**Community Services Business Unit**

**Health And Wellness Operations Supplemental Form**

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| **For all Health and Wellness Operations**  **Risks such as: rehabilitation facilities, family practitioners, respite care facilities, medical diagnostic laboratories, in home nursing care, residential treatment centres, disability support services, youth or group homes and more.** | | | | |
| **Please note: This supplemental form must be completed in addition to the General Application** | | | | |
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| **General Information** | | | | |
| Legal Name of Applicant |  | Key Broker Contact | |  |
| Mailing Address |  | Brokerage Name | |  |
| Postal Code |  | Brokerage Address | |  |
| Email |  | Postal Code | |  |
| Website |  | Phone and Email | |  |
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| **Operations and Licensing Information** | | | | |
| Describe **all** operations of the Applicant including any Group Homes or Treatment Facilities | | | | |
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| Number of Group Homes or Treatment Facilities | | |  | |
| Number of Residents per Group Home or Treatment Facility | | |  | |

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| Ratio of caregivers to group home residents |  |

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| If operations include residents, does owner reside in the Facility? | | | YES | |  | NO |  |
| For Non-Group Home or Treatment Facilities – Number of Residents | | | |  | | | |
| Maximum number of beds |  |  | | | | | |

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| Ratio of caregivers to patient/residents | |  | | | | | |
| What are the criteria for persons to be admitted to the facility? | |  | | | | | |
| What is the age range of the residents of the facility? | |  | | | | | |
| Number of Persons Accessing Service |  | |  | | | | |
| Is there mixed gender in home? | | | | YES |  | NO |  |
| If yes, is there segregation? | | | | | | | |
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| For applicable operations, annual number of client visits/clinical encounters |  |

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| If the Applicant offers respite care (temporary relief for a primary caregiver) do any of the staff stay over night with the clients? | YES |  | NO |  |
| Is the respite care area separate from the facility? | YES |  | NO |  |

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| Is there 24-hour supervision? | YES |  | NO |  |

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| Is the Applicant licensed within the Province of Operation? (Please submit a copy of the Ministry License) | YES |  | NO |  |
| If diagnostic laboratory, indicate the type of diagnostic tests run | | | | |
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| **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** |
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| 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? | YES |  | NO |  |
| 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 | | | | |
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| **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** | | | | |
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| **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 |  |
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| **Applicant Acknowledgement** | | | |
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| 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. | | | |
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| 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. | | | |
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| **Applicant Name** |  | **Title/Position** |  |
| **Applicant Signature** |  | **Date** |  |
| **Broker Name** |  |  | |
| **Broker Signature** |  |  | |