Confirm that they have no pending license suspensions or revocations, or any pending disciplinary actions by other facilities. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>• Require information on any medical professional liability or work-related claim that has previously been made against any individual <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> </ul>	
9.	If an individual has had a previous medical professional claim, describe how this would affect your hiring of that person. _____	
10.	What training do you provide for new paraprofessionals (e.g., aides)? _____	
11.	Are all medical staff members required to maintain professional liability coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Is there such a requirement stated in the staff bylaws?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	What limits of liability are required? _____	
14.	What evidence of compliance is required? _____	
15.	For whom do you have written job descriptions? <span style="margin-left: 20px;"><input type="radio"/> Professionals</span> <span style="margin-left: 100px;"><input type="radio"/> Paraprofessionals</span>	
16.	In the past 12 months, what percentage of your nursing staff was provided by a staffing agency? _____	

## PART V – CONTRACTUAL AGREEMENTS

1.	Do you enter into any contractual agreements (e.g., with hospitals, nursing homes or other health care facilities)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> a. If "Yes," please list and attach copies of all agreements: _____ _____	
	b. Do these agreements contain a hold harmless or indemnification clause favorable to the applicant? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	

2.	<p>If the facility has any contracted professional services performed as shown below, please check and indicate the minimum professional liability limits required.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">Limit</td> <td style="width: 50%; text-align: center;">Limit</td> </tr> <tr> <td><input type="checkbox"/> Anesthesiology                    \$ _____</td> <td><input type="checkbox"/> Respiratory Therapy                    \$ _____</td> </tr> <tr> <td><input type="checkbox"/> Home Health Care                    _____</td> <td><input type="checkbox"/> Emergency Room                    _____</td> </tr> <tr> <td><input type="checkbox"/> Lab/Pathology                    _____</td> <td><input type="checkbox"/> Other professional services                    _____</td> </tr> <tr> <td><input type="checkbox"/> Pharmacy                    _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Physical/Occupational Therapy                    _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Radiology/Nuclear Medicine                    _____</td> <td>_____</td> </tr> </table> <p style="text-align: center;"><i>Please submit a copy of each contract</i></p>	Limit	Limit	<input type="checkbox"/> Anesthesiology                    \$ _____	<input type="checkbox"/> Respiratory Therapy                    \$ _____	<input type="checkbox"/> Home Health Care                    _____	<input type="checkbox"/> Emergency Room                    _____	<input type="checkbox"/> Lab/Pathology                    _____	<input type="checkbox"/> Other professional services                    _____	<input type="checkbox"/> Pharmacy                    _____	_____	<input type="checkbox"/> Physical/Occupational Therapy                    _____	_____	<input type="checkbox"/> Radiology/Nuclear Medicine                    _____	_____
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<input type="checkbox"/> Physical/Occupational Therapy                    _____	_____														
<input type="checkbox"/> Radiology/Nuclear Medicine                    _____	_____														
3.	<p>Do you lease any equipment from others? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></p> <p>If "Yes," please list: _____</p> <p>_____</p>														
4.	<p>Who services the equipment listed above? _____</p> <p>_____</p> <p>Do you service any of the equipment yourself? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></p> <p>How often is the equipment serviced? _____</p> <p>Do you indemnify (hold harmless) the owner for liability? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></p> <p>If "Yes," is it a mutual hold harmless agreement? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></p> <p>If "No," please explain for each on a separate sheet.</p>														
5.	<p>Are certificates of insurance obtained from all subcontractors? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></p> <p><i>Please provide a list of all subcontractors</i></p>														
6.	<p>Are there any other service contracts in effect? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></p> <p>If "Yes," please describe services: _____</p> <p>_____</p> <p>_____</p> <p>Do you indemnify (hold harmless) the service provider? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></p> <p><i>If "Yes," please submit a copy of the contract.</i></p>														
7.	<p>Do you have any contract(s) to provide management services to other facilities? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></p> <p><i>If "Yes," please provide name(s) and address(es) and a copy of each contract.</i></p>														
8.	<p>Does another facility or entity provide management services to you? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span></p> <p><i>If "Yes," please provide name(s) and address(es) and a copy of each contract.</i></p>														
9.	<p>List all entities to be named as Additional Insureds, including names and insurable interest.</p> <p><i>Please attach a copy of each contractual agreement (excluding agreements with landlords.)</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border-bottom: 1px solid black;">Name</td> <td style="width: 50%; border-bottom: 1px solid black;">Name</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Address</td> <td style="border-bottom: 1px solid black;">Address</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Insurable Interest</td> <td style="border-bottom: 1px solid black;">Insurable Interest</td> </tr> </table>	Name	Name	Address	Address	Insurable Interest	Insurable Interest								
Name	Name														
Address	Address														
Insurable Interest	Insurable Interest														

