Professional & General Liability Application for Outpatient Mental Health Counseling & Substance Abuse Services

1. Name of Applicant: _____
(as it should appear on the policy)

2. Mailing Address: _____

3. Location Address: _____
(If multiple locations, please attach list)

4. Telephone Number: _____ Website Address: _____

5. Exposure:

Gross Receipts for the Past 12 Months:	$
Estimated Gross Receipts for the Next 12 Months:	$
Payroll for the Past 12 Months:	$
Estimated Payroll for the Next 12 Months:	$
Number of Visits (not patients) for the Past 12 Months:	
Estimated Number of Visits (not patients) for the Next 12 Months:	

NOTE: Please provide # of visits, not the # of patients, in response to the above. Please count each time each client/patient has contact with staff member, whether in person or via telehealth, as an individual visit.

6. Full description of services provided: _____

_____

7. Does the applicant own or manage any other businesses or locations not shown on this application?

Yes ☐ No ☐

If yes, is there separate professional and general liability coverage for these other operations elsewhere at a minimum of $1M/$3M limits and does the applicant agree to maintain separate coverage in force for these other operations throughout the duration of this policy?

Yes ☐ No ☐

8. Are all services provided at the applicant's location address(s)? Yes ☐ No ☐

If no, please provide details of any off-site exposure including a breakdown as to where services are provided by % at each type of location:

_____

9. a) List the number and type of employees/owners by shift:

	Number		**Number**
Physician/Psychiatrist (patient contact)		Physician/Psychiatrist (no patient contact)	
Physician Assistant		Nurse Practitioner	
Psychologist		Nurse	
Social Worker/Counselor		Medical Technician	
Admin/Clerical		Other (please describe) _____	

b) List the number and type of independent contractors by shift:

	Number		**Number**
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant/Nurse Practitioner		Nurse	
Physical/Occupational/Speech Therapist		Social Worker/Counselor	
Nurse Aide/Caregiver		Administrator/Manager/Owner	
Admin/Clerical		Other (please describe) _____	

c) Are all the individuals listed in response to Q17a & b licensed in accordance with applicable state and federal regulations?

Yes ☐ No ☐ If no, attach explanation.

10. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ If yes, at what limits? $_____ / $_____

If no, is coverage desired with shared limits on this policy? Yes ☐ No ☐

11. Do you require employed, contracted or volunteer physicians to carry their own Professional Liability Insurance at a minimum of $1M/$3M limits and secure Certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ **Please attach proof of coverage.**

12. Please confirm which of the following you obtain, review, verify and keep on file as part of the employee/ independent contractor hiring & screening process:

	Yes	No
Employment Application		
Criminal Background Checks		
Drug / HIV/ Hepatitis Testing		
Licenses Held		
Education/Training/Competence		
Multi-State Registry		

13. Additional employment related questions:

	Yes	No
Do you question prospective employees/independent contractors about prior claims or suits?		
Are employees required to actively participate in continuing education?		
Do you prepare job descriptions and instructional manuals for your staff?		
Do you have a written incident/occurrence reporting policy and procedures?		
Are all owners/employees/independent contractors current on any training that is required by the state or any other governing body, and is there proof of any required training on file at the home/facility for review?		

14. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

_____

15. Is there any physical contact which may occur between you and any patients/clients or between two or more patients/clients at your direction? Yes ☐ No ☐

If yes, please provide details: _____

16. Does the applicant provide any beds for overnight stays? Yes ☐ No ☐

If yes, give details:

_____

17. Do you act as legal guardian or power of attorney for anyone?

Yes ☐ No ☐ If yes, please provide details: _____

18. Please provide a breakdown of the types of counseling services provided:

Substance Abuse (Alcohol/Drugs)	%
Ex-Offender Therapy/Evaluation	%
Family/Marriage	%
General	%
Victims of Domestic/Sexual Abuse	%
Early Intervention for Developmentally Disabled Children	%
Counseling for Developmentally Disabled Adults	%
Crisis Intervention (please describe below)	%
Other (please describe below)	%

Please describe if requested above: _____

19. Does the applicant, or do any of their employees or independent contractors, prescribe medications?

Yes ☐ No ☐ If yes, please answer the following:

a) Who is prescribing them (including professional designation): _____

b) Under what circumstances/for what reasons: _____

c) Provide a list of all medications prescribed: _____

d) Is an in-person examination performed prior to the prescription of any medication?

Yes ☐ No ☐

If no, please provide details: _____

20. Does the applicant do any of the following:

a) Provide services to anyone under the age of 18 years old? Yes ☐ No ☐

If yes, give % of patients who are minors: _____ and services provided: _____

b) Provide testimony in child custody hearings? Yes ☐ No ☐

If yes, # times in past 3 years: _____

c) Provide testimony in competency hearings? Yes ☐ No ☐

If yes, # times in past 3 years: _____

d) Act as an expert witness in criminal/civil trials or other legal proceedings? Yes ☐ No ☐

If yes, # times in past 3 years: _____

e) Treat patients referred/remanded by courts of law or attorneys or other legal representative of the patient?

Yes ☐ No ☐ If yes, give % of patients: _____

f) Use hypnotherapy, treat for failed/repressed memory syndrome, or use any alternative/non-traditional counseling methods as part of their practice? Yes ☐ No ☐

If yes, please provide details & what % this is of total operations: _____

21. Does the applicant pre-screen all clients/patients prior to acceptance to see if they currently have, or have had a history of, suicidal thoughts, self-harming thoughts and/or thoughts of harming others?

Yes ☐ No ☐ If yes:

a) are such clients/patients accepted by the applicant for treatment? Yes ☐ No ☐

b) would any clients/patients who develop suicidal thoughts, self-harming thoughts and/or thoughts of harming others during their treatment be immediately referred out to a higher level of care with a follow up shortly afterwards to ensure that the patient received the required treatment elsewhere?

Yes ☐ No ☐

22. Please complete the table below showing the applicant's Professional Liability coverage for last 5 years: (if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

23. Please complete the table below showing the applicant's General Liability coverage for last 5 years: (if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

24. Has the applicant or have any of their employees (please attach a detailed explanation for any "yes" answers):

	Yes	No
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
c) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?		
d) Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

25. Has any claim ever been made against the firm or any of its employees?

Yes ☐ No ☐ **If yes, please attach completed claims supplement.**

26. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes ☐ No ☐ **If yes, please attached a separate sheet with date(s) and details.**

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)