



- o DEERFIELD INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
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**APPLICATION FOR CLINICS (MEDICAL, DENTAL, PUBLIC HEALTH, MENTAL HEALTH, OTHER)
PROFESSIONAL LIABILITY INSURANCE**

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) Full name of Applicant: HIDALGO COUNT; Juvenile Probation Dept. – Infirmary Unit
- (b) Principal practice address: 1001 N. Doolittle Rd. Hidalgo
(Street) (County)
Edinburg TX 78542
(City) (State) (Zip)
- (c) Location: Stand alone Hospital School Correctional Facility Other
- (d) (i) Phone: (956)587-6200
(ii) E-Mail Address: _____ (iii) Website Address: www.co.hidalgo.tx.us
- (e) Date Established: _____
Attach a proforma business plan if the Applicant is newly established.

2. Applicant is a:
 - professional corporation joint venture
 - limited liability company professional association
 - other County run probation facility partnership

3. Name(s) of all partners or members of the clinic who provide professional services: Dr. Marin Garza, M.D.; Doctor Ramiro Ramirez, Lic. Phd Psychologist ; Dr. Abel Cain, Lic. Phd Psychologist

4. Does any owner, partner or director operate or administer, wholly or in part, any hospital, nursing home or other institution where medical services are rendered? Yes No
If Yes, provide details, including name, location, size and number of beds. N/A

5. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No
If Yes,
(a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?..... Yes No
(b) Provide the name and title of the Applicant's Privacy Officer. All 3 LVN's are charged with HIPAA compliance
Our Business Associate Agreement is available at www.markelcorp.com. This is the only Business Associate Agreement we will recognize.

II. OPERATIONS

1. Days/hours of operation: 24 hours a day 7 days a week
2. (a) Provide the name and specialty of the Applicant's Medical Director: Dr. Marin Garza
(b) Does the Applicant's Medical Director have direct patient contact? Yes No
(c) Is the Applicant's Medical Director full-time or part-time? Contracted on an as needed basis

3. Applicant's professional specialty: _____

4. Provide the percentage of patients/clients:

Bariatrics	<u>N/A</u> %	Holistic medicine	<u>N/A</u> %	Sleep Disorders	<u>N/A</u> %
Communicable Disease	<u>2</u> %	Obstetrical	<u>N/A</u> %	Stress Testing	<u>N/A</u> %
Correctional Medicine	<u>70</u> %	Oncology	<u>N/A</u> %	Students	<u>N/A</u> %
Dental	<u>5</u> %	Pain Management	<u>N/A</u> %	Substance Abuse	<u>N/A</u> %
Disability Evaluation	<u>N/A</u> %	Pediatric	<u>N/A</u> %	Surgical	<u>N/A</u> %
Family Planning	<u>5</u> %	Physical Rehabilitation	<u>N/A</u> %	Urgent Care	<u>N/A</u> %
Free Clinic	<u>N/A</u> %	Psychiatric	<u>18</u> %		
Hemodialysis	<u>N/A</u> %	Research or Experimental	<u>N/A</u> %		

5. List all Locations where Applicant is registered and licensed to operate:

Location 1: Hidalgo County Juvenile Probation Department

Location 2: _____

Location 3: _____

Location 4: _____

6. Name(s) and location(s) of any hospital or medical facility that the Applicant refers in practice: _____

7. Has the Applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered?..... [] Yes [X] No
If Yes, provide details. _____

8. List all accreditations and association memberships held by Applicant's facility and include a copy of the most recent report: N/A

9. Does the Applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism?..... [] Yes [X] No

10. Is the Applicant "deemed" under the Federal Tort Claims Act ("FTCA")? [] Yes [X] No
If Yes, what percentage of services are provided under the FTCA? _____

11. Does the Applicant or any of its employees or independent contractors provide services for correctional facilities, such as a jail, detention center, prison, etc.? [X] Yes [] No

12. Applicant's Gross Revenues:

	<u>Last Twelve Months</u>	<u>Next Twelve Months</u>
Fee for Service	\$ <u>4,397,714.00</u>	\$ <u>4,667,653.00</u>
Medicare/Medicaid Funds	\$ _____	\$ _____
Research	\$ _____	\$ _____
Other (describe) Infirmiry Dept	\$ <u>395,126.00</u>	\$ <u>479,926.00</u>
TOTAL GROSS REVENUES	\$ <u>4,792,840.00</u>	\$ <u>5,147,579.00</u>

13. Number of outpatient/client visits:

	<u>Last Twelve Months</u>	<u>Next Twelve Months</u>
Clinics or Physician	<u>1,944 Nurses & Doctor In/Out</u>	<u>2,200 Nurses & Doctor In/Out</u>
Laboratory	<u>300</u>	<u>300</u>
X-ray/Imaging	<u>15</u>	<u>15</u>
Pharmacy	<u>75</u>	<u>100</u>
TOTAL VISITS:	_____	_____

NOTE: If Applicant provided services for correctional facilities, provide number of inmates: 96 at max capacity

14. Does the Applicant maintain any beds for overnight occupancy:

(a) On the Applicant's premises?..... [X] Yes [] No

If Yes,

(i) No. of beds: 96

(ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing. Registered with the State of Texas see the Texas Juvenile Justice Dept. website @ www.tjjd.texas.gov. This is a 24 hour facility.

