



SOCIAL SERVICES GENERAL/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
 Occurrence Claims Made Retro Date: _____

Attach Acord 125 with Schedule of Locations with square footage and occupancy

1. Applicant: _____
2. Business Address: _____

Street Address and P.O. Box
City
State
Zip
County
3. Applicant is: Individual Partnership Corporation Non-Profit Other (describe) _____
4. a. Contact person for inspection, etc.: _____
b. Website Address: _____
c. Telephone: _____ d. Fax: _____
5. a. Number of years in operation: _____ b. States registered/licensed in: _____
6. What association(s) are you a member of? _____
7. a. Annual budget: _____ b. If For Profit, Financials are needed to quote. (please attach)
c. Primary funding source: _____ d. Secondary funding source: _____
8. List the anticipated "Special Events/Fund Raisers" you may sponsor throughout the year. _____

9. a. 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
b. If Yes, describe: _____
10. a. Do you lease dwellings/apartments on behalf of your clients? Yes No
b. If Yes, number leased annually? _____
11. a. Are you currently accredited by any organization(s)? – Attach copy Yes No
b. If Yes, by whom? JCAHO CARF COA Other _____

II. LOSS HISTORY

1. Please provide currently valued loss runs for the past 4 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.

III. PREVIOUS PROFESSIONAL LIABILITY INSURANCE (PAST 4 YEARS)

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made Only)

IV. PREVIOUS GENERAL LIABILITY INSURANCE (PAST 4 YEARS)

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made Only)

1. a. Has any company canceled, declined to renew, or refused insurance within the past five (4) years? Yes No
(Not applicable in MO)
- b. If Yes, explain: _____
2. If no insurance exists, is this a new venture? Yes No
If no, please explain: _____
3. Does this policy provide Physical/Sexual Abuse Exclusion? Yes No
If no, is there a sublimit? Yes No Limit: _____
Is coverage claims made? Yes No Retro Date: _____

V. 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. a. Does your state permit you to do criminal background investigations on all prospective employees and volunteers? Yes No

- b. Do you always request and receive background investigations from police reports, child abuse registries or FBI checks on all prospective employees and volunteers? Yes No
4. 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
5. Do you follow a plan of supervision that monitors staff in day-to-day relationships with clients/children? Yes No
6. 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? If Yes, please attach. Yes No
7. Do you have a formal written Quality Assurance/Risk Management Program? If Yes, please attach. Yes No
8. Is there a Staff Training and Development Program? If Yes, please attach. Yes No

VI. RESIDENTIAL FACILITIES

Not Applicable

1. a. **Type of facility:**

	# of Beds		# of Beds
<input type="checkbox"/> Contracted Beds		<input type="checkbox"/> Residential Treatment MH/MR	
<input type="checkbox"/> Group & Residential Home		<input type="checkbox"/> Halfway House	
<input type="checkbox"/> Home for the Battered		<input type="checkbox"/> Inpatient Mental Health	
<input type="checkbox"/> Supervised Living		<input type="checkbox"/> Inpatient Detox	
<input type="checkbox"/> Hospice		<input type="checkbox"/> Non-medical Detox (Secondary Stage)	

- b. Are you a Psychiatric Hospital? Yes No
- c. Are you an alternative to incarceration for youths or adults? Yes No
- d. Do you provide assisted living services: Yes No
If yes, what is the average age of the residents? _____
- e. How does the applicant obtain the residents utilizing the applicant's services? _____

- f. How many visits are made per month by a caseworker to a resident? _____
2. a. Resident age groups (number of each): Under 18: _____ 18 to 65: _____ Over 65: _____
b. Male Female Coed
Average Occupancy: _____ Average Length of Stay: _____
3. a. Number of non-ambulatory (wheelchair) patients: _____
b. _____ # of stories c. Are their rooms above the ground floor? Yes No
4. Indicate resident/staff ratio: Day: _____ Night: _____ Number of awake staff: _____
5. a. Are residents screened by a physician prior to admission? Yes No
b. If No, please describe the procedure which determines who is eligible for admission: _____

6. Is staff trained in current, approved, non-violent crisis intervention? Yes No
7. In the event of an evacuation, is a temporary housing plan in place for clients and staff? Yes No
8. a. Is the hot water heater(s) supplying water to client/resident restrooms set at 110 degrees or below? Yes No
b. Are tubs, showers and sinks equipped with mixer valves? Yes No
9. Are there handrails on all steps, ramps, hallways and all bathrooms? Yes No

10. a. Are you using electronic monitoring devices? Yes No

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

11. a. How many exits from each floor? _____ b. Are they clearly marked? Yes No

12. 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:

a. What are the ages of children placed in foster homes? _____

b. How many foster homes do you utilize? _____

c. Are they licensed by applicable state and/or local authorities? Yes No

If not, who licenses the foster homes? _____

d. Describe the process used to obtain foster homes: _____

e. How often are children moved from one foster home to another? _____

f. How often does the applicant's employees visit the children in the foster homes? _____

g. Who compensates the foster parents? _____

h. How does the applicant handle allegations of child abuse (sexual or physical) in the foster homes? _____

