

# 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