

Social Services

Professional Liability Application for Residential Facilities

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired. If the answer is none, state none. If the answer is not applicable, state not applicable (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Note: Application must be dated and signed by owner, partner, officer, or administrator.

Please type or print in ink.

Part I. General Information

1.1 Applicant Name: _____

1.2 Mailing Address: _____

1.3 Location Address(es): _____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office: _____ Fax: _____

1.6 Person to Contact for Survey: Name: _____ Title: _____

1.7 Proposed **Effective Date**: _____ Year Entity Established: _____

1.8 The applicant is (please check and complete A or B) below:

A. The **applicant** is an individual. If so, the individual is a(n):

Employee (W-2) Student Sole Practitioner

B. The **applicant** is a:

Sole Proprietorship Partnership Corporation

Other; Describe: _____

1.9 Entity is: For Profit Non-Profit

Describe source of funds: _____

1.10 Requested Limits of Liability (if available): \$ _____ / \$ _____

Professional Liability \$ _____ Each Medical Incident / \$ _____ Aggregate

General Liability \$ _____ Each Occurrence / \$ _____ General Aggregate

1.11 Annual Gross Receipts or Budget: Estimated Next 12 Months: \$ _____

Last 12 Months: \$ _____

1.12 Annual Payroll or Remuneration: Estimated Next 12 Months: \$ _____

Last 12 Months: \$ _____

1.13 Type of Facility: Licensed? Yes No If no, explain: _____

Check one or describe:

Alcohol/Drug Rehabilitation

Home for Retarded

Halfway House

Hospice

Home for Alzheimers Patients

Partial Hospitalization Program

Home for Disabled

Temporary Shelter

Home for Mentally Ill

Youth Home/Orphanage

Other: _____

- 1.14 Describe the nature of insured's operation including types of services rendered and activities conducted: _____
- 1.15 List memberships in professional organizations: _____
- 1.16 Is the applicant/facility and all professional employees licensed in accordance with applicable state and federal laws? Yes No
If no, explain: _____

Part II. Exposures

- 2.1 Facility is **licensed for how many beds?** _____ **Average Occupancy?** _____ **Length of Stay?** _____
If Day Care/Partial Hosp. Program, how many licensed client spaces? _____

2.2 **Patient Census:**

Resident Ages

Under 13	13–18	18–25	26–54	55–64	65 +

Day Patient/Participant Ages

Under 13	13–18	18–25	26–54	55–64	65 +

- Source** of Patients/residents: _____ Referred from a psychiatric facility
 _____ Voluntary from general public
 _____ Remanded here by the courts or other judicial body
 _____ Other; Describe: _____

- 2.3. Number of patients/residents suffering from Alzheimer's Disease or Dementia? _____ / None _____
- 2.4 If facility is a Home for Retarded, are residents/patients mentally retarded or suffering from a similar affliction closely related to mental retardation, which results in similar impairment of general intellectual function or adaptive behavior and requires treatment and services similar to those required for retarded persons, which can be expected to continue indefinitely and constitutes a substantial handicap to such person's ability to function normally in society? Yes No
If no, provide detailed description: _____
- 2.5 Does facility provide **"Day"** services as well as residential? Yes No
If yes, what is the number of "day patients" (include "independent living" persons)?
Maximum # _____ Average # _____
- 2.6 Do you conduct a **Sheltered Workshop**? Yes No
If yes, the application for Sheltered Workshops for Retarded and Developmentally Disabled Persons must be completed.
- 2.7 Indicate annual number of Alcohol Detoxifications: _____; Drug Detoxifications: _____
- 2.8 Is Methadone prescribed? Yes No
If yes, indicate annual number of doses: _____
Are clients allowed to take Methadone off premises? Yes No
If yes, how many doses at any one time: _____
Is counseling required prior to distribution of Methadone? Yes No
Is drug screening conducted each time the client visits the center, prior to further distribution of Methadone? Yes No
- 2.9 Are all residents/patients fully ambulatory (including use of cane or walker)? Yes No
If not, explain: _____

