# DANE COUNTY APPLICATION

# FOR CCS SERVICE PROVIDERS

Revised: 5.18.18

**APPLICATION SUMMARY**

|  |  |
| --- | --- |
| **ORGANIZATION LEGAL NAME** |  |
| **MAILING ADDRESS**If P.O. Box, include Street Address on second line |       |
| **TELEPHONE** |       | **LEGAL STATUS** |
| **FAX NUMBER** |       | [ ]  Private, Non-Profit[ ]  Private, For ProfitFederal EIN:       DUNS Number:       |
| **NAME CHIEF ADMIN/ CONTACT** |       |
| **INTERNET WEBSITE****(if applicable)** |       |
| **E-MAIL ADDRESS** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **CCS CONTACT PERSON** | **CCS CONTACT TITLE** | **PHONE NUMBER** | **E-MAIL** |
|       |       |       |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **FISCAL OR ACCOUNTING FIRM CONTACT PERSON** | **FISCAL CONTACT TITLE** | **PHONE NUMBER** | **E-MAIL** |
|       |       |       |       |

**I hereby attest that all statements made in this application and any attachments are correct to the best of my knowledge and that I will comply with all laws, rules, and regulations governing Comprehensive Community Services for persons with mental disorders and substance-use disorders. I have reviewed** [**Chapter DHS 36**](http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/36.pdf)**.**

|  |  |  |
| --- | --- | --- |
|  |  |       |
| Signature of Legal Representative/Organization Head |  | Title |
|       |  |       |
| Printed Name  |  | Date |

**SECTION 1. AGENCY BACKGROUND**

1. Date Business Originally Established
2. Number of Years Under Current Ownership
3. How many years have you been doing business under your present firm or trade name?

       years

1. Please list any other names under which this business may have operated:

|  |
| --- |
|       |
|       |

1. Total number of current employees (CCS + non-CCS):

       Full-time

       Part-time

       Independent Contractors

1. If you are working with an accounting firm to handle fiscal operations, how long have you worked with this firm?

|  |  |
| --- | --- |
| [ ]  | Less than 2 years |
| [ ]  | 2 years or more |
| [ ]  | Not working with an accounting firm |

1. Please provide information on the employees in your organization who will have CCS fiscal responsibilities, such as billing and claiming, payroll, etc.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  | **Job Title** | **Percent of Time Spent Per Week on Fiscal Duties** | **If Less than 100% of Time is Spent on Fiscal Duties, Describe the Other Duties** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

1. Please provide information on the accounting/auditing practices of your organization.

| **Statement** | **Yes** | **No** |
| --- | --- | --- |
| 1. Agency maintains accounting records in accordance with Generally Accepted Accounting Principles (GAAP). GAAP is the general guidelines and principles, standards and detailed rules, plus industry practices that exist for financial reporting. (If you are unsure or don’t know, please mark No.)
 | [ ]  | [ ]  |
| 1. Agency maintains a uniform double entry accounting system which is compatible with cost accounting and generally accepted accounting principles.
 | [ ]  | [ ]  |
| Name of accounting system:       |  |  |
| 1. Agency maintains a cost allocation plan with costs allocated in a manner consistent with these plans.
 | [ ]  | [ ]  |
| 1. Agency audit is performed annually by an independent, outside party in accordance with generally accepted auditing standards.
 | [ ]  | [ ]  |
| Name of auditing agency:       |  |  |
| 1. Has the most recent audit revealed any significant or ongoing concerns?
 | [ ]  | [ ]  |

1. Is your agency currently DHS 35 (Outpatient Mental Health Clinics) or 75 (Community Substance Abuse Service Standards) certified?

|  |  |
| --- | --- |
| [ ]  | Yes, DHS 35 certified |
| [ ]  | Yes, DHS 75 certified |
| [ ]  | Yes, DHS 35 and 75 certified |
| [ ]  | No |

**SECTION 2: OTHER CCS CERTIFICATION**

Please list the CCS Programs in Wisconsin for which you or your organization provides service facilitation or other services to CCS clients.

|  |  |  |
| --- | --- | --- |
| County/Region/Tribe | Services Provided | Dates Services Provided |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

**SECTION 3: CCS PSYCHOSOCIAL REHABILITATION (PSR) SERVICE ARRAY**

1. **SERVICES:** Check all of the service for which you request approval to offer in Dane County’s CCS program. Definitions for each service may be found in the on-line ForwardHealth Handbook for Comprehensive Community Services found at: <https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=12&s=2&c=61> .

