Name of Insurance Company to which Application is made (herein called the "insurer", "company", etc.):

**GRANITE STATE INSURANCE COMPANY**  **ILLINOIS NATIONAL INSURANCE CO**   **NEW HAMPSHIRE INSURANCE COMPANY**

\*Above is for Company Use Only

HUMAN SERVICES

PROFESSIONAL LIABILITY APPLICATION

IMPORTANT: ALL OPERATIONS MUST BE DECLARED AND THE APPROPRIATE SECTION OF THE SUPPLEMENTAL APPLICATION COMPLETED WHERE APPLICABLE. THIS IS NOT A BINDER.

I. GENERAL INFORMATION

**Effective Date Requested:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Quotation Desired:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **FEIN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Check Coverage Desired:**  General Liability  Professional Liability  Employee Benefits Liability |
| Are General & Professional Liability being requested on an Occurrence or Claims Made Basis?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Please submit the following with this application:***  \* A complete ACORD submission must accompany this Application. \* Drivers list.  \* Please provide five (5) years Hard Copy of Loss Runs. \* Driver eligibility guidelines.  \* Please include any Agency descriptive or brochures. \* Schedule of any EDP/Equipment.  \* A current list of Vehicles must accompany this application. \* Financials, if Agency is For Profit.  \* MVR's on all drivers. |
| **IF YOU ARE APPLYING FOR CLAIMS MADE COVERAGE, THE FOLLOWING IMPORTANT NOTICE APPLIES:**  **NOTICE: THIS IS A CLAIMS MADE AND REPORTED POLICY. THIS POLICY APPLIES ONLY TO  THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND REPORTED TO THE  COMPANY DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF APPLICABLE.** |

1. Applicant:
2. Business Address:

Street Address and P.O. Box City State Zip County

1. Applicant is:  Individual  Partnership  Corporation  Non-Profit  Other (describe)
2. Contact person for inspection & email, etc.:

Website Address:

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Number of years in operation: States registered/licensed in:
2. Annual budget: \_\_\_\_\_\_\_\_\_\_\_ If For Profit, Financials are needed to quote. (please attach)

Primary funding source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary funding source:

1. List the anticipated “Special Events/Fund Raisers” you may sponsor throughout the year.

1. Have you entered into any contracts to be covered other than: lease of premises you occupy,

easements, elevator maintenance agreements or municipal ordinances?  Yes  No

If Yes, describe:

