**Community Services Business Unit**

**Community Living Operations Supplemental Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **Not for profit organizations that provide programs/services and supported independent living to clients with disabilities.** | | | |
| **Please note: This supplemental form must be completed in addition to the General Application** | | | |
|  | | | |
| **General Information** | | | |
| Legal Name of Applicant |  | Key Broker Contact |  |
| Mailing Address |  | Brokerage Name |  |
| Postal Code |  | Brokerage Address |  |
| Email |  | Postal Code |  |
| Website |  | Phone and Email |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | |
| **Operations and Licencing Information** | | | | | | | | |
| Indicate all programs/services including any Group Homes | | | | |  | | | |
| Number of Group Homes |  |  | | | | | | |
| Number of Residents in Group Homes |  |  | | | | | | |
| Total number of Supported Independent Living Residents (individuals being supported to enable them to achieve their potential and be independent in the community) | | | | | | | |  |
| Is the Applicant licensed within the Province of Operation? (Please submit a copy of the Ministry License) | | | | YES | |  | NO |  |
| Ratio of caregivers to group home residents | | |  | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is Associate Family Homes cover required? | YES |  | NO |  |
| If yes, please attach copy of Agreement. | | | | |
|  | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
| **Employee Information** | | | |
| **Category** | **# Of Full-Time** | **# Of Part-Time** | |
| Registered Nurses (RN) & Nurses |  |  | |
| Registered Nurse Practitioners (RPN) |  |  | |
| Restorative Nurse Assistants (RNA) |  |  | |
| Counsellors |  |  | |
| Physiotherapist |  |  | |
| Occupational Therapist |  |  | |
| Social Worker |  |  | |
| Personal Support Workers (PSW) |  |  | |
| **Others (include Volunteers)** | **# Of Full-Time** | **# Of Part-Time** | |
|  |  |  | |
|  |  |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are all professionals licensed/certified to practice in the province? | YES |  | NO |  |
| Do all qualified medical staff, including any interns, residents and fellows have professional insurance coverage? |  |  |  |  |
| If yes, do you obtain proof of coverage? | YES |  | NO |  |

|  |
| --- |
| Describe policies/procedures for administering medications (including whether all staff (including non-medical staff) are allowed to do so |
|  |

|  |
| --- |
|  |

|  |
| --- |
| **Activities and Trips** |
| Attach complete details of all **activities** and **trips** off premises (including information on the frequency, duration, purpose and destination, number of residents attending, number of staff, number of volunteers, method of transportation and supervision involved). |

|  |
| --- |
| **If more than one activity or trip (off premises) we must have all the above information for each activity and/or trip** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activities and Trips Non-Owned Automobile Exposure** | | | | |
| Do you hire private transportation (e.g., buses)? | YES |  | NO |  |
| Do staff or volunteers transport residents (for any reason) in their own vehicles? | YES |  | NO |  |
| If yes, do you confirm they always carry a valid driver's license and minimum insurance requirements? | YES |  | NO |  |

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant Acknowledgement** | | | |
|  | | | |
| The undersigned authorized officer of the organization declares that, to the best of his/her knowledge, the statements set forth herein | | | |
| are true. Signing of this application does not bind the Insurer to offer, nor the Applicant to accept Insurance, but it is agreed that this | | | |
| form shall be the basis of the contract should a policy be issued, and this form will be attached to and become part of the policy. | | | |
|  | | | |
| The undersigned, on behalf of the insured organization, acknowledges that any personal information provided in connection with this | | | |
| application (including but not limited to the information contained in this form) has been collected in accordance with applicable | | | |
| privacy legislation and this information shall only be used or shared by the Company to assess, underwrite and price insurance | | | |
| products and related services, administer and service insurance policies, evaluate and investigate claims, detect and prevent | | | |
| fraud, analyze and audit business results and/or comply with regulatory or legal requirements. | | | |
|  | | | |
|  | | | |
| **Applicant Name** |  | **Title/Position** |  |
| **Applicant Signature** |  | **Date** |  |
| **Broker Name** |  |  | |
| **Broker Signature** |  |  | |