|  |  |  |
| --- | --- | --- |
| [ ]  | 1.  | Screening and Assessment. |
|  |  |  |
| [ ]  | 2. | Service Planning. |
|  |  |  |
| [ ]  | 3. | Service Facilitation. |
|  |  |  |
| [ ]  | 4. | Diagnostic Evaluations |
|  |  |  |
| [ ]  | 5. | Medication Management |
|  |  |  |
| [ ]  | 6. | Physical Health Monitoring |
|  |  |  |
| [ ]  | 7. | Peer Support |
|  |  |  |
| [ ]  | 8. | Individual Skill Development and Enhancement |
|  |  |  |
| [ ]  | 9. | Employment Related Skill Development |
|  |  |  |
| [ ]  | 10. | Individual and/or Family Psychoeducation |
|  |  |  |
| [ ]  | 11. | Wellness Management and Recovery/Recovery Support Services |
|  |  |  |
| [ ]  | 12. | Psychotherapy |
|  |  |  |
| [ ]  | 13. | Substance Abuse Treatment |
|  |  |  |

**SECTION 4: CCS SERVICE DESCRIPTION**

The following information will be used to set up the services in the web-based application. This will be used by Service Facilitators who may be searching for services for clients. This information will also be incorporated into a directory of CCS services that will appear in an on-line service directory made available to the general public.

1. **AGE GROUPS SERVED** (Check all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Prenatal |  | [ ]  | 60-64 |
| [ ]  | Birth – 3 |  | [ ]  | 65-69 |
| [ ]  | 4-12 |  | [ ]  | 70-74 |
| [ ]  | 13-17 |  | [ ]  | 75-79 |
| [ ]  | 18-21 |  | [ ]  | 80-84 |
| [ ]  | 22-49 |  | [ ]  | 85+ |
| [ ]  | 50-54 |  | [ ]  | Other: Specify |
| [ ]  | 55-59 |  |  |       |

1. **SPECIAL POPULATIONS SERVED** (Check all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Abuse/Neglect, Victim of |  | [ ]  | Homeless |
| [ ]  | ADD/ADHD |  | [ ]  | Immigrant or Undocumented |
| [ ]  | Alcoholic/Alcohol Impaired |  | [ ]  | Juvenile Delinquent(s) |
| [ ]  | Alzheimer’s Disease/Related Dementia |  | [ ]  | LBGT |
| [ ]  | Blind/Visually Impaired |  | [ ]  | Mentally Ill |
| [ ]  | Deaf/Hard of Hearing |  | [ ]  | Migrant |
| [ ]  | Developmental Disability – Autism |  | [ ]  | Physically Disabled/Mobility Impaired |
| [ ]  | Developmental Disability – Brain Trauma |  | [ ]  | Pregnant Teens |
| [ ]  | Developmental Disability – Cerebral Palsy |  | [ ]  | Rape/Incest/Sexual Assault, Victim of  |
| [ ]  | Developmental Disability – Cognitive Imp. |  | [ ]  | Refugee |
| [ ]  | Developmental Disability - Epilepsy |  | [ ]  | Severe Emotional Disturbance |
| [ ]  | Developmentally Disabled |  | [ ]  | Sexual Offender |
| [ ]  | Domestic Violence, Victim of |  | [ ]  | Trauma Informed |
| [ ]  | Drug Impaired |  | [ ]  | Unmarried Parents |
| [ ]  | Gambling Client |  | [ ]  | Other: Specify |
|  |  |  |  |       |

1. **GENDER SERVED** (For gender specific services only. Check that which applies.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Females |  | [ ]  | Males |
| [ ]  | Gender, non-conforming |  | [ ]  | Transgender |

1. **SPECIAL RESTRICTIONS**

In the following space, please provide a description of any restrictions on the type of the population you intend to serve.

|  |
| --- |
|       |

1. **SERVICE LOCATIONS** (Please record the locations of any key facilities where services may be provided.)

|  |  |  |
| --- | --- | --- |
| Building Name | Street Address | City |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

Do you provide community-based services?