1. Are you currently accredited by any organization(s)? – Attach copy  Yes  No

If Yes, by whom?  JCAHO  CARF  COA  Other

II. EXPOSURE SCHEDULE

Please indicate the exposures applicable to your location(s) on the Location Schedule below, utilizing appropriate codes from the following Client Description and Program Description legends. Please attach HHS 1204a (12/01) if additional sheet(s) if necessary.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CLIENT DESCRIPTION | | | | | | | | | | | | | | | | | | | | | | | |
| **DESCRIPTION** | | | **CODE** | | **DESCRIPTION** | **CODE** | | **DESCRIPTION** | | | **CODE** | | **DESCRIPTION** | | | | **CODE** | | **DESCRIPTION** | | **CODE** | | |
| Drug & Alcohol – w/ Detox | | | DAD | | Developmentally Disabled Adults | DDA | | Mentally Ill Adults | | | MHA | | Physically Handicapped Adults | | | | PDA | | Emotionally Disturbed/Abused Neglected Youth | | ED/ ANY | | |
| Drug & Alcohol – w/o Detox | | | DAW | | Developmentally Disabled Youth | DDY | | Mentally Ill Adults | | | MHY | | Physically Handicapped Youth | | | | PDY | |  | |  | | |
| Homeless | | | HO | | Adjudicated Youth | AY | | Sexual Offender Program | | | SOP | | Hospice | | | | HOS | |  | |  | | |
| PROGRAM DESCRIPTION | | | | | | | | | | | | | | | | | | | | | | |
| **DESCRIPTION** | | | | | | **CODE** | | **DESCRIPTION** | | | | | **CODE** | | **DESCRIPTION** | | | | | | | **CODE** |
| Adoption Placements (number) | | | | | | AP | | Clubs , Halls and Social Gatherings | | | | | CLB | | Respite Care | | | | | | | RC |
| Adventure Courses | | | | | | ADV | | Counseling | | | | | CS | | Restaurants – operated by concessionaires (Sales) | | | | | | | RST |
| Adult Day Care (Per Person) | | | | | | ADC | | Commercial Child Care (each person) Supplemental Apps Required | | | | | CC | | Schools – NOC (Area) | | | | | | | SC |
| Alcohol and Drug Treatment – Outpatient (area) | | | | | | ADO | | Dwellings – one – four family (each dwelling) | | | | | DW | | Schools – private, elementary, junior high or high school (Each Student) | | | | | | | SCHN |
| Alcohol and Drug Treatment - Inpatient (area) | | | | | | ADI | | Foster Care Placements (Per Placement) | | | | | FCPL | | Schools – special needs | | | | | | | SSN |
| Apartment Buildings – Supported (units) | | | | | | ABS | | Food Bank | | | | | FB | | Shelters, Mission, Settlement or Halfway Houses (Area) | | | | | | | SHT |
| Apartment Buildings – Unsupported (units) | | | | | | ABU | | Group Homes (area) | | | | | GH | | Sheltered Workshops | | | | | | | SW |
| Animals – saddle – private (Each Animal) | | | | | | AS | | Home Health Care Services (Payroll) | | | | | HHC | | Stores – NOC (Sales) | | | | | | | SGM |
| Association of Retarded Citizens | | | | | | ARC | | Homes for the Aged (Sales) | | | | | HA | | Swimming Pools (Each Pool) Supplemental Application Required | | | | | | | SWM |
| Athletic Games Sponsored by the Insured - | | | | | | AG | | Janitorial Services (Payroll) | | | | | JAN | | Thrift Stores - Secondhand or Salvage Dealers or Distributors (Sales) | | | | | | | TS |
| Big Brother / Big Sister | | | | | | BBS | | Mental Health Treatment Center - Outpatient | | | | | MHO | | Vacant Buildings (Area) | | | | | | | VB |
| Boats – | | | | | | BC | | Mental Health Treatment Center – Inpatient | | | | | MHI | | Vacant Land (Each Acre) | | | | | | | VL |
| Buildings or Premises – office (area) | | | | | | BPO | | Physical Therapy - Inpatient | | | | | PTI | | Warehouses – Private (Area) | | | | | | | WRH |
| Camps (camper days) Supplemental Apps Required | | | | | | CMP | | Physical Therapy – Outpatient | | | | | PTO | | Youth Recreational Programs (Each Registrant) | | | | | | | YRC |
| Caterers - Providing food for the disadvantaged (sales) | | | | | | CAT | | Professional Consulting | | | | | PC | |  | | | | | | |  |
| LOCATION SCHEDULE | | | | | | | | | | | | | | | | | | | | | | |
| Loc. # | Bldg. # | | Facility Name/Address | | | | | | EXPOSURE | | Client Description | | | Program Description | | | # of Clients | | # of Beds | | # of OPVs | |
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III. LOSS HISTORY

1. Please provide currently valued loss runs for the past 5 years
2. After inquiry, is any person or entity proposed for this insurance aware of any actual or alleged incident, accident, event, occurrence, error, omission, charge or demand that has been the basis for or might reasonably be expected to be the basis for a claim or suit? If Yes, please explain:

**It is agreed that any claim(s) arising from any incident, accident, event, occurrence, error, omission, charge or demand listed above is excluded from coverage.**

IV. PREVIOUS PROFESSIONAL LIABILITY INSURANCE (PAST 5 YEARS)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Company | **Limits of Liability** | **Effective Dates** | **Annual Premium** | **Claims Made Form or Occurrence Form** | **Retroactive Date (Claims Made Only)** |
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V. PREVIOUS GENERAL LIABILITY INSURANCE (PAST 5 YEARS)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Company** | **Limits of Liability** | **Effective Dates** | **Annual Premium** | **Claims Made Form or Occurrence Form** | **Retroactive Date (Claims Made Only)** |
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1. Has any company canceled, declined to renew, or refused insurance within the past five (5) years?  Yes  No

**(MISSOURI APPLICANTS NEED NOT REPLY)**

If Yes, explain:

1. If no insurance exists, is this a new venture?  Yes  No

If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does this policy provide Physical/Sexual Abuse Coverage?  Yes  No

If yes, is there a sublimit?  Yes  No Limit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is coverage claims made?  Yes  No Retro Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VI. HIRING AND TRAINING PRACTICES

