



DIALYSIS CENTER

LOCATION APPLICATION

This is a supplemental application. Please complete a separate application for each facility. If a question does not apply to the facility, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. Your signature is required on page 13.

In addition to the completed application, please provide the following items:

- Copies of the facility's letterhead(s) and advertisements

SECTION I IDENTIFYING INFORMATION

Name of Facility				
Address	City	County	State	Zip Code
Telephone Number	Fax Number		Website Address	
Location Type:	<input type="checkbox"/> Freestanding – Hospital Satellite <input type="checkbox"/> Freestanding – Independent <input type="checkbox"/> Hospital-based <input type="checkbox"/> Physician's Office <input type="checkbox"/> Mobile Unit <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Transplant Center (explain): _____			

1. Please describe the ownership of the facility. If there is more than one owner, attach an organizational chart that identifies the facility's ownership structure and each owner's percentage of ownership interest:

2. Are the services provided in the facility limited to a specific physician or medical group? Yes No

If yes, please identify the physician or medical group:

SECTION II COVERAGE/INSURANCE INFORMATION

Facility Requested Effective Date (the date you wish coverage to begin)

NOTE: Please complete this question only if this is an application to add a new location to an existing NORCAL policy. NORCAL should receive the application at least thirty days before the Requested Effective Date.

_____ 12:01 a.m. Local Time
 Month Day Year

Facility Prior Acts Coverage (check one)

If approved, Prior Acts Coverage, also known as Retroactive Coverage or Nose Coverage, would provide protection for claims that 1) are first reported to NORCAL after the Policy Effective Date with NORCAL and the effective date of coverage for this location and 2) arose out of acts or omissions occurring on or after the Policy and location Retroactive Dates and before the termination or Expiration Date of that policy and location. The Retroactive Date is the earliest date on which a medical incident or occurrence may occur and for which coverage may be afforded under the NORCAL policy. Prior Acts Coverage provides an alternative to purchasing Tail Coverage from your current carrier, if applicable. This coverage does not apply to the optional Health Care General Liability Insurance. **NORCAL does not automatically provide Prior Acts Coverage.**

- The facility wishes to apply for Prior Acts Coverage. Additional premium will be charged if this coverage is approved. Unless you are notified by NORCAL that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Tail Coverage from your current carrier. (Please identify the Requested Retroactive Date below and complete the Prior Acts Coverage section on page 12):
- The facility does **not** wish to apply for Prior Acts Coverage. It is understood that if the facility does not obtain Prior Acts Coverage, it will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the effective date of coverage for this location.

Facility Requested Retroactive Date

_____ 12:01 a.m. Local Time
 Month Day Year

NOTE: The Retroactive Date, if specified, must be the same as the Retroactive Date of your current policy.

Facility Professional Liability Insurance History

NOTE: Please complete the questions in this section only if one of the following applies:

- This is an application to add a new location to an existing NORCAL policy and it is not a brand new facility, or
- The facility's professional liability insurance history is different from the organization's professional liability insurance history as indicated on the Health Care Facilities Policy Application

1. Please complete the following regarding all professional liability insurance maintained by the facility during the past ten years, beginning with the most current. Please photocopy this page if additional space is needed.

Name of Insurer	Coverage Dates (month/day/year)	Deductible or Self-insured Retention?	Policy Type	If Claims Made, Check One
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____

2. If any one of the insurance coverages identified above was Claims Made Coverage, and the group/organization did not purchase Tail Coverage or Prior Acts Coverage, please explain in the Remarks section on page 13.

SECTION III HEALTH CARE PROVIDERS

1. Please provide the names and designations of the facility's medical director and nursing director:

2. Please identify the number of individuals in the following categories who provide services in or on behalf of the facility.

Provider Type	Partner/ Shareholder	Employee	Independent Contractor	Staff Member (excluding those in other categories)	Other: _____ _____
Physician/Surgeon					
Certified Registered Nurse Anesthetist					
Nurse Practitioner					
Physician Assistant					
Dialysis Technician					
Dietician					
Laboratory Technician/Technologist					
Licensed Practical/Vocational Nurse					
Registered Nurse					
Other: _____					
Other: _____					

3. Does the facility lease any health care personnel from other organizations or individuals (e.g., temporary employment agencies)?
 Yes No

If yes, please provide a copy of the contract(s).

