

Contracted Providers of Non-Homemaker Services Minimum Insurance Requirements

The following minimum insurance requirements must be documented by all contracted providers of non-homemaker services. A Certificate of Insurance, naming each contracting ASAP as an **Additional Insured** with 20 days written notice of cancellation noted, must be provided as requested for the duration of the agreement.

| TYPE OF INSURANCE | MINIMUM REQUIREMENTS | ASAP NAMED AS ADDITIONAL INSURED | ADH PROGRAMS | FISCAL | TRANSPORTATION | CHORE | PERS and Medication Dispensing | ENVIRONMENTAL ACCESSIBILITY | RESPIRE/EMERGENCY SHELTER | TRANSLATION/ INTERPRETING | GROCERY SHOPPING & | BEHAVIORAL HABILITATION THERAPY | NUTRITIONAL ASSESSMENT | WANDERER LOCATOR SERVICES |
|---|---|----------------------------------|--------------|--------|----------------|-------|--------------------------------|-----------------------------|---------------------------|---------------------------|--------------------|---------------------------------|------------------------|---------------------------|
| General Liability | \$1,000,000 each occurrence \$3,000,000 general aggregate | Yes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Automobile (1) | \$1,000,000 combined single limit owned/leased non-owned/hired | | (1) | | ✓ | | | | | | | | | |
| Workers Compensation | \$100,000 E.L. each accident \$100,000 E.L. each employee \$500,000 E.L. disease policy limit | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Professional Liability | \$1,000,000 each occurrence \$3,000,000 general aggregate | Yes | ✓ | ✓ | | | | | ✓ | ✓ | | ✓ | ✓ | |
| Abuse, Sexual Harassment, Discrimination, and Molestation | \$100,000 each occurrence \$300,000 general aggregate | | ✓ | | | ✓ | | | ✓ | ✓ | | ✓ | ✓ | |
| Crime | \$25,000 limit | | ✓ | ✓ | | ✓ | | | | ✓ | | | | |

(1) If ADH Program provides transportation they must show proof of insurance. If they subcontract transportation services, sub-contractor must show proof of insurance. Any exception to these requirements must be presented in writing by the Provider and approved by the Executive Director of the appropriate ASAP(s).

I certify that the above noted insurance requirements will be maintained for the term of the agreement(s) with either GLSS and (or) NSES.

Provider Name: _____ Signature: _____ Date: _____ Printed Name/Title: _____