Supplemental Questionnaire: **Home Healthcare/ Hospice/ Medical Staffing/ DME**

Instructions:

1. This application must be completed in conjunction with the Pro-Praxis Allied Healthcare Application.
2. Answer ALL questions completely, leaving No blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.
3. This application must be completed, dated and signed by a Principal or Officer of your firm. Underwriters will rely on all statements made in this application.

Applicant Name: _____

1. Is your business involved in:
   ☐ Home Health Care ☐ Hospice ☐ Medical Equipment Supplier
   ☐ Medical Staffing Agency ☐ Telemonitoring (specify): ___ ☐ Other (specify): ___

2. Where do you provide services?
   Private Home ___% Doctor's Office/Clinic ___% Hospital ___%
   Hospice ___% Nursing Home ___% Child Day Care ___%
   Surgicenter ___% Adult Day Care ___% Other ___%

3. Do you employ: ☐ Skilled: ___% ☐ Unskilled: ___%

4. Do you place any:
   a. Physicians incl., Psychiatrists, Osteopaths, Dentists or Chiropractors ☐ Yes ☐ No
   b. Nurse Practitioners or Physician Assistants ☐ Yes ☐ No

5. Do any of your employees staff the:
   a. Emergency Room ☐ Yes ☐ No
   b. Labor & Delivery Rooms ☐ Yes ☐ No
   c. Intensive Care Units ☐ Yes ☐ No
   d. Surgical Units ☐ Yes ☐ No
   If yes, please specify the number of employees in each category: _____

6. Does your operation include 50% or more of the following advanced skilled care:
   a. Infusion Therapy ☐ Yes ☐ No
   a. Trach/Ventilator Therapy ☐ Yes ☐ No
   b. Chemo/Radiation therapy ☐ Yes ☐ No
   c. Obstetrical/ Doula ☐ Yes ☐ No
   d. Special Care (Alzheimer's/ Demetia) ☐ Yes ☐ No

This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICANT'S NAME AND TITLE: _____

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APPLICANT'S SIGNATURE: _____ DATE: _____

(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: _____ DATE: _____ _____