## PART VI – LOCATION OF SERVICES

1.	Are any professional services provided on your premises? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If “Yes,” please explain: _____ _____																						
2.	Are any bed or board or overnight services provided? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If “Yes,” please explain: _____ _____																						
3.	Location where services are provided (%) – total must equal 100% <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Private Homes _____ %</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Clinics _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Nursing Homes _____ %</td> <td style="border: none;"><input type="checkbox"/> Doctor’s Office _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Hospitals _____ %</td> <td style="border: none;"><input type="checkbox"/> Other Locations (please specify) _____ %</td> </tr> </table>	<input type="checkbox"/> Private Homes _____ %	<input type="checkbox"/> Clinics _____ %	<input type="checkbox"/> Nursing Homes _____ %	<input type="checkbox"/> Doctor’s Office _____ %	<input type="checkbox"/> Hospitals _____ %	<input type="checkbox"/> Other Locations (please specify) _____ %																
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<input type="checkbox"/> Hospitals _____ %	<input type="checkbox"/> Other Locations (please specify) _____ %																						
4.	Types of services provided (%) – total must equal 100% <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Personal Care, Chore or Companion _____ %</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Radiation Therapy _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Rehabilitation _____ %</td> <td style="border: none;"><input type="checkbox"/> Skilled Nursing Care _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Infusion Therapy _____ %</td> <td style="border: none;"><input type="checkbox"/> Training Consultants _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Hospice _____ %</td> <td style="border: none;"><input type="checkbox"/> Infant Care _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Supplemental Staffing (Complete section IX below) _____ %</td> <td style="border: none;"><input type="checkbox"/> Pediatric Care _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Obstetrical Services _____ %</td> <td style="border: none;"><input type="checkbox"/> Retail Pharmacy _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Adult Day Care _____ %</td> <td style="border: none;"><input type="checkbox"/> Closed Pharmacy _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Child Day Care _____ %</td> <td style="border: none;"><input type="checkbox"/> Clinics Owned/Operated _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Medical Equipment Supplier _____ %</td> <td style="border: none;"><input type="checkbox"/> Other Services (please specify) _____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Meals on Wheels _____ %</td> <td style="border: none;">_____ %</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Respiratory Therapy – trach care / ventilator care (please circle) _____ %</td> <td style="border: none;">_____ %</td> </tr> </table>	<input type="checkbox"/> Personal Care, Chore or Companion _____ %	<input type="checkbox"/> Radiation Therapy _____ %	<input type="checkbox"/> Rehabilitation _____ %	<input type="checkbox"/> Skilled Nursing Care _____ %	<input type="checkbox"/> Infusion Therapy _____ %	<input type="checkbox"/> Training Consultants _____ %	<input type="checkbox"/> Hospice _____ %	<input type="checkbox"/> Infant Care _____ %	<input type="checkbox"/> Supplemental Staffing (Complete section IX below) _____ %	<input type="checkbox"/> Pediatric Care _____ %	<input type="checkbox"/> Obstetrical Services _____ %	<input type="checkbox"/> Retail Pharmacy _____ %	<input type="checkbox"/> Adult Day Care _____ %	<input type="checkbox"/> Closed Pharmacy _____ %	<input type="checkbox"/> Child Day Care _____ %	<input type="checkbox"/> Clinics Owned/Operated _____ %	<input type="checkbox"/> Medical Equipment Supplier _____ %	<input type="checkbox"/> Other Services (please specify) _____ %	<input type="checkbox"/> Meals on Wheels _____ %	_____ %	<input type="checkbox"/> Respiratory Therapy – trach care / ventilator care (please circle) _____ %	_____ %
<input type="checkbox"/> Personal Care, Chore or Companion _____ %	<input type="checkbox"/> Radiation Therapy _____ %																						
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<input type="checkbox"/> Meals on Wheels _____ %	_____ %																						
<input type="checkbox"/> Respiratory Therapy – trach care / ventilator care (please circle) _____ %	_____ %																						