1. Does your staff (paid and volunteer) employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offenses in any state or country?  Yes  No
2. Does your employment application (paid and volunteer) include a question about whether the professional has ever been required by any licensing board or professional ethics body to surrender their license or if they have ever been found guilty of violation of professional ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence, in any state or country?  Yes  No
3. Do you do criminal background investigations on all prospective employees and volunteers?  Yes  No

CountyState Federal  National

1. Do you discuss at staff orientation, how to recognize the signs of abuse, and what to do if a client/child reports someone abused/molested him/her?  Yes  No
2. Do you follow a plan of supervision that monitors staff in day-to-day relationships with clients/children?  Yes  No
3. Do you have a written crisis management plan for dealing with staff personnel, victim, parents, authorities, and media if you have an incident of abuse?  Yes  No
4. Do you have a formal written Quality Assurance/Risk Management Program?  Yes  No
5. Is there a Staff Training and Development Program?  Yes  No
6. Consumer Age Groups (number of each): Under 18\_\_\_\_\_ 18-65\_\_\_\_\_ Over 65\_\_\_\_\_

VII. RESIDENTIAL FACILITIES  Not Applicable

1. Do you lease dwellings/apartments on behalf of your clients? Yes  No

If Yes, number leased annually?

2. Are you a Psychiatric Hospital?  Yes  No

3. Are you an alternative to incarceration for youths or adults? Yes  No

4. Do you provide assisted living services: Yes  No

If yes, what is the average age of the residents? \_\_\_\_\_\_\_\_\_\_

How does the applicant obtain the residents utilizing the applicant’s services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

5. How many visits are made per month by a caseworker to a resident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Resident age groups (number of each): Under 18: \_\_\_\_\_\_ 18 to 65: \_\_\_\_\_\_ Over 65: \_\_\_\_\_

b.  Male  Female  Coed

Average Occupancy: \_\_\_\_\_\_\_\_\_\_\_ Average Length of Stay: \_\_\_\_\_\_\_\_\_\_\_

7. Please advise how residents are segregated by gender and age group? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Number of non-ambulatory (wheelchair) patients: \_\_\_\_\_\_\_\_\_\_\_

b. \_\_\_\_\_# of stories c. Are their rooms above the ground floor?  Yes  No

9. Indicate resident/staff ratio:

Day: \_\_\_\_\_\_ Night: \_\_\_\_\_\_ - Awake staff: \_\_\_\_\_\_ Frequency of bed checks\_\_\_\_\_

Are residents screened by a physician prior to admission?  Yes  No

If No, please describe admission procedure \_\_\_\_\_\_\_\_\_\_\_\_

1. Is staff trained in current, approved, non-violent crisis intervention?  Yes  No
2. In the event of an evacuation, is a temporary housing plan in place for clients and staff?  Yes  No
3. Is the hot water heater(s) supplying water to client/resident restrooms set at 110 degrees or below?  Yes  No

Are tubs, showers and sinks equipped with mixer valves?  Yes  No

Are tubs, and showers equipped with non-slip floors Yes  No

1. Are there handrails on all steps, ramps, hallways and all bathrooms?  Yes  No
2. Are you using electronic monitoring devices?  Yes  No

If Yes, please describe type and location within each residence:

1. How many exits from each floor? \_\_\_\_\_\_\_\_\_\_\_ Are they clearly marked?  Yes  No
2. What security measures are used for monitoring clients entering/exiting the facility?

Adoption & Foster Care

|  |  |
| --- | --- |
| Adoption Placements: | Foster Care Placements: |
| \_\_\_\_\_\_\_ # of Child/Adolescent Placements (Annual) | \_\_\_\_\_\_\_ # of Child/Adolescent Placements (Annual) |
| \_\_\_\_\_\_\_ # Adult Placements | \_\_\_\_\_\_\_ # Adult Placements |

Foster Care:

1. What are the ages of children placed in foster homes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many foster homes do you utilize? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are they licensed by applicable state and/or local authorities?  Yes  No

If not, who licenses the foster homes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Describe the process used to obtain foster homes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. How often are children moved from one foster home to another? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How often does the applicant’s employees visit the children in the foster homes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Who compensates the foster parents? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. How does the applicant handle allegations of child abuse (sexual or physical) in the foster homes? \_\_\_\_\_\_\_\_\_\_\_\_\_

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

Adoption:

