



**SUPPLEMENTAL APPLICATION
MEDICAL GROUP HOME**

(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: Yes No

1. Name on License: _____

2. Licensed by state of: _____

3. License # _____

4. Expiration Date: _____

Please provide copy of the current license with this application

C. Has license ever been revoked, suspended, placed on probation or restricted in anyway? Yes No

If YES, please explain: _____

II. GENERAL INFORMATION:

A. Is facility certified for Medicare/Medicaid? Yes No

If YES, please list your Provider Numbers: Medicare _____

Medicaid _____

B. Are you accredited by any organizations? Yes No

If yes, by whom: _____

C. Is the facility affiliated with any correctional or penal facilities? Yes No

III. BUILDING INFORMATION:

- A. Are there any fire arms on premises? Yes No
If YES, please provide details: _____
- B. Are the firearms locked in a secure place away from the residents? Yes No
If NO, please provide details: _____
- C. Are hand rails provided in hallways and bathrooms? Yes No

IV. PATIENT TREATMENT INFORMATION:

- A. Number of licensed beds: _____
- B. Number of occupied beds: _____
- C. Range of client ages: _____
- D. How many male: _____ How many female: _____

E. Patient Census	# Ambulatory	Ambulatory w/ Assistance	# Non Ambulatory
Severely/ Profoundly Retarded	_____	_____	_____
Mild/Moderately Retarded	_____	_____	_____
Psychotic or Sociopath	_____	_____	_____
Emotionally Disturbed/Depressed	_____	_____	_____
Other	_____	_____	_____

- F. What precautions are taken to keep track of patients? _____

- G. Are there sign out procedures? Yes No
- H. Are there alarms on doors to prevent patients from wandering from the residence? Yes No
- I. Is a complete physician's examination required prior to admission? Yes No
If NO, please explain: _____
- J. Is medication or drugs given:
1. Only under a physician's written orders? Yes No
2. Only by authorized medical professionals? Yes No
- If the answer to 1. or 2. above is NO, please explain: _____

V. EMPLOYEE INFORMATION:

Number of Employees by Shift (if applicable):	<u>1st</u>	<u>2nd</u>	<u>3rd</u>
A. Physicians, Interns, Residents or Volunteers	_____	_____	_____
B. RN	_____	_____	_____
C. LPN	_____	_____	_____
D. Nurses Aides/Orderlies	_____	_____	_____
E. Student Nurses	_____	_____	_____
F. Physical Therapists	_____	_____	_____
G. Inhalation Therapists	_____	_____	_____
H. Respiratory Therapists	_____	_____	_____
I. Occupational Therapists	_____	_____	_____
J. X-Ray Technicians	_____	_____	_____
K. Volunteers (non-medical)	_____	_____	_____
L. Lab Technicians	_____	_____	_____
M. Psychologists	_____	_____	_____
N. Psychiatrists	_____	_____	_____
O. Counselors (certified)	_____	_____	_____
P. Counselors (non-certified, such as prior substance abusers)	_____	_____	_____
Q. Social Workers	_____	_____	_____
R. Pharmacists	_____	_____	_____
S. Clerical	_____	_____	_____
T. Physician's Assistants	_____	_____	_____
U. Surgeon Assistants	_____	_____	_____
V. Nurse Practitioners	_____	_____	_____
W. Others (please give details) _____			

VI. EMERGENCY & SAFETY PROCEDURES:

- A. How often are fire drills conducted? _____
- B. How are medical emergencies handled?
1. On Call Physicians? Yes No
 2. Affiliated Physicians on Premises? Yes No
 3. Hospital and/or emergency center? Yes No
If YES, is hospital and/or emergency center located within a 15 minute drive under typical conditions?
 4. Other? Yes No
(explain) _____
- C. Specify arrangements for storage and dispensing of drugs: _____

VII. STATE INSPECTION

- A. Date of last State Inspection/Survey (if applicable): _____
- B. Total # of Deficiencies: _____
- C. Corrective Action Plan Accepted by State Yes No
 Date Accepted: _____
- D. Number of Complaints investigated by State the past 2 years : _____
- E. Number of Substantiated complaints: _____

VIII. PHYSICIAN INFORMATION

- A. Please identify by name and function served, all physicians including (psychiatrists, osteopaths, chiropractors or dentists) 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