- (b) Off the Applicant's premises?[] Yes [] No
 If Yes,
 (i) No. of beds: _____
 (ii) Attach a copy of license and an explanation including protocols for on-site 24 hour staffing.

III. STAFF

1. Indicate the number of professional employees, independent contractors and volunteers. If None, state None.

	Employees		Independent Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	None	None	1	None	None	None
Physicians: Minor surgery or obstetrical procedures not constituting major surgery	None	None	None	None	None	None
Anesthesiologists	None	None	None	None	None	None
Obstetrics-Gynecologists	None	None	None	None	None	None
Oncologists	None	None	None	None	None	None
Ophthalmologists	None	None	None	None	None	None
Urologists	None	None	None	None	None	None
Dentists	None	None	1	None	None	None
Chiropractors	None	None	None	None	None	None
Nurse Anesthetists	None	None	None	None	None	None
Nurse Practitioners	None	None	None	None	None	None
Optometrists	None	None	None	None	None	None
Pharmacists	None	None	None	None	None	None
Physician Assistants	None	None	None	None	None	None
Podiatrists	None	None	None	None	None	None
Psychologists	None	None	2	None	None	None
RNs/LPNs/LVNs	3	None	None	None	None	None
Social Workers	None	None	None	None	None	None
Other(describe):	None	None	None	None	None	None

NOTE: If the Applicant requires any of the above to be Insureds, submit a separate application for each such individual.

2. Are all of the above persons licensed in accordance with applicable state and federal regulation?.....[] Yes [] No
 If No, attach explanation.
3. Do all professional staff maintain a Professional Liability Insurance Policy?[] Yes [] No
 If Yes, what are the minimum limits of liability that the Applicant requires?
Liability insurances maintained at \$1,000,000.00 for physician and \$500,000.00 for each psychologist

IV. PROFESSIONAL SERVICES

1. Does the Applicant's employees or independent contractors:
- (a) Perform any minor surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia?[] Yes [] No
 If Yes, list all minor/invasive procedures _____
- (b) Perform any anti-aging procedures, including Botox or other injectables?[] Yes [] No
 If Yes, complete a Supplement for Medical Spa/Anti-Aging Clinics (SM31001).

- (c) Perform abortions and/or menstrual extractions? [] Yes [X] No
 If the Applicant provides pregnancy termination complete a Supplement for Abortion Centers (SM31002)
- (d) Perform any experimental procedures or research testing? [] Yes [X] No
 If Yes, are they FDA approved? [] Yes [X] No
 If No, attach a description. _____
- (e) Perform any chelation therapy services? [] Yes [X] No
 If Yes, explain: _____
- (f) Administer anesthesia other than topical or local infiltration? [] Yes [X] No
 If Yes, attach detailed explanation. _____
- (g) Use drugs for weight reduction for patients? [] Yes [X] No
 If Yes, attach list of drugs used and percentage of practice devoted to weight reduction;
 frequency and duration of prescriptions or weight reduction drugs and quantity dispensed. _____
- (h) Administer any methadone treatment? [] Yes [X] No
 If Yes,
 (i) Provide the number of treatments during the:
 Last 12 months _____ Next 12 months _____
 (ii) Attach a description of treatment and controls used. _____
- (i) Provide teleradiology services? [] Yes [X] No
 If Yes, provide description of services and for whom services are provided. _____
- (j) Offer professional advice to the public via the internet, newspapers or broadcasts? [] Yes [X] No
 If Yes, provide details. _____
- (k) Advertise professional services in any manner other than a simple listing in a telephone directory?
 [] Yes [X] No
 If Yes, attach a copy of all advertisements. _____
2. Does the Applicant use a collection agency: [] Yes [X] No
 If Yes,
 (i) Name of agency: _____
 (ii) Does the agency have authority to file a collection suit on behalf of the Applicant? [] Yes [X] No