4. Are all personnel who provide professional health care services in or on behalf of the facility licensed and/or certified as required by state law for the services they provide? Yes No

If no, please explain:

5. Please answer the following regarding those individuals who render services in or on behalf of the facility but who are **not** employees:

- a. Are they required to maintain professional liability insurance with limits of liability of at least \$1 million per claim/\$3 million annual aggregate? Yes No
- b. Are they required to provide proof of professional liability insurance at least annually? Yes No

If you answered no to question 5a or 5b, please explain:

6. Please check all that apply to individuals who are rendering services in or on behalf of the facility but who are not owners or employees:

- | | | |
|---|------------------------------|-----------------------------|
| Share in the facility's profits and/or overhead expenses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use the facility's letterhead? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use the facility's advertisements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bill under the facility's name? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered yes to any one of the above, please identify the name and designation of each individual and the applicable common action(s) pertinent to him or her:

SECTION IV ACCREDITATION, CERTIFICATION AND LICENSURE

1. Has the facility ever been denied accreditation, certification and/or licensure or has its accreditation, certification and/or licensure ever been suspended or revoked? Yes No

If yes, please explain and provide a copy of the results of the inspection(s) that led to the denial, suspension or revocation:

2. Please provide copies of the facility's state license(s) and Medicare certification.

If the facility is not currently licensed and/or certified, please explain:

3. Is the facility currently accredited? Yes No

If yes, please identify each agency, provide proof of accreditation, a copy of the agency's most recent inspection report and the facility's responses to any contingencies and/or deficiencies:

If no, please indicate if the facility is scheduled for an inspection, and so, specify with which agency and the date of the inspection:

SECTION V DIALYSIS SERVICES

- How many hemodialysis stations does the facility have? _____
- Please complete the following table regarding the *estimated* number of treatments to be provided during the current year and the *actual* number of treatments that were provided during the applicable prior years. Please provide the numbers for each calendar year (January through December).

Current Year Estimate	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Fifth Prior Year

- Are kidney transplants performed in the facility? **Yes** **No**

If **yes**, please explain and identify the number performed annually:

- Please identify which health care provider(s) are always on-site when a patient is undergoing dialysis treatment in the facility (please check all that apply):

Physician
 Registered Nurse with dialysis experience
 Licensed Vocational/Practical Nurse with dialysis experience
 Individual certified in basic life support
 Other: _____

- If an individual certified in basic life support is not always on-site when a patient is undergoing dialysis treatment, please explain:

- If a physician is not always on-site when a patient is undergoing dialysis treatment, is a physician always on call and immediately available? **Yes** **No**

If **no**, please explain:

- Does the facility maintain a crash cart that is immediately available to each patient in the facility at all times and that is equipped with at least cardiac drugs (needed to comply with current ACLS standards), basic airway and IV access equipment, a cardiac monitor/defibrillator *and* supplemental oxygen? **Yes** **No**

If **no**, please identify the emergency equipment that is available in the facility:

SECTION VI ANCILLARY SERVICES

1. Please identify if the following are available to each patient undergoing dialysis:

- a. Dietary services by a licensed dietician? Yes No
- b. Social services by a licensed social worker? Yes No

If you answered no to question 1a or 1b, please explain:

2. Does the facility provide the following services on-site?

Pharmaceutical Yes No Laboratory Yes No

If yes, please answer the remaining questions in this section.

3. If laboratory and/or pharmaceutical services are provided on-site, please answer the following:

- a. Does the facility maintain separate professional liability insurance for any one of these services? Yes No

If yes, please identify the service(s) for which the separate professional liability insurance is maintained and provide proof of the insurance:

- b. Are the services provided only for individuals who will undergo dialysis services in the facility? Yes No

If no, please explain:

4. If laboratory services are provided on-site, please answer or provide the following:

- a. Please identify which one of the following currently applies regarding the facility's CLIA certification:

Certificate of Compliance Certificate of Accreditation Certificate of Waiver
 Certificate for Provider-Performed Microscopy Procedures Certificate of Registration
 No Certificate (please explain): _____

If the facility has a certificate of registration, when is the facility scheduled to be inspected? _____

- b. Please provide a copy of the facility's laboratory license.

c. Please provide the name and designation of the laboratory director: _____

- d. Are the laboratory services provided in the facility limited to those authorized by its CLIA certification? Yes No

If no, please explain:

SECTION VII TELEMEDICINE

Telemedicine is defined as “the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine.”

