



## Professional Liability History-Confidential

Please list any professional liability suits over the past five years, which are pending or which went to final disposition. You may substitute a written explanation and supporting documentation from your insurance carrier, provided that all requested information is included for each case. (Photocopy this page as needed and submit information on each claim/lawsuit.)

Date of occurrence: \_\_\_\_\_ Date claim was filed: \_\_\_\_\_ Claim or  
file #: \_\_\_\_\_

Professional liability carrier involved: \_\_\_\_\_

Patient/Client Name: \_\_\_\_\_

Name of claimant/plaintiff,  
if other than patient: \_\_\_\_\_

Describe your role in this incident:      Primary Defendant      Co-Defendant

Describe the allegations against you: \_\_\_\_\_

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Describe the alleged injury to the patient: \_\_\_\_\_

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Current status of the claim or case:

The case or claim is still pending

Verdict or judgment for the plaintiff was entered in the amount of: \$ \_\_\_\_\_ the portion of the verdict or judgment which was attributed to me was: \$ \_\_\_\_\_

Case or claim settled for \$ \_\_\_\_\_ the portion of the settlement which was paid on my behalf was: \$ \_\_\_\_\_

The case was dismissed by the court.

The claimant/plaintiff voluntarily withdrew the claim/lawsuit.

The claimant/plaintiff voluntarily dismissed me from the lawsuit.

No Claims History within last 5 years

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PROFESSIONAL LIABILITY INSURANCE INFORMATION (continued)**

**Previous Carrier**

Carrier Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Length of time with previous carrier: _____

**SERVICE LOCATIONS (Please list all counties that you service)**

_____	_____	_____	_____
_____	_____	_____	_____

**LICENSE and CERTIFICATION INFORMATION**

**(please provide for all members of your practice if completing as a group practice)**

Care Manager Name: _____	License # _____	State _____	Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____

Care Manager Name: _____	License # _____	State _____	Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____

Care Manager Name: _____	License # _____	State _____	Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____

Care Manager Name: _____	License # _____	State _____	Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____

Care Manager Name: _____	License # _____	State _____	Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____
Certification: _____	Certificate # _____		Exp. Date _____

**UNDERGRADUATE INFORMATION (please complete this section only if you are an individual care manager)**

Name of Institution: _____	Dates Attended: _____
City: _____	State/Country: _____ Degree: _____

**GRADUATE EDUCATION (please complete this section only if you are an individual care manager)**

Name of Institution: _____	Dates Attended: _____
City: _____	State/Country: _____ Degree: _____

**GRADUATE EDUCATION (please complete this section only if you are an individual care manager)**

Name of Institution: _____	Dates Attended: _____
City: _____	State/Country: _____ Degree: _____

**Please list other professionals within your organization (i.e., CPA, attorney, etc.)**

Name: _____	Profession: _____	Position: _____
Name: _____	Profession: _____	Position: _____
Name: _____	Profession: _____	Position: _____
Name: _____	Profession: _____	Position: _____

**Please answer all questions.**

1. Has the corporation ever been sanctioned, placed under probation, currently under investigation, lost accreditation or certification status by any State, Federal or other institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the corporation ever been refused, denied, restricted, limited, suspended, revoked or forced to terminate Malpractice/Liability Insurance or State License?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have any general liability or malpractice claims been filed against the provider during the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have any general liability or malpractice claims, been settled or paid by or on behalf of the provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is the corporation currently under investigation by HCFA, Medicare, Medicaid, DEA, State CDS or any other Federal State or local governmental agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered yes to any of the questions above, please attach a detailed explanation.**

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**Please include the following documents with your application (where applicable).**

- Completed application signed & dated
  - Current copy of Insurance coverage (including expiration date & amount of coverage)
  - Current copy of State Business License
  - Current copy of State License (where applicable; for each care manager)
  - Copy of Resume (for each care manager)
  - Copy of Care Manager Certification (for each care manager) if applicable
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## Care Manager Clinical Specialties

Please check all clinical specialties and populations with which you have clinical experience, AND which you would be willing to receive referrals for community-based care management services:

- Geriatrics
  - Disability Care/Case Management
  - Chronic Illnesses/Disabilities
    - Cancer
    - Diabetes
    - Cardiac Conditions
    - Head/Spinal Cord Injuries
    - HIV
    - Parkinson's Disease
    - Multiple Sclerosis
    - Other \_\_\_\_\_
- \_\_\_\_\_

- Mental/Behavioral Health
  - Depression/Other Affective Disorders
  - Substance Abuse/Dependence
  - Schizophrenia/Other Psychotic Disorder

- Adolescents
- Pre-Teens (10-12 years)
- Children (<10 years)
- Infants

- Other:  
\_\_\_\_\_  
\_\_\_\_\_

## Languages Spoken

Please indicate languages other than English in which you are able to provide care management services:

- Spanish
- Asian Languages – please specify below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- American Sign
- Greek
- French
- Russian
- Italian
- Other European – please specify below:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## ATTESTATION FORM

I represent and warrant to CareGuide, Inc and its employees, officers, directors, subsidiary corporations, affiliates and agents, that the information contained in this application and all attachments are true and complete to the best of my knowledge and belief. The contents of this application and its attachments do not omit any information necessary to keep the information that is included from being misleading. I agree not to alter this application in any way, except to provide additional space for requested information. I agree to inform CareGuide within ten (10) days if any material changes in such information occurs, whether before or after this facility entering into an agreement with CareGuide or their client for the provision of non-medical services. Should I furnish any false information in this application or the attachments, or if I fail to notify CareGuide within ten (10) days of any material change, I hereby agree that such act or omission shall constitute denial, suspension or termination of my application and/or contract.

I understand that if CareGuide accepts this application, the provider will be bound by the terms of CareGuide’s provider agreement, of which this application is a part. I have read and understand the terms of CareGuide’s provider agreement and agree to be bound by them.

I understand that I have the right to review and correct any information CareGuide obtains from my malpractice insurance carrier(s), the state licensing board(s), and any accrediting body.

I understand that this application form is proprietary to CareGuide and I agree not to provide copies of this application on paper, diskette, or in any other format to any person who is not employed by me for the purpose of providing administrative support services for CareGuide. I agree to return any copies of the form received on diskette. I may retain both paper and computer file copies of the application for my own archival purposes.

**Provider Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

## CREDENTIALS VERIFICATION RELEASE FROM LIABILITY FORM

I acknowledge and agree that CareGuide, Inc. and its employees, officers, directors, subsidiary corporations, affiliates, agents and other health care organizations, with whom it is contracted, have a valid and legitimate interest in obtaining and verifying information concerning this facility's qualifications. This information will be used in determining whether to enter into an agreement with me for the provision of non-medical services to members of its contracted health plans.

I authorize CareGuide to consult with malpractice carriers, state licensing boards, HCFA, and any other persons or entities to obtain and verify information concerning this application. I release their employees, officers, directors, affiliates and agents from any and all liability for their acts performed in good faith in verifying such information and in evaluation of this application.

I consent to the release of any and all information, files or records, reasonable and relevant to an evaluation of this application, by any person or entity. This will include but not be limited to any information relating to insurance claims history; disciplinary action, denial, suspension, sanction, voluntary or involuntary relinquishment of any license, accreditation or certification, and malpractice/liability insurance.

I consent to CareGuide providing credentialing information to contracted payors/clients, government and regulatory bodies, and other appropriate healthcare agencies as allowed by law.

A photocopy of this original Credentials Verification Release Form shall serve as a written authorization and request to release any written or verbal information or documentation necessary for the completion of the credentialing process.

**Provider Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_