## PART VII – SERVICES PROVIDED

1.	Do you provide any “high tech” services (i.e., trach care, ventilator care, chemotherapy, etc.)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If “Yes,” please explain: _____ _____
2.	<b>SERVICES PROVIDED:</b> Directions: Check each box that applies; also please provide requested information for each classification. Provide projected information for next 12 months.  <u>Visits:</u> Use a threshold count. Count each patient each time they enter your facility for health related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time you visit for health related services.  <u>Beds:</u> Use the average number of occupied beds, which is defined as total annual inpatient days divided by 365.  <u>Annual Receipts:</u> This figure can be found on your financial statement. Do not adjust this figure for items such as profit, uncollectible amounts or amounts billed but not paid by third party payors.

2. SERVICES PROVIDED: (continued)

	Visits	Beds	Annual Receipts
<b>Counseling/Rehabilitation</b>			
<input type="checkbox"/> Cardiac Rehabilitation	_____	_____	
<input type="checkbox"/> Developmental Disability	_____	_____	
<input type="checkbox"/> Mental Health/Counseling	_____	_____	
<input type="checkbox"/> Physical or Occupational Rehab	_____	_____	
<input type="checkbox"/> Substance Abuse			
Counseling	_____	_____	
Residential	_____	_____	
Skilled Medical Services	_____	_____	
<input type="checkbox"/> Trauma Rehabilitation			
Therapy	_____	_____	
Transitional Living	_____	_____	
Skilled Medical	_____	_____	
<input type="checkbox"/> Weight Loss Center	_____	_____	
<b>Surgical Center</b>			
<input type="checkbox"/> Birthing Center	_____	_____	
<input type="checkbox"/> Emergicenter	_____	_____	
<input type="checkbox"/> Surgicenter	_____	_____	
<b>*Home Care/Hospice</b>			
<input type="checkbox"/> Hospice Care	_____	_____	
<input type="checkbox"/> Intravenous Therapy	_____	_____	
<input type="checkbox"/> Personal/Companion Care	_____	_____	
<input type="checkbox"/> Rehabilitation Therapy	_____	_____	
<input type="checkbox"/> Respiratory Therapy	_____	_____	
<input type="checkbox"/> Skilled Care	_____	_____	
<input type="checkbox"/> Durable Equipment	_____	_____	
<input type="checkbox"/> Other	_____	_____	
<b>Treatment</b>			
<input type="checkbox"/> College or University Health Ctr.	_____	_____	
<input type="checkbox"/> Crisis Stabilization	_____	_____	
<input type="checkbox"/> Dialysis	_____	_____	
<input type="checkbox"/> Health Department	_____	_____	
<input type="checkbox"/> Urgicenter	_____	_____	
<input type="checkbox"/> Infirmary	_____	_____	
<b>Other</b>			
<input type="checkbox"/> Day Care – Number of Attendees		_____	
<input type="checkbox"/> Adult Day Care – Number of Attendees		_____	
<b>Laboratory</b>			
<input type="checkbox"/> Dental			_____
<input type="checkbox"/> Medical			_____
<input type="checkbox"/> Ocular			_____
<input type="checkbox"/> Optical Establishment			_____
<input type="checkbox"/> Pathology			_____
<input type="checkbox"/> Pharmaceutical			_____
<input type="checkbox"/> Pharmacy			_____
<input type="checkbox"/> Quality Control/Reference			_____
<input type="checkbox"/> Research/Development			_____
<input type="checkbox"/> X-Ray/Imaging Center			_____
<input type="checkbox"/> Durable Medical Equipment			_____
<input type="checkbox"/> Pharmacy within Home Health Agency			_____
<b>Organ-Blood Tissue</b>			
<input type="checkbox"/> Organ or Tissue Procurement (No Direct Processing or Contact)			_____
<input type="checkbox"/> Organ or Tissue Procurement (Direct Processing or Contact)			_____
<i>For the following services, describe your operations in the "Other" section below</i>			
<b>Schools for Health Care Professionals</b>			
	# Students		# Students
<input type="checkbox"/> Dental	_____	<input type="checkbox"/> Optometry	_____
<input type="checkbox"/> Medical	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Nursing	_____		
<b>Ambulance Companies</b>			
Do you operate a helipad? <input type="checkbox"/> Yes <input type="checkbox"/> No			
# Staff			
<input type="checkbox"/> Air Ambulance		# of Helicopters & Planes	_____
<input type="checkbox"/> Ambulance Service Company		# of Vehicles	_____

