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

Tax ID/SSN: _____

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
☐Halfway House
☐Home for Alzheimers Patients
☐Home for Disabled
☐Home for Mentally Ill
☐Home for Retarded
☐Hospice
☐Partial Hospitalization Program
☐Temporary Shelter
☐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**)

E	C		E	C	
☐	☐	Dieticians/Nutritionists	☐	☐	Physiotherapists/Physical Therapists
☐	☐	Occupational Therapists	☐	☐	Psychologists/Psychotherapists
☐	☐	Pharmacists	☐	☐	Psychiatrists*
☐	☐	Physicians*/Dentists*	☐	☐	Speech Therapists
☐	☐	Nurse Practitioners	☐	☐	RNs/LVNs/LPNs
☐	☐	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	Claims-Made Form 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	Claims-Made Form 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