HCFM
Health Care Facilities of Missouri
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Health Care Facilities of Missouri

APPLICATION PROCEDURE

1. Complete the attached questionnaire
2. Provide 3-5 years prior claims history (Loss Runs)
3. Provide copy of most recent experience rating worksheet.
4. Attach the Division of Aging Surveys for the past 12 months.
5. Attach a copy of your most recent financial statement.

If you have any questions at any time while completing the application, do not hesitate to contact Scott or Sara Gilmore, or Kirk Carpenter at 816-932-9333.

Carpenter and Company, Inc.
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Phone: (816) 932-9333 ● Fax: (816) 444-7935

SAVE AS

PRINT

2021

0%
0%
0%
0%

NUMBER OF FULL/TIME EMPLOYEES STAFFED EACH DAY

	1st Shift	2nd Shift	3rd Shift
Nursing Providing Direct Patient Care			
Nursing NOT Providing Direct Patient Care			
All Other employees			

TOTAL NUMBER OF EMPLOYEES

Full-Time_____ Part-Time_____ Volunteers_____

Are Agency Personnel Used? Y☐ N☐ What Dept.?_____ Appt.# Per Day_____

Last Pay Period:

Number of Days _____ Total Census _____

Total Hrs Nursing _____ Total Hrs Other _____ Total Hrs Per Pay Pd. _____

Gross Payroll _____

Is group medical insurance provided? Y☐ N☐ # of employees covered : F/T_____P/T_____

Is individual insurance Provided? Y☐ N☐ # of employees covered : F/T_____P/T_____

Does the facility own or lease aircraft? Y☐ N☐

Are services provided outside of facility? Y☐ N☐

Is any service provided outside the normal scope of a Long-Term Care Facility? Y☐ N☐

If yes, please explain:

_____

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE:

SIGNATURE: _____ DATE: _____

PRINT NAME: _____