V. CLAIMS AND HISTORY

1. Has the Applicant or any of its employees ever:
 (a) Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing,
 administrative or governmental agency? [] Yes [X] No
 (b) Been convicted for an act committed in violation of any law or ordinance including traffic
 offenses? [] Yes [X] No
 If Yes, provide details. _____
- (c) Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional
 disorders? [] Yes [X] No
 If Yes, provide details. _____
- (d) Had any professional license or license to prescribe or dispense narcotics been denied,
 limited, refused, suspended, revoked, renewal refused or accepted only on special terms or
 has the Applicant or any of its employees voluntarily surrendered any professional license? [] Yes [X] No
 If Yes, provide details. _____
2. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed
 for this insurance? [] Yes [X] No
 If Yes, how many? _____
3. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed
 for this insurance that has not been reported to the Applicant's current or prior insurer? [] Yes [X] No
 If Yes, explain. _____
4. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact,
 circumstance, or records request from any attorney which may result in a malpractice claim or suit? [] Yes [X] No
 If Yes, how many? _____

5. Has any insurer cancelled, rescinded, non-renewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for his insurance in the last five years?..... Yes [] No [X]
 If Yes, attach a copy of such insurer's notice.

6. List prior Professional Liability Insurance for each of the last five (5) years, including the current year:
 If None, check here. []

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date
N/A					

7. List prior General Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date
See Attached					

VI. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)

1. Complete the following for each of the Applicant's facilities:

Location Number	Name of Facility	Address	Description of Facility	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
1					
2					
3					

2. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percentage of Building Occupied by Applicant				
Other occupants? (Yes/No)				

*Include square footage of parking facilities if owned or rented by the Applicant.

3. Are all of the Applicant's locations equipped with:

- (a) Complete Sprinkler System? [] Yes [] No
- (b) At least two clearly marked exits on each floor? [] Yes [] No
- (c) Self-closing fire doors on each floor? [] Yes [] No

Hidalgo County – Professional Liability Application

Question #7 of the MASAM 5004 (01/10) Application for Market

Prior General Liability Insurance Information

Insurance Company	Limits of Liability	Premium	Policy Term	Type of Form	Retroactive Date
Princeton Excess	1,000,000/2,000,000	\$398,290	01/01/2013 – 2014	Occurrence	N/A
Travelers	1,000,000/2,000,000	\$140,676	01/01/2012 – 2013	Occurrence	N/A
Travelers	1,000,000/2,000,000	\$154,150	01/01/2011 – 2012	Occurrence	N/A
Travelers	1,000,000/2,000,000	\$175,911	01/01/2010 – 2011	Occurrence	N/A
Travelers	1,000,000/2,000,000	\$179,993	01/01/2009 – 2010	Occurrence	N/A

- (d) Automatic fire alarm system connected to a local fire department? [] Yes [] No
- (e) Smoke detectors? [] Yes [] No
- (f) Emergency electrical system? [] Yes [] No
- (g) Heat sensors? [] Yes [] No
- (h) Fire escape(s)? [] Yes [] No
- (i) Posted emergency evacuation procedures? [] Yes [] No
- (j) Properly maintained fire extinguishers? [] Yes [] No

If any of the above are answered No, provide details by attachment.

- 4. Does the Applicant have a written safety program in place? [] Yes [] No
If Yes, attach a copy of the written safety program.
- 5. Does the Applicant have written procedures for incident reporting? [] Yes [] No
- 6. Do any of the Applicant's locations have any:
 - (a) Exposure to flammables, explosive, chemicals? [] Yes [] No
 - (b) Catastrophe exposure? [] Yes [] No
 - (c) Exposure to radioactive materials? [] Yes [] No
- 7. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? [] Yes [] No
- 8. Does the Applicant sell or lease any medical equipment or products to patients/clients or others in connection with Applicant's operation? [] Yes [] No
If Yes, Total Annual Sales \$ _____
Total Annual/Lease Rental Receipts \$ _____
- 9. Does the Applicant:
 - (a) Loan or rent machinery or equipment to others? [] Yes [] No
 - (b) Own any elevators or escalators? [] Yes [] No
 - (c) Own or rent any parking facility? [] Yes [] No
 - (d) Provide any recreational facility? [] Yes [] No
 - (e) Have a swimming pool on the premises? [] Yes [] No
 - (f) Sponsor any sporting or social events? [] Yes [] No
- 10. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? [] Yes [] No

If Yes, answer the following:

Provide three year loss history for claims under \$100,000 Loss and Expense and ten years for claims \$100,000 and greater. Attach further sheets if needed.

Date of Occurrence	Date Claim Made	Description of Loss	Amount of Loss Reserved and Paid	Amount of Expenses Reserved and Paid	Open (O) or Closed (C)

- 11. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? [] Yes [] No
If Yes, provide details for each incident. _____

VII. ADDITIONAL INFORMATION

As part of this Application attach the following:

- 1. A CV of Medical Director including specialty and board certification.
- 2. Five (5) years of currently valued Professional Liability Insurance and General Liability Insurance claim runs from current and prior insurers or complete a Supplemental Claim Information form (SM6236) for each claim.
- 3. A list of any activities or procedures performed that are not otherwise described in this Application.