Other: \_\_\_\_\_  
 If "Other" is selected, please attach a separate page with a complete description of operations.

\*If you provide Home Health Care, what is the annual payroll of the employees providing this care? \_\_\_\_\_

**SECTION VIII- EMPLOYED AND CONTRACTED PHYSICIANS, SURGEONS AND OTHER PROFESSIONAL EMPLOYEES**

1	Please provide total number in each category.					
	Position	Employed	Contracted		Employed	Contracted
a.	Dentists*	_____	_____	o.	Other Employees	_____
b.	Employed Physicians*	_____	_____	p.	Paramedics	_____
c.	Employed Surgeons*	_____	_____	q.	Pharmacists	_____
d.	Externs*	_____	_____	r.	Physicians Assistants*	_____
e.	Heart-Lung Technicians	_____	_____	s.	Podiatrists*	_____
f.	Interns*	_____	_____	t.	Psychologists	_____
g.	Lab Technicians	_____	_____	u.	Registered Nurses	_____
h.	LPNs	_____	_____	v.	Residents*	_____
i.	Mental Health Counselors	_____	_____	w.	Respiratory Therapists	_____
j.	Nurse Anesthetists* (CRNAs)	_____	_____	x.	Social Workers	_____
k.	Nurse Midwives*	_____	_____	y.	Student Nurses	_____
l.	Nurse Practitioners*	_____	_____	z.	Teaching Doctors*	_____
m.	Occupational Therapists	_____	_____	aa	X-ray technicians	_____
n.	Chiropractors*	_____	_____		Volunteers	_____

\* If coverage is requested for any of the above categories, please provide a listing of names and specialties, including date of hire. Individual applications are required if coverage is requested

2. **ANESTHESIA SERVICES**

a. Anesthesia Department staffing is by:

Employed Physicians       Contracted Physicians       Residents       Certified Registered Nurse Anesthetists (CRNAs)

b. Are all physicians board certified/eligible?  Yes  No  
If "No," please explain \_\_\_\_\_

c. If under contract, to whom is staffing contracted? \_\_\_\_\_

d. Are contracted physicians required to carry professional liability insurance?  Yes  No  
If "Yes," what limits are required? \_\_\_\_\_

Do you obtain a certificate of insurance?  Yes  No

e. Describe the minimum qualifications required for administration of general anesthesia:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

f. Is an anesthesiologist immediately available on a 24 hour basis?  Yes  No  
If "No," please explain:  
\_\_\_\_\_  
\_\_\_\_\_

g. Do CRNAs provide anesthesia services?  Yes  No  
 If "Yes," are they:    Employed by you?  Yes  No  
                                     Employed by the Anesthesiologist?  Yes  No  
                                     Employed by the Surgeon?  Yes  No  
                                     Independent?  Yes  No

h. Do CRNAs work under the medical direction of an anesthesiologist?  Yes  No  
 If "No," please submit written guidelines for supervision

3. **RADIOLOGY SERVICES**

a. Radiology Department staffing is by:  
 Employed Physicians                       Contracted Physicians                       Residents

b. Are all physicians board certified eligible?  Yes  No  
 If "No," please explain \_\_\_\_\_  
 \_\_\_\_\_

c. If under contract, to whom is staffing contracted? \_\_\_\_\_

d. Are contracted physicians required to carry professional liability insurance?  Yes  No  
 If "Yes," what limits are required? \_\_\_\_\_  
 Do you obtain a certificate of insurance?  Yes  No

e. Please state the number of X-ray machines owned or operated and whether they are used for diagnosis, or treatment or both. Please state by whom the treatment is given:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PART IX - SUPPLEMENTAL STAFFING (Providing health care providers to other facilities for a fee)**

