



# COMMUNITY HEALTH CENTER RENEWAL APPLICATION

### Instructions:

- Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
- All application questions must be fully answered. If a question does not apply, please write "N/A".
- If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

1. **Name of Applicant:** \_\_\_\_\_

(Provide names of all legal entities past and present that are intended for coverage. This would include any additional entities acquired this past year).

2. Do you want to change your current insurance structure?  Yes  No
3. Has the applicant had any change to their business operations over the past 12 months?  Yes  No  
If "Yes" have the exposures and losses been included with this application?  Yes  No
4. Are there any plans to acquire other facilities within the next 12 months?  Yes  No
5. Has there been any change in where services are provided?  Yes  No

**If the answer is "yes" to any of the above, provide details on a separate sheet of your letterhead.**

6. Are you designated as a Federally Qualified Health Center (FQHC)  yes  no.

7. Type of Facility (check all that apply):

- Critical Access Hospital Based
- Free Standing
- Provider Based (unit of hospital, nursing home, or home health agency)
- Other (Describe): \_\_\_\_\_

8. What population do you service?

The Public Housing Primary Care Program (PHPC) \_\_\_\_\_%

Elderly \_\_\_\_\_% Migrant \_\_\_\_\_%

Homeless \_\_\_\_\_% School based \_\_\_\_\_%

Other \_\_\_\_\_% Describe: \_\_\_\_\_

9. Current Number of Patients: \_\_\_\_\_

- a. Typical % of pediatric patients \_\_\_\_\_%
- b. Typical % of adult patients \_\_\_\_\_%

10. Indicate % of Gross Receipts by Type of Care and Visits. "Visits" are defined as the number of patients entering the facility for health related services per year.

Services Provided	% of Gross Receipts	Projected Annual Number of Visits/Revenue as noted
Adult Primary Health Care	%	#
Behavioral Health – indicate number of visits in sections below	%	N/A
Substance Abuse Counseling	N/A	#
Mental Health Counseling	N/A	#
Chronic Disease Management, e.g. asthma, obesity, diabetes	%	#
Clinical Trials	%	#



Services Provided	% of Gross Receipts	Projected Annual Number of Visits/Revenue as noted
Dental Care	%	#
Emergency Care/Urgent Care	%	#
Eye Care	%	#
Home Health Care	%	#
Imaging Services, e.g. x-ray, ultrasound	%	#
Immunizations, including tetanus diphtheria and influenza	%	#
Insurance Eligibility Screening and Enrollment	%	#
Invasive Procedures/Minor surgery(describe)	%	#
Laboratory Testing – indicate revenue		\$
Medical Referral Services	%	#
Medical Social Services	%	#
Methadone Dispensing – indicate revenue		\$
Nutritional Counseling	%	#
Pediatric Primary Health Care		#
Pre-employment physical exams	%	#
Social Services	%	#
TB Testing	%	#
Women’s Health Care – Indicate number in sections below	%	
Abortions	N/A	#
Breast examination;	N/A	#
D&C’s (dilatation and curettage)	N/A	#
Family planning services	N/A	#
Mammography Referral	N/A	#
Obstetrical Deliveries	N/A	#
Post-partum care	N/A	#
Prenatal care	N/A	#
Other (_____)	%	
Other (_____)	%	

11. Do you have after hours coverage?  Yes  No.  
 If yes, please describe: \_\_\_\_\_
12. Do you provide a flu shot program?  yes  no  
 If “yes”, what is the expected number of clients? \_\_\_\_\_  
 Do you provide a follow-up phone number to the patients in the event of a reaction to the vaccination?  yes  no
13. Do you use volunteers?  yes  no  
 If “yes”, what type of services do they provide? \_\_\_\_\_  
 If “yes” do all volunteers undergo a criminal background check?  yes  no



14. Do you operate a Pharmacy?  yes  no  
 a. If "yes", Receipts \$ \_\_\_\_\_  
 b. If the Applicant is selling or distributing pharmaceuticals/ medications are the drugs being sold /distributed, is the applicant:  packaging  compounding, or  performing admixture?  
 c. Does the pharmacy dispense controlled narcotics?  yes  no
15. Do you operate a CLIA approved laboratory?  yes  no  
 a. If "yes", Receipts \$ \_\_\_\_\_
16. Provide an updated loss history dated within 60 days for the past 5 years (including the current year) on a report-year basis. Loss data must include the incident/occurrence date, report date/claim made date, expense payments, indemnity payments, expense reserves, indemnity reserves, description of allegation and close date.

### AUTHORIZATION

Signature in full

Date

Name - please print

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

**This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation**