

Return to:

**RESIDENTIAL HOSPICES
SUPPLEMENTAL APPLICATION**

(This application is supplemental to the Home Health Care / Temporary Staffing application.)

(Please note that this Supplemental Application must be completed for each facility/location providing residential hospice care. The Home Health Care / Temporary Staffing Application must be completed and submitted with all Residential Hospice Supplemental Applications).

NAME OF FACILITY: _____

ADDRESS: _____

Street

City

State/Zip

County

LICENSING

1. Licensed by state of: _____

2. License #: _____

3. Expiration Date: _____

4. Has License ever been revoked, suspended, placed on probation or restricted in any way? Yes No
If YES, please explain: _____

PATIENT / TREATMENT INFORMATION

5. Fully describe the exact purpose of the operations, activities, services and professional procedures administered:

6. Are medication or drugs given:

a. Only under a physician's written orders? Yes No

b. Only by authorized medical professionals? Yes

No

If the answer to a. or b. above is NO, please explain

7. Are all patients terminally ill? Yes No

If NO, please explain: _____

8. Is a complete medical history of each patient or client retained on premises? Yes No

9. Is a complete physician's examination required prior to admission? Yes No

If NO, please

explain: _____

10. Are medical records released to third parties without the written consent of the patient ? Yes No
 YES, please explain: _____

BUILDING INFORMATION

Location	1	2	3	4
a. Year of Construction				
b. Number of Stories				
c. Which Stories are Occupied by Applicant?				
d. Area Occupied (sq. ft.)				
e. Number of Fire Escapes / Exits				
f. Number of elevator				
g. Distance to fire station				
h. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Heat Sensors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Smoke Detectors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
i. CONSTRUCTION UPDATES	Year: _____	Year: _____	Year: _____	Year: _____
Plumbing	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
Wiring	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

11. Do you lease or sub-lease to others any portion of the locations listed above? Yes No
 If yes, do you require the tenant(s) carry liability insurance for occupancy? Yes No
 Do you require certificated of insurance? Yes No

12. Is a pool or gymnasium located on premises: Yes No
 If YES, please provide details regarding use and safety precautions:

EMERGENCY & SAFETY PROCEDURES:

13. How often are fire drills conducted? _____

14. Are smoke detectors installed in all hallways and rooms? Yes No

15. How are medical emergencies handled?
 a. On Call Physicians? Yes No
 b. Affiliated Physicians on Premises? Yes No
 c. Hospital and/or emergency center? Yes No
 If YES, is hospital and/or emergency center located within a 15 minute drive under typical conditions? Yes No

d. Other (explain) _____

16. Specify arrangements for storage and dispensing of drugs: _____

STAFF

17. Health Care Professionals

	# Employees/ Contractors Shift 1	# Employees/ Contractors Shift 2	# Employees/ Contractors Shift 3
Administrators			
Clerical			
Counselors			
Dieticians			
Medical Records			
Nurses / Nurse Aides			
Nurse Practitioner / Clinical Nurse Specialist			
Occupational Therapists / Speech & Hearing Therapists			
Pastoral Counselors			
Pharmacists			
Physical Therapists			
Physician / Physician Assistant			
Psychologists			
Respiratory Therapists			
Social Workers			
Volunteers			

(Complete job descriptions must accompany this application for those professionals indicated in Question 28 above.)

18. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Effective Date	Policy Limits	State of Licensur e	License Number	Employee or Contractor	Hours Per Month

Name - Medical Dir.						
Name - Physician						
Name - Physician						

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