1. Does the facility:
 - a. Provide telemedicine services? **Yes** **No**
 - b. Receive telemedicine services? **Yes** **No**

If you answered yes to either of the above, please explain and provide a copy of the contract(s):

SECTION VIII MISCELLANEOUS

1. Does the facility maintain a transfer agreement with a general acute care hospital(s)? **Yes** **No**

If yes, please identify each hospital and the facility's distance to it (in miles):

If no, please explain:

2. Are any drugs, pharmaceuticals, devices or equipment used, administered, distributed or prescribed in or on behalf of the facility that are disapproved or not yet approved by the United States Food and Drug Administration (FDA) for treatment of human beings?
 Yes **No**

If yes, please explain:

3. Are all medications stored in a secure location and handled in compliance with federal, state and local laws and regulations?
 Yes **No**

4. Is there an emergency power source available? **Yes** **No**

5. Does the facility comply with all federal, state and local laws and regulations regarding the disposal of hazardous material?
 Yes **No**

6. Is all facility equipment maintained, tested and inspected according to manufacturers' guidelines and federal, state and local laws and regulations? **Yes** **No**

If you answered no to any one of questions 3 – 6, please explain:

7. Is the facility involved in any teaching program or is it utilized to train individuals other than employees? **Yes** **No**

If yes, please describe the program, identify who provides the training, who is trained, what type of training is provided and how often this occurs, and attach any applicable information regarding the program:

8. Are services of the facility provided under any contractual agreement(s) (excluding those with managed care organizations)? Yes No

If yes, please identify the organization(s) and person(s) with which it contracts and provide a copy of the contract(s):

9. Are the services provided on behalf of the facility limited to those that are usual and customary to dialysis centers? Yes No

If no, please explain:

10. Are there any changes planned for the facility (for example, new specialties or new procedures)? Yes No

If yes, please identify the changes and the anticipated date on which the changes will be made:

SECTION IX RISK MANAGEMENT

1. Does the facility have a formal risk management program? Yes No

a. If yes, who (name and title) is responsible for the risk management program?

b. If no, please explain:

Credentialing

1. Does the facility have a formal process to credential its health care providers? Yes No

a. If yes, please identify who performs the initial credentialing (e.g., employee, hospital, outside company):

b. If no, please explain:

2. Does the facility evaluate the following when credentialing its health care providers?

Claim History Yes No If yes, source(s) used: _____

Hospital Privileges Yes No

Employment History Yes No If yes, source(s) used: _____

Education History Yes No If yes, source(s) used: _____

Felony/Misdemeanor History Yes No If yes, source(s) used: _____

Medical/Dental/Nursing and Narcotic Licenses Yes No If yes, source(s) used: _____

If you answered no to any one of the above, please explain:

3. Does the facility use the same credentialing procedures to credential independent contractors and locum tenens health care providers? Yes No

If no, please describe the credentialing process used:

4. How often are the facility's health care providers recredentialed?

Quality Assurance

1. Please identify which of the following written policies and procedures have been established by the facility:

- Criteria for admission, transfer and discharge from dialysis treatments
- Availability and accessibility of services in an emergency
- Responsibilities and duties of all health care providers
- Medical supervision and physician services
- Patient care plans and methods of implementation, including ancillary services (e.g., dietary and social)
- Transfer of patient to a general acute care hospital
- Home care dialysis treatments

If the facility does not have written policies and procedures for any one of the above, please explain:

2. Does the facility maintain written policies and procedures for the handling of nonmedical (for example, loss of water supply or power) and medical emergency situations and are all health care personnel trained on them? Yes No

If yes:

- a. Are new employees required to complete this training before being allowed patient contact? Yes No

b. How often is training updated? _____

If you answered no to question 2 or 2a, please explain:

3. Is the medical director's and nursing director's approval required for any new or revised policies and procedures? Yes No

4. How often does the medical director review the facility's policies and procedures for possible updates? _____

5. How often does a qualified professional do the following:

a. Perform preventive maintenance and testing of the dialysis equipment? _____

b. Test and analyze the water supply to ensure that it is biologically and chemically compatible with acceptable dialysis techniques? _____

6. Does the facility have a formal process to evaluate and address concerns of unexpected patient outcomes? Yes No

7. Does the facility have a formal process to evaluate patient complaints? Yes No

8. Does the facility conduct patient satisfaction surveys? Yes No

If yes, how often: _____

Utilization Review

1. Does the facility have its own utilization review committee? **Yes** **No**

If yes:

- a. Does the facility have written policies and procedures for appeals of denied procedures? **Yes** **No**
- b. Who performs the utilization reviews? _____

- c. Are claim denial procedures explained in writing to patients? **Yes** **No**
- d. Does a physician review all proposed denials of benefits? **Yes** **No**
- e. Is there a fast track appeal system for denied procedures that may severely impair the quality of life for a patient if not performed? **Yes** **No**

Medical Records

1. Does the facility currently use electronic medical records? **Yes** **No**

If yes:

- a. Who is the vendor? _____
- b. How often are the electronic files backed up? _____
- c. Who backs up the files? _____
- d. Are the backed-up files stored at an off-site location? **Yes** **No**

If you answered no to question 1d, please explain:

- _____
- _____
- e. Do all facility locations (if more than one) use electronic medical records? **Yes** **No**
- f. Are all systems (e.g., inpatient, outpatient, billing, scheduling) electronic? **Yes** **No**

If you answered no to question 1f, how are the different systems coordinated?