Adoption:

a. What are the ages of the children placed? _____

b. Outline the 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

VII. OUTPATIENT FACILITIES

Not Applicable

	# of Daily Clients		# of Annual Clients
<input type="checkbox"/> Behavioral Day Care (Adult/Child)		<input type="checkbox"/> DUI Classes	_____
a. Mental Health Day Care	_____	<input type="checkbox"/> Methadone Maintenance	_____
b. Developmentally Disabled	_____	<input type="checkbox"/> Alcohol/Drug Counseling (Outpatient)	_____

a. Please describe all methods of detox, including the medications utilized: _____

b. If the applicant provides a crisis hotline, please answer the following:

1. What types of problems are treated by the hotline: _____
2. Do you use volunteers on the hotline? Yes No
3. If volunteers are used as counselors, please describe the training they receive: _____

4. Hours of operation for the hotline: _____

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

c. If the applicant provides a recreation program, please describe activities in full detail: _____

Do they have an Accident & Health Policy? Yes No

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: _____

VIII. PROFESSIONAL STAFF/STAFFING

Not Applicable

1. Please complete the following, or attach a separate staffing list.

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		
Therapist/Counselor			Paramedic		
Dialysis Tech			Physician Assistant		
LPN			Volunteers		
Teachers			Other		
Speech Pathologist			Describe:		

2. Please indicate the total number of staff: _____

IX. PSYCHIATRISTS

Not Applicable

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

A	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.

1. Is an employment application obtained on all psychiatrists? Yes No
2. Does your professional employment application for psychiatrists ask the following questions:
 - a. Have you ever been convicted of a crime in any state or country? Yes No
 - b. Has your license ever been suspended or revoked in any state or country? Yes No
 - c. Have you ever been treated for alcoholism or drug addiction? Yes No
 - d. Have you ever been subject to an investigation, disciplinary proceeding, or reprimanded by a governmental or administrative agency, hospital or professional association? Yes No
 - e. Are you aware of any acts, errors, omissions, or circumstances which may result in a claim against you? Yes No
3. Do you check all psychiatrist credentials prior to hire/contract? Yes No
4. Is a current Certificate of Insurance obtained annually, verifying that the psychiatrist carries his/her own malpractice insurance? Yes No
5. Check medical services provided by physicians: Routine Physical Electroconvulsive Therapy Hypnosis Prenatal Care/Delivery Other _____

X. 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 and Universal Precautions? Yes No
7. How do you verify pre-employment-related references? In Person By Telephone Written
8.
 - a. Is staff required to report all incidents? Yes No
 - b. Are written records of all reported incidents which could lead to a claim kept by the administrator? Yes No
 - c. Are all incidents reviewed by a committee? Yes No
9. Is smoking confined with signs posted, and are smoking regulations enforced? Yes No

10. Do you have written policies and procedures in place for storing/prescribing/administering all medications? If Yes, please attach. Yes No
11. a. Are all medication errors monitored? Yes No
 b. If Yes, please describe: _____
12. Do you follow current statutory requirements regarding clinical documentation and confidentiality? Yes No
13. a. Do employees use their personal autos for company business or client transport? Yes No
 b. If Yes, please describe: _____
 c. If Yes, do you obtain a copy of their Drivers License, Registration and auto liability insurance? Yes No
 d. What minimum limits of auto liability do you require? _____
 e. Do you provide transportation for clients? Yes No
 f. If transportation is outsourced, do you provide a "ride along" staff member on all transports? Yes No
14. Has the facility ever been held to be in violation of any health, safety or building codes? Yes No
15. a. Have you had a recent inspection of your facility(ies) for the existence of toxic mold? Yes No
 b. If No, are you planning on having a toxic mold inspection conducted? Yes No
16. Do you have a written evacuation plan? Yes No
18. 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
19. 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.
20. 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
21. Are complete records kept on all patients? Yes No
 Where are they stored and how are they secured? _____
22. 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.

- A. Name: _____ Insurance Interest (funding, landlord-if
 Address: _____ landlord, provide location number _____
 General Liability Professional Liability
- B. Name: _____ Insurance Interest (funding, landlord-if
 Address: _____ landlord, provide location number _____
 General Liability Professional Liability
- C. Name: _____ Insurance Interest (funding, landlord-if
 Address: _____ landlord, provide location number _____
 General Liability Professional Liability

XI. ADDITIONAL OPERATIONS

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

- a. Sheltered Workshop Complete Section I of Supplemental Application
- b. Camp/Adventure Course Complete Section II of Supplemental Application
- c. Day Care Complete Section III of Supplemental Application
- d. Thrift Store Indicate Estimated Annual Receipts: \$ _____
Description of goods sold: _____
- e. 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 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 IN THE THIRD DEGREE.

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 AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND 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 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 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 MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime.

Applicant's Signature _____ Date _____

Agent _____

Agent's Signature _____ Date _____