



**SUPPLEMENTAL APPLICATION  
HOME HEALTH AND STAFFING AGENCIES**

*(Please note that this Supplemental Application must be completed for each facility/location. The Medical Professional Liability Coverage Application must be completed and submitted with all Supplemental Applications).*

NAME OF FACILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**I. LICENSING:**

A. Is the applicant licensed to do business in the states where required?  Yes  No

B. If YES, please provide copy of the current license with this application and complete the following.

1. Name on License: \_\_\_\_\_

2. Licensed by state of: \_\_\_\_\_

3. License #: \_\_\_\_\_

4. Expiration Date: \_\_\_\_\_

C. Has License ever been revoked, suspended, placed on probation or restricted in any way?  Yes  No

If YES, please explain: \_\_\_\_\_

**II. GENERAL INFORMATION:**

A. Are you a member of the National Association for Home Care (NAHC) or any other association?  Yes  No

If yes, please specify: \_\_\_\_\_

B. Are you accredited by CHAP, JCAHO or any other accrediting organization?  Yes  No

If yes, please specify: \_\_\_\_\_

**III. FACILITY OPERATIONS/ STAFFING:**

A. Does the applicant provide any overnight bed facilities?  Yes  No

B. Does the applicant perform any treatment or services on the applicant's premises?  Yes  No

If YES, please describe: \_\_\_\_\_

\_\_\_\_\_

- C. Do you want independent contractors added to the policy as insureds?  Yes  No
- D. Where are employees placed, by percentage?  
 Private Homes\_\_\_\_ Hospitals\_\_\_\_ Nursing Homes\_\_\_\_ Medical Clinics\_\_\_\_  
 Doctor's Offices\_\_\_\_ Other\_\_\_\_ (Describe) \_\_\_\_\_
- E. Do you engage in any business other than Home Health Care / Temporary Staffing? If so, describe:  
 \_\_\_\_\_  
 \_\_\_\_\_
- F. Are employees completing Daily Work reports (Nursing notes, Hospital notes, etc.)?  Yes  No
- G. Are all employees bonded?  Yes  No
- H. Do you place any Nurse Practitioners?  Yes  No
- I. Do any of your employees staff the:  
 Emergency Room  Yes  No  
 Labor & Delivery Rooms  Yes  No  
 Intensive Care Units  Yes  No  
 If yes, please specify the number of employees in each category: \_\_\_\_\_
- J. Complete job descriptions must accompany this application for professionals employed/ contracted by your facility.
- K. Attach a copy of your employment application.

**IV. PHYSICIAN INFORMATION**

- A. Please identify by name and function served, all physicians including (psychiatrists, osteopaths, dentists or chiropractors) employed or affiliated with the facility:

Name	Type of Doctor	Specific Duties in Facility Operations

- B. Is your facility insured under the Professional Liability issued to each person specified above?  Yes  No

Certificates of insurance for doctors will be required, so please state:

Name of Doctor	Insurance Carrier	Insurance Limit	Expiration date of Coverage

**This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. These medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.**

I **DECLARE** that the information contained in this supplement is true and that no material facts have been suppressed or misstated.

I **UNDERSTAND** that an incorrect or incomplete response could void my coverage.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date