



Executive Offices:  
33 W. Monroe Street  
Chicago, Illinois 60603

### SUPPLEMENTAL APPLICATION SOCIAL SERVICE 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:  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C. Has license ever been revoked, suspended, placed on probation or restricted in anyway?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: \_\_\_\_\_

**III. FACILITY OPERATIONS:**

C. Please check all that describes your facility's operations:

- Foster Placement Agency  
Estimated annual placements \_\_\_\_\_
- Adoption Placement Agency (Provide copy of written procedures)  
Estimated annual placements \_\_\_\_\_
- Mental Health Counseling Center
- Other, Describe: \_\_\_\_\_

D. Do you provide primary medical services?  Yes  No

If the answer is YES, please explain: \_\_\_\_\_

E. Are pre-natal services provided?  Yes  No

F. 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: \_\_\_\_\_

G. Please check all that describes the type of patients/clients:

- Drug and alcohol abuses  Yes  No
- AIDS  Yes  No
- Mentally Ill  Yes  No
- Mentally Retarded  Yes  No
- Battered/abused  Yes  No
- Ex-Criminal offenders  Yes  No
- Teenage Runaways  Yes  No

H. Are patients/clients:  Permanent  Transitional

I. Are off -premises services provided?  Yes  No

If YES, please give complete details: \_\_\_\_\_

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

K. Is the facility engaged in vocational training activities services?  Yes  No

If YES, please describe the vocational training activities in detail: \_\_\_\_\_

**IV. 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: \_\_\_\_\_

**V. 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: \_\_\_\_\_

**VI. 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