GenStar

SUPPLEMENTAL APPLICATION

HOME HEALTH CARE & HOSPICE CARE
MISCELLANEOUS HEALTHCARE FACILITIES

This application must be completed, signed and dated by the applicant. All questions must be answered completely. The information is required to make an underwriting and pricing evaluation. Your answers are considered legally material to that evaluation. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please provide the details in the Additional Information section of this form or you may attach a separate page using your letterhead. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

I. GENERAL INFORMATION

1	Applicant Name:
	Entity Name:

II. OPERATIONS

1 Types of services provided and exposes (include all that apply):

	Annual Visits		
Types of Services	Projected Year	Past Year	Second Past Year
☐ Home Care – Personal Care			
☐ Home Care – Skilled Care			
☐ Home Care – Rehabilitation			
☐ Home Care – Intravenous Therapy			
☐ Home Care – Kidney Dialysis			
☐ Home Care – Respiratory Therapy			
☐ Hospice Care			
☐ Hospital Care			
☐ Nursing Home Care			
☐ Obstetrical Care			
☐ Infant Care			
☐ Adult Care			
☐ Nurse Registry, Visiting Nurse, Other			
☐ Staffing Agency			
☐ Other:			

Type of Service:	Projected Year	Past Year	Second Past Year
☐ Home Care – Durable Medical Equipment			
☐ Retail Pharmacy			
☐ Closed Pharmacy			
☐ Other:			

III. ADDITIONAL INFORMATION

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.

Section # and Question #	**Comments**

Signature:	Date: