**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 |
|       |
| 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** |       |  |