



**Professional & General Liability Application for Residential Substance Abuse,
Halfway Houses and Sober Living Homes (adults only)**

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

2. Mailing Address: _____

3. Location Address: _____
(If more than one location address, please complete a separate application per location)

4. Telephone Number: _____ Website Address: _____

5. Entity is:

a) a start-up (i.e. a business of this nature has never been in operation under either this name or at this location)?

Yes _____ No _____

b) a new purchase of an existing business (i.e. a business of this nature has been in operation either under this name or at this location)?

Yes _____ No _____ If yes, please include purchase date: _____

c) an existing operation?

Yes _____ No _____ If yes, please include number of years operational: _____

6. Entity is an:

	<u>Number of Licensed Beds</u>	<u>Number of Occupied Beds</u>
Alcohol & Drug Rehab (No Detox, Adult Only)		
Alcohol & Drug Rehab (Including Detox, Adult Only)		
Halfway House/Sober Living for Adults Recovering from Substance Abuse only		
Shelter or Transitional Living Facility (please describe type of residents accepted)		
Other (please describe)		

7. Are you currently licensed without conditions or restrictions? Yes _____ No _____

If no, please provide details: _____

8. Number of Residents by Age Category: 0-17 _____ 18-39 _____ 40-65 _____ 66+ _____

9. Are any residents under the age of 18 years old accepted? Yes _____ No _____

10. Are any residents accepted on a temporary or emergency basis, or without a complete pre-screening and evaluation having been done by the applicant to ensure that they are a good fit for the home prior to acceptance of the resident?

Yes _____ No _____

If yes, please provide details: _____

11. Are there any circumstances under which the applicant will accept a resident whose needs fall outside of the scope allowed by their license (or if the home is unlicensed, whose needs exceed those that the home is allowed to provide as an unlicensed home)?

Yes _____ No _____

If yes, please provide details: _____

12. Are any services provided to anyone on an outpatient basis? Yes _____ No _____

If yes, please also complete the Outpatient Mental Health Counseling & Substance Abuse Application showing the outpatient exposure.

13. Full description of services provided: _____

14. 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 _____

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

NOTE: The tables below assume that there are 3 shifts, each lasting 8 hours. If this is not the case, please state the duration of each shift next to each category of staff below for both tables below.

	1 st Shift	2 nd Shift	3 rd Shift		1 st Shift	2 nd Shift	3 rd Shift
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)			

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

	1 st Shift	2 nd Shift	3 rd Shift		1 st Shift	2 nd Shift	3 rd Shift
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)			

16. a) Name of Administrator: _____ b) Number of Hours per week at the home: _____
(please attach resume)

17. a) Name of Medical Director: _____ b) Number of Hours per week at the home: _____

c) Does the Medical Director have patient/resident contact? Yes _____ No _____

If yes, is there separate professional liability coverage for this exposure at a minimum of \$1M/\$3M limits and does the applicant agree to ensure that separate coverage is in force throughout the duration of this policy?

Yes _____ No _____ **If yes, please attach proof of coverage.**

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

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

19. Additional employment-related questions:

	<u>Yes</u>	<u>No</u>
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?		

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

21. Does the applicant, or do any of their employees or independent contractors, prescribe medications to the residents of this facility?

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

- a) Who is prescribing them: _____
- b) Under what circumstances/for what reasons: _____
- c) Provide a list of all medications prescribed: _____

22. Are the applicant's staff required to observe all residents as they take any medications prescribed/dispensed on-site to verify that they have been taken as prescribed?

Yes _____ No _____

23. Are all medications securely stored, locked and inaccessible to residents until dispensed by the applicant's staff?

Yes _____ No _____

24. Is a resident agreement signed by all residents upon entering the facility?

Yes _____ No _____ **If yes, please attach a copy.**

25. a) Is an in-person assessment performed of all new residents prior to acceptance by either the applicant or a third party who is qualified to perform these assessments on behalf of the applicant?

Yes _____ No _____

b) Is a copy of the above assessment on file at the home/facility and available for review?

Yes _____ No _____

26. a) Does the applicant pre-screen all residents prior to acceptance to see if they have committed a criminal offense previously?

Yes _____ No _____

b) If yes, are such residents accepted into the home?

Yes _____ No _____

c) If yes, does the applicant only accept ex-offenders of minor, non-violent crimes?

Yes _____ No _____

d) If no, are all ex-offenders accepted or what are the applicant's admittance criteria when it comes to ex-offenders? Please provide as much detail as possible: _____

27. a) Does the applicant accept/retain any individuals who require monitoring or supervision in any way, for example, through the use of an ankle bracelet or other monitoring device, or through court imposed restrictions?

Yes _____ No _____

28. a) Does the applicant pre-screen all residents prior to acceptance to see if they are combative, or if they have had a history of combative behavior?

Yes _____ No _____

b) Are such residents accepted into the home and retained if residents become combative during their stay?

Yes _____ No _____

If yes, have all staff been formally trained in de-escalation techniques? Yes _____ No _____

29. Does the applicant pre-screen all residents 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, are such residents accepted into the home and retained if residents develop such thoughts during their stay?

Yes _____ No _____

30. Have you had any residents elope (i.e. leave the premises without the staff being aware of it) in the past 3 years?

Yes _____ No _____ If yes, please provide date and details: _____

31. Have you had any residents commit, or attempt to commit, suicide in the past 3 years?

Yes _____ No _____ If yes, please provide date and details: _____

32. Have you had any residents harm, or attempt to harm, themselves or others in the past 3 years?

Yes _____ No _____ If yes, please provide date and details: _____

33. Do you provide any legal and/or financial services and/or act as legal guardian or power of attorney for anyone?

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

34. Are there smoke detectors in all rooms and hallways? Yes _____ No _____

35. Is there a fire alarm? Yes _____ No _____

36. Survey and Complaint Experience

Please attach copies of all surveys and complaint investigations for the past 3 years, and answer all questions relating to the experience of the facility/home, even if under a prior owner and/or administrator.

- a) Date of the last full, on-site state inspection/survey: _____
- b) Number of deficiencies/citations/items to correct in order to be in compliance: _____
- c) Was the plan of correction accepted by the state/governing body? Yes _____ No _____
- d) Number of complaints investigated in the past 3 years: _____
- e) Number of fines in the past 3 years: _____

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

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Date</u>	<u>Retro Date</u> <u>(if applicable)</u>

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

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Date</u>	<u>Retro Date</u> <u>(if applicable)</u>

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

	<u>Yes</u>	<u>No</u>
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?		

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

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

41. 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)