1. What are the ages of the children placed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Provide copy of adoption procedures:

c. Does the applicant have legal custody of the child?  Yes  No

d. Is a guardian appointed to ensure the child’s welfare?  Yes  No

e. International Placements:  Yes  No

If yes, are they Home Study only?  Yes  No

VIII. ALCOHOL AND DRUG TREATMENT FACILITIES  Not Applicable

|  |  |
| --- | --- |
|  | # of Annual Clients |
| DUI Classes  Methadone Maintenance  Alcohol/Drug Counseling  (Outpatient) | \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_ |

1. Please advise level of detox 1, 2, 3 or 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Please describe all methods of detox, including the medications utilized: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does the applicant provide a crisis hotline, if so please answer the following:

What types of problems are treated by the hotline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use volunteers on the hotline?  Yes  No

If volunteers are used as counselors, please describe the training they receive: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Hours of operation for the hotline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ATTACH PROTOCOLS OUTLINING THE PROCEDURES FOR HANDLING A CRISIS HOTLINE CALL.**

IX. OUTPATIENT FACILITIES  Not Applicable

**ELDERLY/AGED SERVICES:**

Meals on Wheels \_\_\_\_\_\_ # of meals annually

Agency for the aged/seniors \_\_\_\_\_\_ # annual client contacts

Please describe the nature of the activities of the agency or senior center: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Does the insured have an Accident & Health Policy?  Yes  No

X. PROFESSIONAL STAFF/STAFFING

Please complete the following, or attach a separate staffing list. Staff schedule should include employees, independent contractors and volunteers.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Schedule of Non-Physician Staff | Number  Full-Time | Number  Part-Time | Schedule of Non-Physician Staff | Number  Full-Time | Number  Part-Time |
| Audiologist |  |  | Medical Director |  |  |
| Home Health |  |  | Ophthalmologist/Optician |  |  |
| Houseparent |  |  | Paraprofessional Social Worker |  |  |
| Intern/Student |  |  | Pastoral Counseling |  |  |
| Nurse Aide/Home Health Aide |  |  | RN |  |  |
| Occupational Therapist |  |  | Phlebotomist |  |  |
| Certified Medical Assistant |  |  | Physical Therapist |  |  |
| Dentist/Dental Hygienist |  |  | Respiratory Therapist |  |  |
| Dietician |  |  | Psychologist |  |  |
| Medical Tech |  |  | EMT |  |  |
| Social Worker |  |  | Nurse Practitioner |  |  |
| Counselor |  |  | Paramedic |  |  |
| Dialysis Tech |  |  | Physician Assistant |  |  |
| LPN |  |  | Volunteers |  |  |
| Teachers |  |  | Other  Describe: | | |
| Speech Pathologist |  |  |

1. Please indicate the total number of staff: \_\_\_\_\_\_\_\_\_\_\_\_
2. Are there any employed, subcontracted or volunteer Physicians (other than Psychiatrists)? If yes then please explain in detail the duties they perform \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

XI. PSYCHIATRISTS  Not Applicable

Please complete if you have employed, volunteer, or contracted psychiatrists.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **B** | **C** | D | **E** | **F** | **G** | **H** | **I** |
| Name | **Board Certified or Board Eligible** | **License Number** | Hours worked per week for clinic/ center | **Employed or Contracted** | **Does psychiatrist carry own malpractice insurance?** | **Does psychiatrist’s insurance cover his acts while working for you?** | **Insurance Carrier? (Attach copy of Certificate of Insurance)** | **Any Claims? If Yes, please explain on separate sheet.** |
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1. Is an employment application obtained on all psychiatrists?  Yes  No
2. Does your professional employment application for psychiatrists ask the following questions:

Have you ever been convicted of a crime in any state or country?  Yes  No

Has your license ever been suspended or revoked in any state or country?  Yes  No

Have you ever been treated for alcoholism or drug addiction?  Yes  No

Have you ever been subject to an investigation, disciplinary proceeding, or reprimanded by a governmental or administrative agency, hospital or professional association?  Yes  No

Are you aware of any acts, errors, omissions, or circumstances which may result in a claim against you?  Yes  No

1. Do you check all psychiatrist credentials prior to hire/contract?  Yes  No
2. Is a current Certificate of Insurance obtained annually, verifying that the psychiatrist carries his/her own malpractice insurance?  Yes  No
3. Check medical services provided by physicians: Routine Physical  Electroconvulsive Therapy  Hypnosis  Prenatal Care/Delivery  Other