|  |  |
| --- | --- |
| [ ]  | Yes |
| [ ]  | No |

1. **SERVICE DAYS AND HOURS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Check if Open | Day of the Week | Opening Time | Please Indicate A.M. or P.M. | Closing Time | Please Indicate A.M. or P.M. |
| [ ]  | Sunday |       |       |       |       |
| [ ]  | Monday |       |       |       |       |
| [ ]  | Tuesday |       |       |       |       |
| [ ]  | Wednesday |       |       |       |       |
| [ ]  | Thursday |       |       |       |       |
| [ ]  | Friday |       |       |       |       |
| [ ]  | Saturday |       |       |       |       |

1. **SERVICE DESCRIPTION**

In the following space, please provide a description of the services (beyond that in the ForwardHealth service array) that will be provided. Attach additional sheets as necessary. This description may be used for marketing purposes. It will be included in the resource directory that will be made available to clients and service facilitators who will be identifying the resources that will be part of the clients’ recovery plans.

|  |
| --- |
|       |

**SECTION 5: EVIDENCE-BASED PRACTICE**

1. **EVIDENCE-BASED PRACTICE (EBP)**

Please indicate below with an “X” which of the listed Evidence-Based Practices (EBPs) will be offered to CCS clients and whether this EBP is being fully or partially implemented in your organization.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Evidence-Based Practice (Adults) | Yes, Implemented – Fully(X) | Yes, Implemented Partially(X) | Not Offered(X) |
| a. | Integrated Treatment for Co-Occurring Disorders (IDDT) |       |       |       |
| b. | Family Psychoeducation |       |       |       |
| c. | Illness Management and Recovery (IMR) |       |       |       |
| d. | MedTEAM |       |       |       |
| e. | Supported Employment |       |       |       |
| f. | Permanent Supportive Housing |       |       |       |
| g. | Tobacco Cessation Bucket Approach |       |       |       |
| h. | Motivational Interviewing |       |       |       |
| i. | Other, Specify: |       |       |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Evidence-Based Practice (Children) | Yes, Implemented – Fully(X) | Yes, Implemented Partially(X) | NotOffered(X) |
| h. | Multisystemic Therapy (MST) |       |       |       |
| i. | Functional Family Therapy (FFT) |       |       |       |
| j. | Parent-Child Interactive Therapy (PCIT) |       |       |       |
| k. | Trauma-Focused Cognitive Behavior Therapy (TF-CBT) |       |       |       |
| l. | Trauma-Informed Child-Parent Psychotherapy (TI-CPP) |       |       |       |
| m. | Motivational Interviewing |       |       |       |
| n. | HeartMath |       |       |       |
| o. | Other, Specify: |       |       |       |

1. **EBP FIDELITY**

Please complete the following items for each EBP listed above which will be offered to CCS clients.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Evidence-Based Practice (EBP) | Have CCS staff been specifically trained to implement this EBP? (Yes/No) | Did you use the EBP’s toolkit to guide your implementation?(Yes/No) | Do you monitor fidelity for this EBP?(Yes/No) | Do you use an outside monitor to review fidelity for this ECP?(Yes/No) |
|       |       |       |       |       |
|  | Fidelity Measure Used: |       |
|       |       |       |       |       |
|  | Fidelity Measure Used: |       |
|       |       |       |       |       |
|  | Fidelity Measure Used: |       |

**SECTION 6: CCS STAFF SUPERVISION AND CLINICAL COLLABORATION**

In accordance with DHS 36.11, all CCS staff are required to be supervised and provided with the consultation needed to perform assigned functions to ensure effective service delivery.

Staff qualified under DHS 36.10(2)(g) 1. to 8. which includes: psychiatrists, physicians, psychiatric residents, psychologists, licensed independent clinical social workers, professional counselors and marriage and family therapists, adult psychiatric and mental health nurse practitioners, and advanced nurse prescribers shall participate in at least one hour of either clinical supervision or clinical collaboration per month for every 120-clock hours of face-to-face psychosocial rehabilitation or service facilitation they provide. Please indicate below by checking the appropriate box(es), how this supervision will be provided for this staff in your agency.

|  |  |  |
| --- | --- | --- |
| Check if Providing | Supervision and/or Clinical Collaboration to be Provided | Name of Person(s) Providing the Supervision and/or Clinical Collaboration |
| [ ]  | Individual sessions with the staff member case review to assess performance and provide feedback |       |
| [ ]  | Individual side-by-side session in which the supervisor is present while the staff member provides assessments, service planning meetings, or psychosocial rehabilitation services and in which the supervisor assesses, teaches, and gives advice regarding the staff member’s performance. |       |
| [ ]  | Group meetings to review and assess staff performance and provide the staff member advice or direction regarding specific situations or strategies. |       |
| [ ]  | Another form of professionally recognized method of supervision designed to provide sufficient guidance to assure the delivery of effective services to consumers by the staff member. |       |

