

REGISTRATION OF CHARITABLE HEALTH CARE PROVIDERS

KRS 304.40-075

CHARITABLE HEALTH CARE PROVIDER INFORMATION:

NAME _____

ADDRESS _____

CITY _____

STATE & ZIP _____

OFFICE PHONE _____

LICENSE # _____

IF A CLINIC POLICY, PLEASE LIST ALL LICENSED PROVIDERS RENDERING MEDICAL CARE COVERED UNDER THE POLICY:

LICENSE #	PROVIDER	ADDRESS	STATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MALPRACTICE INSURANCE COMPANY: _____

POLICY PERIOD _____ POLICY # _____

EXPECTED # OF PATIENTS FOR THE POLICY YEAR: _____

ARE SERVICES RENDERED THROUGH A SPONSORING ORGANIZATION **REGISTERED** WITH THE CABINET FOR HUMAN RESOURCES?

YES ___ NO ___

LIST THE COUNTY(IES) THE PROVIDERS COVERED BY THIS POLICY WILL SERVE:

WHO ARE THE INTENDED RECIPIENTS (patients) OF SERVICES RENDERED BY THIS CHARITABLE HEALTH CARE PROVIDER? _____

WHAT TYPE OF SERVICE WILL THIS PROVIDER RENDER? (e.g. Family Practice, Pediatrics, Internal Medicine, OB/GYN) _____

PROVIDER TYPE:

PHYSICIAN _____ NURSE PRACTITIONER _____

NURSE MIDWIFE _____ PHYSICIAN ASSISTANT _____

OTHER (please explain) _____

WHAT DATES WILL THE SERVICES BE PROVIDED TO THE INTENDED PARTICIPANTS: _____

EMPLOYMENT STATUS:

PRIVATE PRACTICE _____ HOSPITAL STAFF _____

FULL TIME VOLUNTEER _____ # OF HOURS PER WEEK _____

PART TIME VOLUNTEER _____ # OF HOURS PER WEEK _____

NOTORIZED STATEMENT

I hereby acknowledge that I will adhere to all risk management and loss prevention policies and procedures of _____ Insurance Company and do hereby affirm that this is the only medical professional liability insurance policy which covers me or the aforementioned facility. I acknowledge that my license or certificate has never been suspended or revoked and I will not render services outside the scope of practice authorized in my license or certificate.

NOTARY:

State of _____

County of _____

This instrument was signed or acknowledged before me on _____, 20 ___ by _____.

Signed by Notary Public _____

My Commission expires: _____

Affix Notary Seal

**KENTUCKY DEPARTMENT OF INSURANCE
PROPERTY & CASUALTY DIVISION**

The Kentucky Department of Insurance welcomes you as a new Charitable Healthcare Provider.

Our Department reimburses medical malpractice premiums for Charitable Clinics/Care givers (e.g. M.D.s, R.N.s) **as long as** they are in no way compensated for their services.

Providers must be registered with the Kentucky Department of Public Health. If you are not registered you may do so at:

<https://chfs.ky.gov/agencies/dph/dpqi/hcab/Pages/charitablehc.aspx>

If you have any additional questions about the Department of Public Health Registration, you may contact:

Kasey R. Padgett, Health Program Administrator
Health Care Access Branch
Prevention & Quality Improvement
Department for Public Health
275 East Main Street, HS2W-B
Frankfort, KY 40621
Office: (502) 564-8966 ext. 4003
Fax: (502) 564-0655

When requesting the Charitable Healthcare Reimbursement, you are required to submit the following:

- 1) Reimbursement form
- 2) Cancelled check for the premium paid (front & back)
- 3) Copy of the entire insurance policy with the declaration pages
- 4) Copy of the registration form you received from the Department of Public Health

The Department only reimburses the premiums that have already been paid by the doctor/clinic etc...

If we can be of further assistance, please do not hesitate to contact us.

Sincerely,

Jacinda Spencer
Administrative Specialist III
Property & Casualty Branch
Kentucky Department of Insurance
PO Box 517
Frankfort, KY. 40602-0517
502-782-1417
Jacinda.Spencer@ky.gov

REQUEST FOR REIMBURSEMENT

FACILITY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____

MAKE CHECK PAYABLE TO: _____

AMOUNT OF CHECK: _____

COMPANY INSURED BY: _____

POLICY NUMBER: _____

POLICY PERIOD: _____

MAIL TO: PROPERTY & CASUALTY DIVISION
KENTUCKY DEPARTMENT OF INSURANCE
PO BOX 517
FRANKFORT, KY 40602

PHYSICAL ADDRESS:
500 MERO STREET
2 SE 11
FRANKFORT, KY 40601

PHONE: (502) 564-6046

FAX: (502) 564-2728

[EMAIL: DOI.PropertyCasualty@ky.gov](mailto:DOI.PropertyCasualty@ky.gov)