



**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C. Has License ever been revoked, suspended, placed on probation or restricted in any way?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