- _____
- _____
2. Do the facility's health care providers create and maintain a medical record for each patient under their care? **Yes** **No**
3. Is it a requirement that operative/procedure notes be dictated/written on the day of the procedure? **Yes** **No**

If you answered no to question 2 or 3, please explain:

- _____
- _____
4. How are record-keeping deficiencies identified and handled?

SECTION X SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed, written narrative (including, but not limited to, date of occurrence, reason for occurrence and the resolution) and pertinent documentation (e.g., medical board documents, letters from a hospital, diversion program and/or treating physician, etc.).

1. Has any governmental agency **ever** investigated, placed on probation, suspended or taken any action against the facility? Yes No
2. Have the facility's membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions, or otherwise investigated or limited in any way, for possible incompetence, improper professional conduct or breach of conduct, or is any such action pending? Yes No
3. Has the facility **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? Yes No
4. Has the facility or any facility member **ever** been accused of sexual misconduct? Yes No
5. Do you know if any individual who works on the facility's behalf has a prior history or propensity for sexual misconduct? Yes No

SECTION XI CLAIMS HISTORY

Other than any claims, incidents, etc. that have already been reported on the organization's main application, if applicable:

1. Within the past ten (10) years, has a malpractice claim or suit been brought against the facility, or has the facility been notified of its involvement in a malpractice claim or suit, either directly or indirectly? Yes No
2. Is the facility aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against the facility, directly or indirectly, even if you believe the claim or suit would be without merit? Yes No

If you answered yes to question 1 or 2, please complete a Claim Information Form on page 14 for each applicable claim, suit, incident, conduct, etc.

SECTION XII PRIOR ACTS COVERAGE

NOTE: If the facility is not applying for Prior Acts Coverage, please skip this section.

Please ensure that your answers to the following questions reflect the facility's practice as it was during the Prior Acts Period.

1. Since the Requested Retroactive Date, has there been a change in the legal structure of the facility (for example, change in owners, type of entity)? **Yes** **No**

If **yes**, please explain and identify the appropriate dates:

2. Since the Requested Retroactive Date, have there been any material changes in the facility's practice (for example, types of procedures performed or services provided)? **Yes** **No**

If **yes**, please explain and identify the appropriate dates:

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (e.g., 2, 3b). Please photocopy this page if additional space is needed.

Page Number	Section Number	Question Number	Remarks
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Please provide any additional information material to the risk that has not otherwise been addressed in this application:

FOR CALIFORNIA AND RHODE ISLAND FACILITIES ONLY

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to the facility's coverage. I agree to notify NORCAL Mutual Insurance Company immediately if the facility's practice changes in any way and of any change in the information contained on this application.

Signature of Authorized Representative

Date

Print Name

FOR ALASKA FACILITIES ONLY

I represent the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to the facility's coverage. I agree to notify NORCAL Mutual Insurance Company immediately if the facility's practice changes in any way and of any change in the information contained on this application.

Signature of Authorized Representative

Date

Print Name

CLAIM INFORMATION FORM

Name of Patient: _____ Gender: Male Female

Age of Patient (at time of treatment): _____

Name of Claimant (if different than patient): _____

Location of Incident: _____

Allegation Against the Facility: _____

Facility Member Defendants: _____

Non-Facility Member Defendants: _____

Date Incident or Claim Was Reported to the Insurance Company: _____

Name of Insurance Company: _____

Disposition or Current Status of the Incident, Claim or Suit Against the Facility:

Open

- Incident has been reported but claim or suit has not been filed
- Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- Claim or suit is currently in arbitration or mediation or is being tried in court
- Settlement has been made or judgment returned but remains open

Closed

Date Closed (month/day/year): _____

- Incident was reported but claim or suit was not filed
- Claim or suit was filed but was dismissed or dropped before trial
- Claim or suit was filed but settlement was made
- Verdict or judgment was made in the entity's favor
- Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): _____

Amount paid on the facility's behalf: _____

Total verdict amount (if different than total loss payment amount): _____