Staff qualified under DHS 36.10(2)(g) 9. to 22. which includes: certified social workers, certified advance practice social workers, certified independent social workers, psychology residents, physician assistants, registered nurses, occupational therapists, master’s level clinicians, alcohol and drug abuse counselors, certified occupational therapy assistants, licensed practical nurses, peer specialist, rehabilitation workers, clinical students, and other professionals are to receive, from a staff member qualified under DHS 36.10(2)(g) 1. to 8. day-to-day supervision and consultation and at least one hour of supervision per week or for every 30 clock hours of face-to-face psychosocial rehabilitation services or service facilitation they provide. Day–to-day consultation shall be available during CCS hours of operation. Please indicate below by checking the appropriate box(es), how this supervision will be provided for this staff in your agency.

| Check if Providing | Supervision and/or Consultation to be Provided | Name of Person(s) Providing the Supervision and Consultation |
| --- | --- | --- |
| [x]  | Day-to-day supervision and consultation **AND** |       |
| [ ]  | At least one hour of supervision per week **OR** |       |
| [ ]  | At least one hour of supervision for every 30 clock hours of face-to-face psychosocial rehabilitation services or service facilitation provided. |       |

Clinical supervision and clinical collaboration records shall be dated and documented with the signature of the person providing supervision or clinical collaboration. Please indicate below by checking the appropriate box(es), how this will be documented for staff in your agency.

|  |  |
| --- | --- |
| Check if Means of Documentation | Documentation Type |
| [ ]  | The master log. |
| [ ]  | Supervisory records. |
| [ ]  | Staff record of each staff member who attends the session or review. |
| [ ]  | Consumer records. |

**SECTION 7: CCS STAFF LISTING**

Complete the attached CCS Staff Listing chart for all staff who will be providing services under the CCS Program. Include staff providing clinical supervision and collaboration. Be sure to attach to the application, the completed Background Information Disclosure (BID) form, the response from the Department of Justice (DOJ) Wisconsin Criminal History Record Request, and the response letter or print out from the web site for the Department of Health Services report on the person’s status.

If service facilitation services will be provided, please identify in the space below how Mental Health Professional services will be provided:

|  |
| --- |
|       |

**SECTION 8: LEGAL INFORMATION**

|  |  |  |
| --- | --- | --- |
| **Statement** | **Yes** | **No** |
| Has the applicant or any owner been involved in any lawsuits or judgments in the last five (5) years or have any lawsuits pending? | [ ]  | [ ]  |
| Has the applicant or any owner been involved in any bankruptcy or insolvency proceedings or have any proceedings pending? | [ ]  | [ ]  |

Please attach a detailed explanation for any YES responses.

**SECTION 9: APPLICATION ATTACHMENTS**

A completed application is to include both the agency and staff materials cited below:

Agency Materials

|  |  |
| --- | --- |
| [ ]  | Signed, completed application; |
| [ ]  | IRS Form W-9 (Request for Taxpayer Identification Number and Certification); |
| [ ]  | Copy of personnel policies delineating the non-discrimination, background checks, and misconduct reporting; |
| [ ]  | CCS Staff Listing Chart. |
| [ ]  | Fair Labor Practices Certification form, signed and dated |
| [ ]  | Usual and customary rate schedule |
| [ ]  | Rate Proposal Template (if Usual and Customary Rates are higher than county interim rates) (must be submitted electronically) |
| [ ]  | Certificates of Insurance |
|  |  |
|  |  |