- 2.10 Are there any residents/patients under restraint? Yes No
If yes, how many? _____ What restraints are used? _____
- 2.11 What was your total number of outpatient/client visits last year? _____ Estimated next year? _____
What was your total number of outpatient visits by physicians? _____ Estimated next year? _____
- 2.12 Describe any psychometric monitoring devices or other equipment (including feedback techniques) utilized: _____
- 2.13 Do you conduct group therapy sessions? Yes No
If yes, do any sessions exceed four (4) hours in duration? Yes No
If yes, how many annually? _____
- 2.14 Describe any physical contact which may occur between you and any patients/clients or between two or more patients/clients at your direction: _____
- 2.15 Describe any services specifically concerned with sexual response/dysfunction of individual patients/clients: _____
- 2.16 Is there a Registered Nurse on duty? Yes No
If yes, how many shifts per day? _____
- 2.17 Does a physician visit the facility daily? Yes No
Other frequency? _____ Not at all? _____
Note: If **physician** exposure exists in any form: owner, employee, contractor, volunteer, the Physician Supplement must be completed, along with verification of physician's individual professional liability insurance and limit.
- 2.18 Does each patient have their own physician? Yes No
If yes, is this a requirement of your facility? Yes No
- 2.19 Is any medication (other than Methadone) prescribed? Yes No
If yes, list names and frequency: _____
-
- Are medications stored in a secure manner? Yes No
If no, explain in detail: _____
- 2.20 Enclose a copy of all treatment programs.
What is the average cost per person, per program? \$ _____
- 2.21 Do you enter into any contractual agreements? Yes No
If yes, enclose copies of all such contracts including those contracts for use with patients/clients.
- 2.22 Enclose a copy of all brochures or advertising materials distributed by you.
- 2.23 Complete Survey Supplement attached (page 7).
- 2.24 Any activities or events for patients/clients conducted or sponsored away from applicants? Yes No
If yes, describe: _____
- 2.25 Any swimming pools, exercise facilities, or athletic activities? Yes No
If yes, please describe (for pool give information re: pool use rules, life guard, fencing, and depth): _____
-
- 2.26 Describe any "fundraising" or other special events activities conducted: _____
- 2.27 Do you have any other premises or operations not stated in this application? Yes No
If yes, enclose complete description/locations of operations and insurance information.

Part III. Risk Management

- 3.1 Do you require staff to report all incidents (accidents)? Yes No
Are records of such reports kept on file by you? Yes No
If not, explain: _____

3.2 Are precautions taken to prevent residents leaving premises or “wandering” without applicant’s knowledge, such as exit alarms, etc.? Yes No
 Please describe: _____

3.3 Is there a written emergency evacuation plan? Yes No

3.4 State the frequency of fire drills: _____

3.5 Minimum number of trained personnel on premises at night for emergency evacuation: _____

3.6 Does the applicant/facility have personnel trained in emergency medical care in the facility during all hours of operation? Yes No

Please describe: _____

3.7 Explain arrangements for medical emergencies (e.g., physician on call, transfer arrangement with hospital, etc.): _____

3.8 Number of **Professional Staff:** (E = Employed; C = Contract)

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------------------|
| <u>E</u> | <u>C</u> | <u>E</u> | <u>C</u> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Dietitians/Nutritionists | | Physiotherapists/Physical Therapists |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Occupational Therapists | | Psychologists/Psychotherapists |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Pharmacists | | Psychiatrists* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Physicians*/Dentists* | | Speech Therapists |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Nurse Practitioners | | RNs/LVNs/LPNs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Physician Assistants | | Other: _____ |

Complete the following for each Physician, including Medical Director, Dentist, Chiropractor, Podiatrist, Psychiatrist, Nurse Practitioners, and Physician Assistants:

* Complete Physician Supplement when applicable.

Name	Professional Status	E, C, or I	Maintains Own Malpractice Ins.	Limit of Liability	Cert. of Ins. Obtained
		E = Employee C = Contract I = Independent			

3.9 Do you have any physicians on staff admitting patients, or treating patients who have restricted licenses? If yes, explain on separate sheet. Yes No

3.10 Name, qualification, and number of years of experience of the Medical Director, all managers, and supervisors:
 Name Title Experience/Training Association Membership

3.11 Number of **Non-professional Staff:** (describe # and type of additional non-professional staff and whether W-2 or 1099): _____

Part IV. History

4.1 List prior **professional liability** insurers for the past five years, with the most recent year. If none, state none.

	Insurer Number	Policy Liability	Limits of Premium	Eff. Date	Claims-Made Form	
					No	Yes
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____

Note: If prior acts coverage is needed, complete Prior Acts supplemental application.

4.2 List prior **general liability** insurers for the past five years, with the most recent year. If none, state none.

	Insurer Number	Policy Liability	Limits of Premium	Eff. Date	Claims-Made Form	
					No	Yes
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? No Yes

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary): _____

4.4 Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? No Yes

If yes, describe the event and indicate the reason for anticipation of a claim: _____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and ProAssurance Mid-Continent Underwriters, Inc., any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be signed by the applicant. Signing this form does NOT bind the company to complete the insurance.

Date

Applicant/Title

Complete Survey Supplement attached and include photo.

