

BOND NUMBER: _____

STATE OF MINNESOTA
SURETY BOND
PERSONAL CARE ASSISTANCE PROVIDER AGENCY

KNOW ALL PERSONS BY THESE PRESENTS: That _____
(Name of PCA Agency)

(Description of the form of business organization, e.g., corporation, LLC, etc.)

with business office at _____
(Street Address, City, State, Zip Code of office covered by this bond)
a _____
as PRINCIPAL and _____
(Name of Surety)

a corporation duly organized under the laws of the State of _____ which is authorized to engage in the business of insurance in the State of Minnesota, as SURETY, are hereby held and firmly bound to the Department of Human Services of the State of Minnesota in the sum of \$ _____ (Fifty Thousand Dollars for newly enrolling PCA agencies; Fifty Thousand Dollars or 10 percent of a provider's PCA payments from Medicaid in the previous year, whichever is less, for currently enrolled providers). Principal and Surety hereby bind themselves, their representatives, successors and assigns, jointly and severally.

The parties further agree that:

1. The purpose of this obligation, which is required by Minnesota Statutes, section 256B.0659, Subd. 21, is to secure the compliance by Principal with the terms of Minnesota Statute, Chapter 256B, of all rules made by the commissioner, and any other legal obligations arising out of the Principal's conduct as a personal care assistance provider agency.
2. This bond is for the benefit of the State of Minnesota. Surety shall immediately notify the Department of Human Services if the bond lapses or is canceled.
3. This bond shall be an annual bond in effect from _____ until _____.
4. If the Principal shall violate Minnesota Statutes, Chapter 256B, or any rules made by the commissioner or other legal obligations arising out of Principal's conduct as a PCA agency, the Commissioner of the Department of Human Services shall have, in addition to all other legal remedies, a right of action on this bond.
5. This obligation may be canceled by said surety by giving sixty (60) days notice in writing of its intention to do so to the Department of Human Services. Nothing herein shall affect any rights or liabilities which shall have accrued under this bond prior to the date of termination. Surety shall be relieved of any further liability under this bond arising out of Principal's conduct which occurs sixty (60) days after receipt of said notice by the Department of Human Services.

(Name of Surety)

(Name of PCA Agency)

By: _____
(Signature of Attorney in Fact)
Surety must attach a Power of Attorney.

By: _____
(Signature of President/Individual Proprietor)

<p>ACKNOWLEDGMENT OF SURETY STATE OF _____) COUNTY OF _____) On this _____ day of 20____ _____ before me personally appeared _____ who acknowledged that he or she is the attorney in fact who is authorized to sign on behalf of _____ (name of surety company) a _____ corporation, on (state or place of incorporation) behalf of the corporation. _____ Notary Public [Notary Seal]</p>	<p>ACKNOWLEDGMENT OF PCA AGENCY STATE OF _____) COUNTY OF _____) On this _____ day of 20____ _____ before me personally appeared _____ who acknowledged that he or she is the _____ _____ of the PCA agency whose name is subscribed on this bond form, and that he or she is authorized to execute the bond for the purposes contained therein. _____ Notary Public [Notary Seal]</p>
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Surety Bond Application

AGENCY NAME: _____ AGENCY CONTACT: _____
 AGENCY PHONE: _____ AGENCY FAX: _____ AGENCY EMAIL: _____
 AGENCY ADDRESS: _____ City: _____ State: _____ Zip: _____

CURRENT OR EXPIRING QUOTE WE ARE LOOKING TO BEAT? _____

NAME OF PREVIOUS SURETY COMPANY WRITING THE BOND? _____

SECTION I: BOND APPLIED FOR

Type of Bond: _____ Effective Date: _____ Expiration Date: _____

Type of Company **CORP** **LLC** **DBA** **PARTNERSHIP** Bond Amount: _____

(Obligee): _____

Obligee Address _____

SECTION II: GENERAL INFORMATION

Applicant's Name: _____ Spouse Name: _____

SS#: _____ Spouse SS#: _____ Home Phone: () _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Business Name: _____

Business Phone: () _____ Business Fax: () _____ E-mail: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Date Business BEGAN under present Individual or Firm Name: _____ BUSINESS TAX ID: _____

HAS ANY COMPANY REFUSED TO ISSUE BONDS FOR ANY PURPOSE? YES NO DO YOU HAVE ANY LIENS, CLAIMS OR JUDGMENTS AGAINST YOU? YES NO

HAS APPLICANT EVER FAILED IN BUSINESS? YES NO HAS APPLICANT EVER FILED BANKRUPTCY? YES NO

IF YES TO ANY, PLEASE EXPLAIN ON A SEPERATE SHEET OF PAPER

SECTION III: ADDITIONAL OWNERS OR PARTNERS AS REQUIRED

NAME: _____ SPOUSE NAME: _____

SS#: _____ SPOUSE SS#: _____ PHONE: _____

HOME ADDRESS: _____ City: _____ State: _____ Zip: _____

PERSONAL FINANCIALS (IF MORE THAN ONE OWNER, EACH HAS TO FILL OUT THIS APPLICATION)
STATEMENT OF ASSETS AND LIABILITIES AS OF

ASSETS		LIABILITIES	
CASH IN BANK		NOTES PAYABLE TO BANKS	
CASH ON HAND		NOTES TO OTHERS (excl. of equipment)	
STOCKS AND BONDS		ACCOUNTS PAYABLE	
ACCOUNTS RECEIVABLE		FEDERAL & STATE INCOME TAX DUE	
NOTES RECEIVABLE		ALL OTHER TAXES	
INVENTORY		ACCRUALS, PAYROLLS, ETC.	
CASH VALUE LIFE INSURANCE			
EQUIPMENT		DUE ON EQUIPMENT	
REAL ESTATE		DUE ON REAL ESTATE	
OTHER ASSETS		OTHER LIABILITIES	
		CAPITAL STOCK (if a corporation)	
		SURPLUS AND UNDIVIDED PROFITS	
TOTAL ASSETS		TOTAL LIABILITIES	
		NET WORTH	
Name of Owners	Name and Title of Officers	% OWNERSHIP IN COMPANY	

COMPLETION OF THIS FORM CONSTITUTES PERMISSION FOR WORLDWIDE INSURANCE SPECIALISTS INC. TO OBTAIN CONSUMER INFORMATION WHICH WILL BE USED TO DETERMINE BONDING ELIGIBILITY. THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE
 NO PREMIUM FINANCING WILL BE ACCEPTED AS PREMIUM IS EARNED IN FULL.

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