Do you provide supplemental staffing?  Yes  No  
 If "Yes," please indicate below locations where services are provided (%) – total must equal 100%

<input type="checkbox"/> Nursing Homes _____ %	<input type="checkbox"/> Other Facilities (please specify) _____ %
<input type="checkbox"/> Hospitals _____ %	<input type="checkbox"/> Other Facilities (please specify) _____ %
<input type="checkbox"/> Clinics _____ %	<input type="checkbox"/> Other Facilities (please specify) _____ %
<input type="checkbox"/> Physicians' Offices _____ %	<input type="checkbox"/> Other Facilities (please specify) _____ %
<b>TOTAL: 100%</b>	

**PART X - PREMISES**

1. List all buildings owned, controlled or occupied by you. Where mixed features exist for a building, please list wings, floors, or areas separately. Extended care areas should be separately described. Attach separate page if more space is needed.

Location (address, city, state)	Owned or Leased?	Use	Year Built	# of Stories	Type (Brick, Fire Resistive, etc.)	Complete Sprinkler System	Area (Total Sq. Feet)
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	



**PART XI – INSURANCE/CLAIMS HISTORY**

1. LIABILITY COVERAGE, e.g., Professional Liability, Directors & Officers, Errors and Omissions, Stop Loss or Provider Excess, Fiduciary, Crime, Employment Practices Liability (complete with current through last five years.):

Type of coverage	Insurance Carrier	Limits of Liability	Deductible	Effective Dates	Annual Premium	Claims Made or Occurrence (check one)	Retroactive Date (Claims Made Only)
						<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
						<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
						<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
						<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
						<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
						<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
						<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
						<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	

2. GENERAL LIABILITY COVERAGE, current through last five years:

Insurance Carrier	Limits of Liability	Deductible	Effective Dates	Annual Premium	Claims Made or Occurrence (check one)	Retroactive Date (Claims Made Only)
					<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
					<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	
					<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	

3. Please provide details of self-insurance and reinsurance currently in force (If none, so state.): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Do you have knowledge of any incident in the past that may give rise to a claim being filed in the future that has not been reported to any previous insurance carrier?  Yes  No

5. Have you ever been notified of your involvement in a malpractice claim, suit, or "incident," either directly or indirectly?  Yes  No

6. Please provide information regarding each professional or general liability claim or suit during the last five years. Include any claims that you are aware of that might be made against you or activities that might give rise to a claim or suit in the future. (Include any non-billing or non-record transfer related requests for medical records.)

a. If a current valued loss experience summary is available from present or previous carriers, please attach a copy.

b. If a summary is not available, attach a separate page showing the following for each claim:

- Name of the insurance company
- Date of the event and date the claim was reported to the insurance company
- Description (cause) of the loss or claim
- Location of loss
- Current status (e.g., closed with payment, closed with no payment, pending, dismissed)

Paid amount for closed claims or current reserve amount, if known, for open claims

7. Has any insurance company or Lloyd’s syndicate declined, canceled, or refused to renew any of your liability insurance? If “Yes,” please explain in the attached Comments Section.  Yes  No





## BUSINESS ASSOCIATE AGREEMENT

This Agreement is executed this \_\_\_ day of \_\_\_\_\_, 2008, by Medical Mutual Insurance Company of Maine ("Business Associate"), a Maine corporation located at One City Center, 9<sup>th</sup> Floor, Portland, Maine 04101.

**WHEREAS**, Business Associate's insurance application process requires an applicant to disclose protected health information to Business Associate.

**WHEREAS**, Business Associate must use and/or disclose protected health information in the evaluation of an applicant's insurance application. Business Associate may, for any reason, decline to issue a professional insurance policy to an applicant.

**WHEREAS**, an applicant for insurance becomes an insured when Medical Mutual Insurance Company of Maine issues a professional liability insurance policy ("Insurance Policy"). For the convenience of Business Associate, the applicant for insurance, and the insured, this Agreement shall remain in effect and apply to an applicant for insurance ("Covered Entity") and an insured ("Covered Entity").