XII. RISK MANAGEMENT

1. Do you maintain Certificates of Insurance from all providers who carry their own insurance?  Yes  No
2. Is any percentage of the facility owned or operated by a physician?  Yes  No
3. Is an employment application obtained on all prospective employees and volunteers?  Yes  No
4. Are you “Drug Free Workplace” Compliant?  Yes  No
5. Do you require pre-employment physicals or medical screening?  Yes  No
6. Are all staff members trained in First Aid – including Universal Precautions and CPR?  Yes  No
7. How do you verify pre-employment-related references?  In Person  By Telephone  Written
8. Is staff required to report all incidents?  Yes  No

Are written records of all reported incidents which could lead to a claim kept by the administrator?  Yes  No

Are all incidents reviewed by a committee?  Yes  No

1. Is smoking confined with signs posted, and are smoking regulations enforced?  Yes  No
2. Do you have written policies and procedures in place for storing/prescribing/administering all medications? If Yes, please attach.  Yes  No
3. Are all medication errors monitored?  Yes  No

If Yes, please describe:

1. Do you follow current statutory requirements regarding clinical documentation and confidentiality?  Yes  No
2. Do employees use their personal autos for company business or client transport?  Yes  No

If Yes, please describe:

If Yes, do you obtain a copy of their Drivers License, Registration and auto liability insurance?  Yes  No

What minimum limits of auto liability do you require?

Do you provide transportation for clients?  Yes  No

If transportation is outsourced, do you provide a “ride along” staff member on all transports?  Yes  No

1. Has the facility ever been held to be in violation of any health, safety or building codes?  Yes  No
2. Have you had a recent inspection of your facility(ies) for the existence of toxic mold?  Yes  No

If No, are you planning on having a toxic mold inspection conducted?  Yes  No

1. Do you have a written evacuation plan?  Yes  No
2. Do you conduct emergency drills on a regular basis?  Yes  No
3. Do you have emergency signs and lighting?  Yes  No
4. Do you require consumers to sign in / out of facility?  Yes  No

20. Is ANYONE applying for insurance under this policy aware of any state, federal, local code or professional violations, unethical misconduct, incompetence or negligence? If yes, please describe on a separate sheet.  Yes  No

21. Is ANYONE applying for insurance under this policy aware of any circumstances involving sex or sexual abuse/molestation with any patients, former patients or relatives thereof?  Yes  No

If yes, please describe on a separate sheet.

22. Does ANYONE applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate? If yes, please describe on a separate sheet.  Yes  No

23. Are complete records kept on all patients?  Yes  No

Where are they stored and how are they secured? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Does the applicant require signed release forms for the release of records to other individuals of institutions?

Yes  No

SUPPLEMENTAL INFORMATION

Please list all additional insured and their addresses, check coverage required and their insurable interest.

1. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Interest (funding, landlord-if

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ landlord, provide location number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

General Liability  Professional Liability

1. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Interest (funding, landlord-if

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ landlord, provide location number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

General Liability  Professional Liability

1. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Interest (funding, landlord-if

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ landlord, provide location number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

General Liability  Professional Liability

XIII. ADDITIONAL OPERATIONS

1. Check **ALL** applicable operations and complete the designated “SECTION NUMBER” of the SUPPLEMENTAL APPLICATION where indicated.

1. Sheltered Workshop Complete Section I of Supplemental Application

1. Camp/Adventure Course Complete Section II of Supplemental Application

1. Day Care Complete Section III of Supplemental Application

1. Thrift Store Indicate Estimated Annual Receipts: $

Description of goods sold:

1. Other Describe:

**Attach copies of ALL brochures and services literature**

**NOTicE to applicants:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ALABAMA APPLICANTS**: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO COLORADO APPLICANTS**: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**NOTICE TO FLORIDA APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**NOTICE TO KANSAS APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

**NOTICE TO KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

**NOTICE TO LOUISIANA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MAINE APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**NOTICE TO MARYLAND APPLICANTS:** ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MINNESOTA APPLICANTS:** A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

**NOTICE TO NEW JERSEY APPLICANTS**: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO NEW YORK APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

**NOTICE TO OHIO APPLICANTS**: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

**NOTICE TO OREGON APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE GUILTY OF A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO PENNSYLVANIA APPLICANTS**: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**NOTicE to vermont applicants:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE ACCURATE, TRUE AND COMPLETE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Signed                                                                                                                                  Date

                                                (**Applicant**)

Title                                                                                      Organization

(must be signed by authorized officer)                                                                 (Organization’s Seal)

Attest

Agent/Producer

License Number

Address