Staff Materials

For each person who will be providing CCS services, please provide:

|  |  |
| --- | --- |
| [ ]  | Resume; |
| [ ]  | Degree, License, or Rehab Worker training verification; |
| [ ]  | Two (2) professional references in the form of a professional reference letter or reference check; |
| [ ]  | Background Information Disclosure Form (HFA-64A); |
| [ ]  | Department of Justice “No Record Found” or criminal record transcript; |
| [ ]  | Department of Health Services Response to Caregiver Background Check (IBIS) letter or on-line print out. |

|  |  |
| --- | --- |
| Agency Name: |       |

**CCS STAFF LISTING – Chapter DHS 36**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name**(Last, First, MI) | **Position Description** | **Credentials/****License Number** | **Functions and Qualifications** | **FTE %** | **Caregiver Misconduct****Background Checks – Dates Conducted** |
|  |  |  | Functions1 – MH Professional2 – Administrator3 – Serv Director4 – Serv Facilitator5 – Services Array | Minimum Qualifications Per DHS 36.10 (c)1-81-141-21Any | **E** = Employed (full or part time)**C** = Contracted | **BID**(Mon/Yr) | **DOJ**(Mon/Yr) | **DHS****IBIS**(Mon/Yr) | **Review within last 4 yrs/** |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name**(Last, First, MI) | **Position Description** | **Credentials/****License Number** | **Functions and Qualifications** | **FTE %** | **Caregiver Misconduct****Background Checks – Dates Conducted** |
|  |  |  | Functions1 – MH Professional2 – Administrator3 – Serv Director4 – Serv Facilitator5 – Services Array | Minimum Qualifications Per DHS 36.10 (c)1-81-141-21Any | **E** = Employed (full or part time)**C** = Contracted | **BID**(Mon/Yr) | **DOJ**(Mon/Yr) | **DHS****IBIS**(Mon/Yr) | **Review within last 4 yrs/** |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
|       |       |       |       |       |       | ☐E☐C |       |       |       | ☐Y☐N |
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| **FAIR LABOR PRACTICES CERTIFICATION****Dane County Ordinance 25.11(28)** |

The undersigned, for and on behalf of the PROPOSER, BIDDER OR APPLICANT named herein, certifies as follows:

1. That he or she is an officer or duly authorized agent of the above-referenced PROPOSER, BIDDER OR APPLICANT, which has a submitted a proposal, bid or application for a contract with the county of Dane.

That PROPOSER, BIDDER OR APPLICANT has: (Check One)

\_\_\_\_\_\_\_\_ not been found by the National Labor Relations Board (“NLRB”) or the Wisconsin Employment Relations Commission (“WERC”) to have violated any statute or regulation regarding labor standards or relations in the seven years prior to the date this Certification is signed.

\_\_\_\_\_\_\_\_ been found by the National Labor Relations Board (“NLRB”) or the Wisconsin Employment Relations Commission (“WERC”) to have violated any statute or regulation regarding labor standards or relations in the seven years prior to the date this Certification is signed

Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Officer or Authorized Agent

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Business Name

**NOTE: You can find information regarding the violations described above at:** [www.nlrb.gov](http://www.nlrb.gov) **and** <http://werc.wi.gov>.

**For Reference Dane County Ord. 28.11 (28) is as follows:**

**(28)** BIDDER RESPONSIBILITY. **(a)** Any bid, application or proposal for any contract with the county, including public works contracts regulated under chapter 40, shall include a certification indicating whether the bidder has been found by the National Labor Relations Board (NLRB) or the Wisconsin Employment Relations Committee (WERC) to have violated any statute or regulation regarding labor standards or relations within the last seven years. The purchasing manager shall investigate any such finding and make a recommendation to the committee, which shall determine whether the conduct resulting in the finding affects the bidder’s responsibility to perform the contract.

If you indicated that you have been found by the NLRB or WERC to have such a violation, you must include a copy of any relevant information regarding such violation with your proposal, bid or application.

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| **Certificate of Insurance** |

Please attach all required Certificates of Insurance (COI) to this application and verify requirements of coverage below.

The following are required:

* The COI must list a minimum General Liability of $1,000,000, minimum Auto Liability of $1,000,000, and minimum Professional Liability of $1,000,000
* Dane County must listed as additional insured for Commercial General Liability
* The policy number must be listed for each type of insurance
* The policy dates must be current
* The name on the COI must match the agency name on the contract as it is listed with the Wisconsin Department of Financial Institutions (DFI).

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| **Insurance Type** | **Requirements** | **Check if appropriate COI documentation is attached** | **Check if policy is active** |
| Commercial General Liability | Required | [ ]  | [ ]  |
| Dane County Must be listed as an additional insured | [ ]  |  |
| Automobile Liability | Required | [ ]  | [ ]  |
| Professional Liability | Required | [ ]  | [ ]  |
| Worker’s Compensation | Required | [ ]  | [ ]  |