Resident Facilities - Survey Supplement

Property Survey Supplement	Building 1	Building 2	Building 3
A. Describe use			
B. Year built			
C. Number of stories			
Any residents above ground floor?			
If yes, how many?_____ All ambulatory? _____			
D. Construction (include roof type)			
E. Total square footage			
F. Located in city limits?	Yes No	Yes No	Yes No
G. Does building meet all local codes?	Yes No	Yes No	Yes No
H. Distance to nearest fire hydrant			
I. Distance to fire station			
J. NFPA protection class			
K. Built for present use?	Yes No	Yes No	Yes No
If not, original purpose			
If not, year converted			
Age and type of heating system			
Age and type of wiring			
L. Is the building sprinklered?	Yes No	Yes No	Yes No
Entirely or partially?			
M. Automatic fire or sprinkler alarm connected to local fire department or monitoring company?	Yes No	Yes No	Yes No
N. Automatic extinguishing system in stove hood?	Yes No	Yes No	Yes No
O. Number of fire extinguishers			
P. Number of fire escapes			
Q. At least 2 clearly-marked exits on each floor?	Yes No	Yes No	Yes No
R. Exits free of obstruction and equipped with panic hardware?	Yes No	Yes No	Yes No
S. Self-closing fire doors on each floor?	Yes No	Yes No	Yes No
T. Smoke detectors in all rooms?	Yes No	Yes No	Yes No
U. Emergency lighting system?	Yes No	Yes No	Yes No
V. Emergency generator?	Yes No	Yes No	Yes No

Sexual Misconduct Coverage Supplemental Application

1. Applicant: _____

2. Has the applicant had any incidents or claims reported for sexual misconduct or any other allegation of abuse?
If yes, provide full details: Yes No

3. Has the applicant or any employee, volunteer, or other person working for the applicant ever been arrested or convicted of a crime? If yes, provide full details: Yes No

4. Describe all background checks performed: _____

5. Are there written guidelines regarding sexual misconduct? If yes, provide copies of all policies and procedures including training materials. Yes No

6. What steps have been taken to prevent or avoid a sexual misconduct incident? _____

Date: _____

Signature: _____

Non-Owned Auto Supplemental Application

If non-owned auto coverage is desired, please complete the following:

Note: Non-owned coverage is written only as an endorsement to the General Liability policy, does not include Hired Car, and shares the limits, deductibles and other conditions of the general liability policy. This coverage is not intended to cover livery operations by the insured, whether a fee is charged or not, and therefore excludes bodily injury to passengers of any insured non-owned autos.

1. How many employees drive their personal auto in connection with your business: _____
How many of these are part-time employees? 15-25 hrs wk _____ Under 15 hrs wk _____

If persons other than employees use their personal auto in connection with your business, please describe and give number:

None _____

2. What are the ages of the drivers? 18-25 25-35 35-45 45-5 55-65 Over 65

3. Does applicant check all driver's MVRs? Yes _____ No _____

4. Does applicant require minimum limits of at least 100/300 BI - 50 PD? Yes _____ No _____
Please attach evidence of each driver's auto insurance showing the limits carried.

5. Does applicant require employees or others to provide transportation for patients/clients in their personal auto? Yes _____ No _____

6. Does applicant have owned, leased, or hired autos used in business? Yes _____ No _____
Insurance coverage: Carrier: _____
Limit: _____ Effective Date: _____

7. Have any auto claims been made or occurrences reported during the past five years? Yes _____ No _____
If yes, describe, indicate open/closed status, and amounts paid or reserved:

Date

Applicant/Title

Day Care or Partial Hospitalization Program Supplemental Application

1. Applicant: _____

Address: _____

Utilized Square Footage: _____ Describe "exit" alarms/security measures: _____

Describe any off premises exposures/field trips, etc: _____

Swimming Pool? Yes No Playground Equipment? Yes No

Give details of all pool use rules, depth, lifeguards. Describe playground equipment: _____

2. Facility's **Licensed # Client Spaces**: _____ Average Occupancy: _____ Hours of Operation: _____

3. Age Group	Number of Children	Staff/Child Ratio	Number of Adult Clients
Under 2 Years _____	_____	_____	18 to 30 Years _____
2 to 5 Years _____	_____	_____	31 to 45 Years _____
6 to 12 years _____	_____	_____	46 to 65 Years _____
13 to 18 years _____	_____	_____	Over 65 Years _____

4. Give **breakdown** of percentage of **types** of clients serviced:

Well Child _____% Mentally Retarded _____% Aged _____% Emotionally Disturbed _____%

Alzheimer/Dementia _____% Alcohol/Drug Rehab _____% Other; Describe: _____ / _____%

5. Does **hiring** procedure include: Background/Reference Check? Yes No

Screening for Criminal Record? Yes No

Brief description of hiring procedures: _____

Staff - Describe credentials, experience, and number of staff: _____

6. Is **transportation** provided? Yes No

If yes, give a description of vehicles, insurance coverage, and driver screening: _____

7. What provisions are in place for **medications, injuries or illness**? _____

8. Does applicant carry an **Accident Insurance** policy for clients? Yes No If Yes, Limit? _____

9. Describe procedures and precautions for child's release: _____

10. **Please attach brochure, advertising copy, copies of enrollment form, and parental release forms.**

Date: _____

Signature: _____