**WHEREAS**, Business Associate and its insured have an insurer/insured relationship by virtue of the Insurance Policy.

**WHEREAS**, Business Associate must use and/or disclose protected health information in its performance of services under the Insurance Policy.

**WHEREAS**, Business Associate and Covered Entity are committed to complying with the U.S. Department of Health and Human Services ("D.H.H.S.") Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996, including the so-called Privacy Rule and Security Rule codified at 45 C.F.R., Parts 160 and 164, as amended ("HIPAA Privacy Standards"). Under the HIPAA Privacy Standards, the applicant for insurance and the insured are "covered entities" and Medical Mutual Insurance Company of Maine is a "business associate" of the applicant and the insured.

**WHEREAS**, Business Associate agrees to abide by the assurances, terms and conditions contained herein in the performance of its obligations.

**NOW, THEREFORE**, Business Associate agrees as follows:

### **I. PROTECTED HEALTH INFORMATION.**

This Agreement shall govern the use and/or disclosure of all protected health information including electronically transmitted or maintained protected health information ("PHI") that Business Associate has obtained from or created on behalf of Covered Entity. The terms business associate, covered entity, designated record set, individual, use, disclosure, security incident, and protected health information shall have the same meaning as set forth in the HIPAA Privacy Standards as amended from time to time.

### **II. PERMITTED USES.**

Business Associate shall keep confidential and shall not use or disclose PHI except as expressly permitted by this Agreement. Business Associate shall use or disclose PHI for the following purposes only:

- A. To evaluate a Covered Entity's application for insurance before issuing an Insurance Policy. Business Associate's use and/or disclosure of PHI on behalf of the Covered Entity who is not an insured, and does not become an insured, is limited to the purpose contained in this paragraph;
- B. To provide insurance products and services ("Services") to the Covered Entity under the Insurance Policy. These Services may include, among others, the provision of professional liability insurance; receiving and evaluating incidents, claims and lawsuits; quality assessment; quality improvement; loss prevention tools; outcomes evaluation; protocol and clinical guidelines development; reviewing the competence or qualifications of health care professionals; evaluating practitioner and provider performance; conducting training programs to improve the skills of health care practitioners and providers; credentialing, conducting or arranging for medical review; arranging for legal services; conducting or arranging for audits to improve compliance; resolution of internal grievances; placing stop-loss and excess of loss insurance; and other functions necessary to perform these Services. Except as otherwise specified herein, the Business Associate may make any uses of PHI necessary to perform its obligations under this Agreement and under the Insurance Policy. Moreover, the Business Associate may disclose PHI for the purposes authorized by this Agreement, including (i) to its employees, subcontractors, and agents, in accordance with paragraphs Section II.B through II.D of this Section below; and (ii) to others as permitted by the terms of this Agreement, or as otherwise permitted or required by law;
- C. For the proper management and administration of the Business Associate;
- D. To carry out the legal responsibilities of the Business Associate;
- E. To provide data aggregation services relating to the health care operations of Covered Entity.

Provided, however, that Business Associate shall not disclose PHI pursuant to Subsections C and D unless the disclosure is required by law, or Business Associate has obtained reasonable assurances from the person or entity to whom the PHI will be disclosed that: (1) the PHI will remain confidential; (2) the PHI will be used or further disclosed only as required by law or for the purposes for which it was disclosed to that person or entity; and (3) the person or entity will notify Business Associate of any instance of which the person or entity is aware in which the confidentiality of the information has been breached.

### **III. BUSINESS ASSOCIATE'S OBLIGATIONS AND ASSURANCES.**

Business Associate hereby assures Covered Entity that it will:

- A. Not use or disclose PHI other than as permitted or required by this Agreement or as permitted or required by law;
- B. Implement appropriate administrative, technical, and physical safeguards to (1) reasonably protect the confidentiality, integrity, security, and availability of PHI obtained from or created on behalf of Covered Entity and (2) prevent a use or disclosure of PHI other than as provided for by this Agreement or as otherwise required or permitted by law;
- C. Report to Covered Entity within a reasonable time after Business Associate becomes aware of a security incident or a use or disclosure of PHI not permitted or required by this Agreement;

