



## Rehabilitation Supplemental Application New Business

### Instructions:

- This application must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue in the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this supplemental application and the general application are completed and all required documents are provided.

**Name of Applicant:** \_\_\_\_\_  
 (Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

This supplemental application should be completed if your facility provides any of the following rehabilitation services:

- Cardiac Rehabilitation
- Physical or Occupational Rehabilitation
- Trauma Rehabilitation

### A. General Information

1. Specify where services are provided:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Inpatient Acute Care Hospital     | <input type="checkbox"/> Outpatient Clinic       | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Inpatient Rehabilitation Facility | <input type="checkbox"/> Long-Term Care Facility | <input type="checkbox"/> Patient's Home           |
| <input type="checkbox"/> Other (specify): _____            |  |   |

2. Check all services provided:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Aquatic Therapy        | <input type="checkbox"/> Occupational Therapy    | <input type="checkbox"/> Social Services           |
| <input type="checkbox"/> Athletic Training      | <input type="checkbox"/> Orthotics/Prosthetics   | <input type="checkbox"/> Speech/Language/Audiology |
| <input type="checkbox"/> Cardiac Rehabilitation | <input type="checkbox"/> Physical Therapy        | <input type="checkbox"/> Sports Medicine           |
| <input type="checkbox"/> Cognitive Therapy      | <input type="checkbox"/> Recreational Therapy    | <input type="checkbox"/> Trauma Rehabilitation     |
| <input type="checkbox"/> Driving, Adaptive      | <input type="checkbox"/> Sexuality Therapy       | <input type="checkbox"/> Vocational Training       |
| <input type="checkbox"/> Hippotherapy           | <input type="checkbox"/> Other (describe): _____ |  |

3. What types of patient populations are served?

- |   |         |
|---|---------|
| <input type="checkbox"/> Children (birth through age 12)  | _____ % |
| <input type="checkbox"/> Adolescents (ages 13 through 18) | _____ % |
| <input type="checkbox"/> Adults (ages 19 through 64)      | _____ % |
| <input type="checkbox"/> Geriatrics (age 65 and older)    | _____ % |

4. Do all practitioners responsible for patient care have an educational concentration, licensure or certification specific to the age group they are treating?  Yes  No

If no, provide level of education requirements:

\_\_\_\_\_

5. Are diagnostic services provided?  Yes  No

If yes, indicate the type of diagnostic services provided and the percentage of total patients being diagnosed:

\_\_\_\_\_ %

6. Do any patients require skilled medical care and/or life support apparatus?  Yes  No

If yes, indicate the type of patients and the percentage of total patients requiring this type of care:

\_\_\_\_\_ %

## B. Cardiac Rehabilitation

Complete this section if the Applicant provides cardiac rehabilitation services. Please indicate if not applicable:  N/A

1. Are AACVPR guidelines followed?  Yes  No
2. Is a physician available on the premises when the program is in operation?  Yes  No
3. Are patients screened with a stress test?  Yes  No
4. Are all exercises prescribed by a physician or exercise physiologist?  Yes  No
5. Is staff certified in BLS and ACLS?  Yes  No
6. Is emergency equipment (defibrillator, O<sub>2</sub>, emergency medications) available?  Yes  No
7. How often is emergency equipment checked? \_\_\_\_\_
8. Are there written emergency protocols?  Yes  No
9. Are mock code drills conducted?  Yes  No

Explain all no answers in the Comments section.

## C. Overnight Care

Complete this section if the Applicant provides overnight care. Please indicate if not applicable:  N/A

1. If inpatient services are provided, indicate the length of stay and annualized number of patients:

Length of Stay	Annualized number of patients
<input type="checkbox"/> Short stay (up to 14 days)	
<input type="checkbox"/> Mid-term (15 to 29 days)	
<input type="checkbox"/> Long-term (30 days or more)	

2. Provide staffing levels, qualifications and patient to staff ratio: \_\_\_\_\_

3. Describe how patient populations are separated: \_\_\_\_\_

## D. Pools

Complete this section if the Applicant uses a pool. Please indicate if not applicable:  N/A

1. Is the pool owned by the applicant?  Yes  No
2. Is it open to the public?  Yes  No
3. Is a certified lifeguard present?  Yes  No
4. Is the area secured when the pool is not in use?  Yes  No
5. What is the depth of the pool? \_\_\_\_\_ feet
6. Is there an emergency call system in close proximity?  Yes  No
7. Where is the pool located?  Inside  Outside  Other \_\_\_\_\_
8. Are employees allowed to access the pool?  Yes  No
9. Is there a life saving flotation device near the pool?  Yes  No
10. How is access controlled? \_\_\_\_\_

