

International Placement Services, Inc.

101 S. Hanley Rd., Ste 700

St. Louis, MO 63105

ALLIED HEALTHCARE GENERAL APPLICATION

APPLICANT'S INFORMATION:

APPLICANT NAME:	
MAILING ADDRESS:	
COUNTY:	
DATE ESTABLISHED:	
INSPECTION CONTACT:	
PHONE NUMBER:	
Type of Enterprise:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Non-Profit <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other:
Estimated receipts/operating budget for the next 12 months:	
Estimated payroll for the next 12 months:	
Full description of services rendered:	

Current Insurance:			
Has applicant had previous insurance for this enterprise?			<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, complete the following:			
General Liability		Professional Liability	
Current Carrier		Current Carrier	
Policy term		Policy term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	

During the past five (5) years, have any claims been presented to your No Yes current or prior insurance carrier or to you? If yes, complete the following:

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, aware of any circumstances, which may result in a claim? No Yes

Has any license or accreditation ever been suspended, denied or revoked? No Yes

Of what professional association(s) is Insured a member in good standing?

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation.

Criminal Background Checks Reference Checks.

Questioning of employees in their previous involvement as defendants in professional malpractice litigation.

Verification of certification or professional licensing.

Drug, alcohol and sexual abuse screening or testing.

Schedule of Physicians – on Staff or Contracted:					
Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted Or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wish physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If yes, explain.					<input type="checkbox"/> No <input type="checkbox"/> Yes

Is electroshock therapy utilized? If yes, how many per year?	<input type="checkbox"/> No <input type="checkbox"/> Yes
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Schedule of Location: If more than 3 locations, attached a separate sheet of locations	
#1 Address	
Type of Services Provided	
#2 Address	
Type of Services Provided	
#3 Address	
Type of Services Provided	

Services Provided:			
Please indicate the Number of Beds			
Mental Health Inpatient		Group Home	
Alcohol/Drug Inpatient		Shelters	
Alcohol/Drug Detox		Independent Living	
Halfway House		Foster Care (children)	
Apartments		Other (specify)	

Please indicate the Number of annual Outpatient or Client Visits			
Alcohol/Drug Rehab		Counseling	
Mental Health		Methodone	
Please indicate the Number of Clients per day			
Adult Day Care		Partial Hospitalization	
Child Day Care		Sheltered Workshops	
Please indicate the Number of Calls (annually)			
Hotline		Information	
Transport – Emergency		Non - Emergency	
Referral		Other (specify):	
Please indicate the Annual Employee Assistance Programs (EAP) contracts or visits			
Assessments		Counseling Visits	
Referrals		# of co.'s under contract	
Please indicate the Number of Home Health Care Visits			
Nonprofessional hours		IV Therapy	
Professional hours		Other (specify):	
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, describe and submit brochure or detailed narrative of activities.			
Are there any swimming or boating activities? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Is pool fenced with a self-locking gate? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Diving board? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Slide? <input type="checkbox"/> No <input type="checkbox"/> Yes			

<input type="checkbox"/> Residential or Inpatient - complete supplemental application
<input type="checkbox"/> Foster Care or Adoption - complete supplemental application

Check the coverages and limits that the applicant would like quoted.			
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach accord app)
Limits Requested:	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500
	<input type="checkbox"/> 1/1	<input type="checkbox"/> 1/2	<input type="checkbox"/> 1/3
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees?			
At what limits:	<input type="checkbox"/> 25/50	<input type="checkbox"/> 50/100	<input type="checkbox"/> 100/300
	<input type="checkbox"/> 250/250	<input type="checkbox"/> 500/500	<input type="checkbox"/> Other
Higher Abuse limits may be available for select risks.			

Applicant's signature _____

Title _____

Date _____