- D. Ensure that any agents, including a subcontractor, to whom Business Associate provides PHI, agree to the same restrictions and conditions set forth in this Agreement as they apply to Business Associate, including the implementation of reasonable and appropriate safeguards to protect PHI, provided that such agents perform a service that Business Associate agreed to perform for, or on behalf of, Covered Entity under the Insurance Policy;
- E. To the extent the Business Associate maintains the Designated Record Set, Business Associate agrees to provide access to PHI in the original Designated Record Set, during normal business hours, provided the Covered Entity delivers prior written notice to the Business Associate, at least five business days in advance, requesting such access but only to the extent required by 45 C.F.R. §164.524;
- F. To the extent the Business Associate maintains the Designated Record Set, Business Associate agrees to incorporate any amendment(s) to PHI in the original Designated Record Set that the Covered Entity directs, pursuant to 45 C.F.R. §164.526;
- G. Make information available as required to provide an accounting of disclosures, to the extent required by HIPAA Privacy Standards; and
- H. Make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. D.H.H.S. for audit as required by federal law and the HIPAA Privacy Standards.

#### **IV. TERM.**

The Term of this Agreement shall be effective on the “compliance date” for the HIPAA Privacy Standards, as amended, and shall remain effective until Business Associate declines to issue the Insurance Policy, or an applicant withdraws its insurance application, or the term of the Insurance Policy expires (so long as the HIPAA Privacy Standards, as amended, require business associate agreements). It shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy the PHI, protections are extended to such information, in accordance with the termination provisions in this Section V.

#### **V. TERMINATION**

This Agreement may be terminated by Covered Entity, upon thirty (30) days’ advanced written notice of Business Associate’s material breach of this Agreement, provided that no such termination notice shall be effective if Business Associate, within the 30 day notice period, cures the breach.

Upon termination of the Agreement, Business Associate shall return all PHI without retaining any copies of such information, or at Covered Entity’s option, destroy all PHI, including all copies, and provide Covered Entity with acceptable written confirmation upon completion. In the event that the return or destruction of all PHI is not feasible, Business Associate shall make no further use or disclosure except for those purposes that make the return or destruction infeasible, and Business Associate shall continue to be bound by Sections II, III and VI so long as it retains possession or control of any PHI, or copies thereof.

#### **VI. IMPERMISSIBLE REQUESTS BY COVERED ENTITY.**

Business Associate understands that the Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy or Security Rule if done by Covered Entity, except that, despite this Section VI, Business Associate may use or disclose PHI for data

aggregation or management and administrative activities of Business Associate as is otherwise permitted by this Agreement.

**VII. MISCELLANEOUS.**

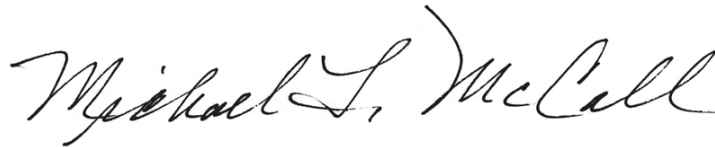
**A. HIPAA Compliance:** Business Associate has structured the Agreement so as to comply with the HIPAA Privacy Standards, and any ambiguity shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy Standards. Any provision of this Agreement found to be inconsistent therewith will be of no effect and will be severable without affecting the validity or enforceability of the remaining provisions of this Agreement. In the event that any subsequent regulations are promulgated by the D.H.H.S. which would be inconsistent with the structure of this Agreement, Business Associate agrees to take such action as is necessary to amend this Agreement, as determined by Business Associate, for compliance with the HIPAA Privacy Standards.

**B. Notices:** Any notice or other communication shall be in writing and shall be given, and be deemed to have been given, if mailed, postage prepaid, by certified mail, to the address above or such other address as Business Associate may from time to time designate in writing.

**C. Survival:** The rights and obligations of Business Associate under this Agreement shall survive the termination of this Agreement and the termination of the Insurance Policy, to the extent required by the HIPAA Privacy Standards, as amended.

IN WITNESS WHEREOF, Business Associate has caused this Agreement to be executed by its duly authorized officer, as of the date first written above.

**MEDICAL MUTUAL INSURANCE  
COMPANY OF MAINE**



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By: Michael L. McCall  
SVP Insurance Operations