Department Malpractice Insurance Premium Grant Application

1. Applicant Name: _____
2. Applicant Address: _____
3. Applicant Phone Number: _____
4. Applicant Email Address: _____
5. State Vendor Number: _____
6. Amount Requested: _____
7. Malpractice Premium Increase Amount: _____

The above information and the enclosed documents are accurate to the best of my knowledge.

_____ Date: _____
Applicant Designated Authority Signature
Print Name:
Title:

_____ Date: _____
Department Designated Authority Signature
Print Name:
Title:

Please submit the following documentation with your application:

a. A copy of your current malpractice liability insurance declaration page.

b. A copy of licensure and/or certification to practice in the State of NH. (See RSA 151:2, I(d) and NH Administrative Rule He-P 810.03(j)[1] Residential Care and Health Care Facility Licensing[2])

c. Proof of malpractice insurance rate increase from March 13, 2019 to June 30, 2023.

[1] Chapter 151 RESIDENTIAL CARE AND HEALTH FACILITY LICENSING (state.nh.us)
[2] https://gencourt.state.nh.us/rules/state_agencies/he-p800.html

Appendix C – Malpractice Insurance Premium Reimbursement Application

Applicants must submit all required documentation with application. Incomplete applications will not be considered. Completed application and supporting documents must be submitted electronically to:

State of New Hampshire
Department of Health and Human Services
Bureau of Contracts and Procurement
Attn: Christy Adamson
Email: christy.d.adamson@dhhs.nh.gov