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:

Shellie Wingate, Health Program Administrator
Division of Prevention and 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,

Cherish Knight
Administrative Specialist III
Property & Casualty Branch
Kentucky Department of Insurance
PO Box 517
Frankfort, KY. 40602-0517
502-782-5324
cherish.knight@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