

Appendix E Supplemental Questionnaire

Vendors are required to complete Part One of this questionnaire in its entirety.

I. PART ONE: ORGANIZATION INFORMATION

Name of Individual/Organization: Click here to enter name.

Current Street Address: Click here to enter address.

City: Click here to enter city.

State: Click here to enter state. Zip Code: Click here to enter zip code.

Primary Contact

First Name: Click here to enter name. Last Name: Click here to enter name.

Primary Phone Number: Click here to enter number.

Primary E-mail Address: Click here to enter address.

Alternate Contact

First Name: Click here to enter name. Last Name: Click here to enter name.

Alternate Phone Number: Click here to enter number.

Alternate E-mail Address: Click here to enter address.

Tax ID Number: Click here to enter number.

(OR) Delaware Business License: Click here to enter number.

IRS 501(c)(3) Determination Letter (if applicable): Click here to enter number.

Commercial General Liability Insurance Policy Number: Click here to enter number.

Automobile Liability Insurance Policy Number: Click here to enter number.

Worker's Compensation & Employer's Liability Insurance Policy #: Click here to enter number.

Umbrella/Excess Liability Insurance Policy Number: Click here to enter number.

Depending on services provided, Vendor must carry at least one of the following insurances:

Medical/Professional Liability Insurance Policy Number: Click here to enter number.

Miscellaneous Errors and Omissions Insurance Policy Number: Click here to enter number.

STATE OF DELAWARE
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

Product Liability Insurance Policy Number: [Click here to enter number.](#)

**Mandatory Requirement- Certificate(s) of Insurance for each policy in effect must accompany Supplemental Questionnaire. For Automobile Liability Insurance, declaration page listing covered vehicles is required.*

II. PART TWO: ATTESTATION

I hereby certify the information provided in this supplemental questionnaire is true and complete.

Further, signature below, indicates that Vendor applying for authorization to provide home and community based services for individuals with intellectual and developmental disabilities is not excluded from participation in the Medicaid Program by the United States Office of Inspector General (OIG), Division of Health and Human Services (DHHS).

PRINT VENDOR REPRESENTATIVE NAME AND TITLE:	Click here to enter representative name. Click here to enter title.
SIGNATURE:	