

Supplemental Application

An updated renewal questionnaire must be submitted annually for the first three renewal terms provided no material changes have occurred within the organization.

Indicate which term this questionnaire applies to:

- first renewal second renewal third renewal

Include all of the following with this completed & signed renewal questionnaire:

- Completed ACORD Applications Updated statements of value Updated schedule of vehicles/driver list

A. INSURED INFORMATION

Insured Name: _____ Policy Number: _____

Contact Person: _____

Email Address: _____

1. 'X' here if there have been no changes in operation during this year OR

Describe changes in operations or programs during this past year. Include any changes, additions, deletions of operation(s), programs, or internal policies, including types of clients served (use additional pages if necessary, reference websites, brochures, etc...)

2. Has there been a change in management this year? Yes No

3. If licensed, is your license current and in good standing? Yes No

4. Were there any violations or deficiencies noted during the last inspection performed by the licensing agency? Yes No

If Yes, please explain:

5. Are you aware of any claims, allegations, and/or incidences (including abuse & molestation) made against your organization, or against anyone working on your behalf in the past five (5) years that may give rise to a claim? Yes No

B. PROFESSIONAL LIABILITY

1. Do you have any employed, contracted or volunteer Nurse Practitioners? Yes No

If Yes, how many? _____

- a. Do all of your Nurse Practitioners Prescribe medication? Yes No

If Yes, how many Nurse Practitioners prescribe medication? _____

Work in non-medical positions within the scope of the Human Services organization such as managers, educators, directors, nursing duties? Yes No

If No, describe duties: _____

- b. Do your Nurse Practitioners provide services to individuals other than your clients? Yes No

If Yes, please explain: _____

2. Does the Insured use employed, contracted, or volunteer Medical Professionals? Yes No

If Yes, complete the following:

a. Are any Psychiatrists/Nurse Practitioners a member of American Academy of Child & Adolescent Psychiatry (AACAP) Yes No

b. Does any Psychiatrist/MD or Nurse Practitioner perform any clinical or pharmaceutical research on clients? Yes No

If Yes, please explain: _____

c. Does the MD/Nurse Practitioner get informed consent prior to prescribing medications? Yes No

d. Please complete the table below for any psychiatrists, MDs, Nurse Practitioners, Dentists or Optometrists.

NAME	Dr. _____	Dr. _____	Dr. _____
Specialty			
Board Certified or Eligible			
Years in Practice			
License Number			
Hours p/wk for Insured			
Employed or Contracted?			
Does physician/Nurse Practitioner carry own Malpractice insurance?****			
If Yes, does coverage include acts while working for this agency?			
If Yes, does coverage include Contingent Coverage for this agency?			
Any claims in past 5 years?			

****Provide Certificate of Medical Malpractice for each Psychiatrist or Physician and Nurse Practitioner

3. Do you practice cyber counseling? Yes No

If Yes, please answer the following:

a. List states you where currently and plan to practice: _____

b. Do you follow the ACA Code of Ethics? Yes No

c. Do you utilize specialized software to monitor sessions? Yes No

If Yes, please provide name: _____

d. Please provide total number of Cyber Counselors: Full time: _____ Part time: _____

Are all licensed? Yes No

If not, how many are not licensed in Cyber Counseling? Full time: _____ Part time: _____

e. Please provide Cyber Counseling client count: Current year: _____ Expected next year: _____

4. Indicate the number of staff (please complete the following table)

POSITION	EMPLOYEE		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Administrator								
Child Case Worker								
Clergy								
Clerical/Office Staff								
Counselor (other)								
Home Health Aide								
Nurse Practitioner								

POSITION	EMPLOYEE		VOLUNTEERS		CONTRACTORS		INTERNS	
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T
Nurse—LPN								
Nurse—RN								
Nutritionist								
Physician								
Psychiatrist								
Psychologist								
Resident Manager								
Social Worker—Bachelors (BSW)								
Social Worker—Masters (MSW)								
Teacher/Tutor/Aide								
Therapist—Occupational								
Therapist—Physical								
Therapist—Speech/Hearing								
Other Positions (specify)								
Other Positions (specify)								

5. Indicate annual number of clients in each age range for all programs/services:

0–8 years: _____ 9–18 years: _____ over 18 years: _____

6. Professional Liability Deductibles—Optional

(Check one, if no option is selected, no deductible will apply)

1,000 2,500 5,000 10,000 25,000

PANDEMIC AND COMMUNICABLE DISEASE

1. Do you have formal procedures in place to handle pandemic or other communicable diseases? Yes No

a. Do your procedures address:

- i. Staffing Yes No
- ii. Training Yes No
- iii. Personal protective equipment Yes No
- iv. Client care Yes No
- v. Vendors/visitors Yes No
- vi. Internal & external communication Yes No
- vii. Maintenance of premises and vehicles Yes No
- viii. CDC guidelines and recommendations Yes No

b. Please provide a copy of your written procedures

2. Have you ever had to implement those procedures? Yes No

a. If yes, please provide details. _____

DECLARATION AND SIGNATURE

Authorized Entity Representative Designation

The person named herein is authorized and designated to give and receive any and all notices on behalf of the entity and all Insureds from the entity or their authorized representative(s) concerning this insurance.

Named Individual: _____

Title/Position: _____

Date: _____

Attestation

The authorized signer of this application represents to the best of his/her knowledge and belief that the statements and information set forth herein are true and include all material information. The authorized signer also represents that any fact, circumstance or situation indicating the probability of a claim or legal action now known to any entity official or employee has been declared, and it is agreed by all concerned that the omission of such information shall exclude any such claim or action from coverage under the insurance being applied for. Signing of this application does not bind The Hanover Insurance Group, Inc. to offer, nor the authorized signer to accept insurance, but it is agreed this application and any attachments hereto shall be the basis of the insurance and will be incorporated by reference and made part of the policy should a policy be issued.

Signature of Authorized Entity Representative

Date _____

