ALLIED HEALTHCARE RESIDENTIAL FACILITIES PROFESSIONAL LIABILITY APPLICATION

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1. Entity Name:_____

2. Mailing Address:_____

_____

3. Location Address(es):_____

_____

4. Date Established:_____

5. Contact:_____ E-mail:_____

6. Business Structure (check one):

[ ] Independent Contractor (1099) [ ] Corporation

[ ] Sole Proprietorship [ ] Partnership

[ ] Other; Describe:_____

7. Entity is: [ ] For Profit [ ] Non-Profit

8. List memberships in professional organizations:_____

PART II. EXPOSURES

1. Facility classification and number of:

	Occupied beds	Licensed beds
Alcohol/Drug Rehabilitation Services include 24-hour a day care by licensed professionals. May include detox services.	_____	_____
Halfway House Living facility for helping former drug addicts, psychiatric patients adjust to life in general society. Typically, non-medical counseling services are provided.	_____	_____

	Occupied beds	Licensed beds
Group Home for Disabled Structured living accommodations for the physically disabled that may be non-ambulatory and dependent on others to perform basic Daily living activities. Facilities are typically under the direct supervision of a live-in supervisor or director.	_____	_____
Home for Mental Health Residents Structured living accommodations for mentally handicapped/mentally retarded residents that are ambulatory and may be dependent on others to perform basic Daily living activities. Facilities are typically under the direct supervision of a live-in supervisor or director.	_____	_____

2. Is the applicant/facility licensed in accordance with applicable state and federal laws? [ ] Yes [ ] No

3. Number of patients/residents suffering from Alzheimer's Disease or Dementia? _____

None _____

4. 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: _____

_____

_____

5. Are all residents/patients fully ambulatory (including use of cane or walker)? [ ] Yes [ ] No

7. Do you conduct Sheltered Workshops? [ ] Yes [ ] No

If yes, complete the application for Sheltered Workshop.

8. Are any residents/patients under restraint? [ ] Yes [ ] No

If yes, how many? _____ What restraints are used? _____

9. Describe any physical contact which may occur between you and any patients/clients or between two or more patients/clients at your direction: _____

_____

10. What was your total number of outpatient/client visits last year? _____

11. Describe any psychometric monitoring devices or other equipment (including feedback techniques) utilized _____

_____

12. 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? _____

13. 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.

14. Are any activities or events for patients/clients conducted or sponsored away from applicants? [ ] Yes [ ] No

If yes, describe:_____

15. Are there 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):_____

_____

_____

17. 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.

18. Indicate annual number of Alcohol Detoxifications: ; Drug Detoxifications: _____

19. "Is Methadone or other controlled substances prescribed or administered?? [ ] Yes [ ] No

If yes, provide details on number of doses, off-premises use, counseling requirements, and drug screening.:_____

_____

_____

_____

PART III. RISK MANAGEMENT

1. Is there a Registered Nurse on duty? [ ] Yes [ ] No

   If yes, how many shifts per day? _____

2. How often does a physician visit the facility? _____

   Note: If physician exposure exists in the form of owner, employee, contractor, or volunteer, the Physician Supplement must be completed, along with verification of physician's individual professional liability insurance and limit.

3. Does each patient have their own physician? [ ] Yes [ ] No

   If yes, is this a requirement of your facility? [ ] Yes [ ] No

4. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? [ ] Yes [ ] No

   Explain any exceptions: _____

   _____

5. Are medications stored in a secure manner? [ ] Yes [ ] No

   If no, explain in detail: _____

6. Are precautions taken to prevent residents leaving premises or "wandering" without applicant's knowledge, such as exit alarms, etc.? [ ] Yes [ ] No

   Please describe: _____

   _____

7. 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: _____

8. Explain arrangements for medical emergencies (e.g., physician on call, transfer arrangement with hospital, etc.):

   _____

   _____

9. Are you equipped with an emergency 24-hour telephone call line for all of staff and patients: [ ] Yes [ ] No

10. Does the applicant/facility have personnel trained in emergency medical care in the facility during all hours of operation? [ ] Yes [ ] No

    If no, please explain: _____

    _____

11. Is there a written emergency evacuation plan? [ ] Yes [ ] No

12. State the frequency of fire drills: _____

13. Minimum number of trained personnel on premises at night for emergency evacuation:_____

14. Do you desire coverage for independent contractor(s) as additional insured(s) on your policy while working on your behalf? [ ] Yes [ ] No

Do you require:

a) contracted staff to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

If yes, indicate minimum limits required: _____

b) employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

If yes, indicate minimum limits required: _____

17. Do you enter into any contractual agreements (other than lease of premises agreements)? [ ] Yes [ ] No

If yes, attach explanation.

18. List memberships in professional organizations: _____

19. What is the staff-to-resident ratio during peak hours? _____

20. How frequently do staff undergo emergency preparedness training, including CPR and first aid? _____

21. What measures are in place to ensure the security of patient records (e.g., encryption, access controls)? _____? _____

22. Do you have a formal process for handling and documenting resident care complaints? [ ] Yes [ ] No

23. Number of **Professional Staff**: (**E = Employed; C = Contract**)

E	**C**		**E**	**C**	
_____	_____	Administrators	_____	_____	Psychiatrists
_____	_____	Dieticians/Nutritionists	_____	_____	Respiratory Therapists
_____	_____	Nurse Practitioners	_____	_____	RNs/LVNs/LPNs
_____	_____	Physicians	_____	_____	Social Workers
_____	_____	Physician Assistants	_____	_____	Speech Therapists
_____	_____	Physiotherapists/Physical Therapists	_____	_____	Other:_____

24. Do you conduct pre-employment screening and investigation? [ ] Yes [ ] No

25. Do you conduct background checks on contractors? [ ] Yes [ ] No

26. Do you prepare job descriptions and instructional manuals for your staff? [ ] Yes [ ] No

27. Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? [ ] Yes [ ] No

28. Does your agency have a written credentializing policy and procedure for all individuals associated with or practicing within the agency? [ ] Yes [ ] No

29. Do you have any physicians on staff admitting patients, or treating patients who have restricted licenses? [ ] Yes [ ] No

If yes, explain on separate sheet.

30. Has the applicant or have any of the above employees:

a. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? [ ] Yes [ ] No

b. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [ ] Yes [ ] No

c. ever been treated for alcoholism or drug addiction? [ ] Yes [ ] No

d. 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? [ ] Yes [ ] No

If Yes to any of the above, please explain.

31. Name, qualification, and number of years of experience of the Medical Director, all managers, and supervisors:

Name Title Experience/Training Association Membership

_____

_____

_____

_____

PART V. CLAIMS AND HISTORY

1. List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Limit of liability	Premium	Effective Dates	Claims-made or Occurrence?

What is the most recent retroactive date? _____

2. List prior **general liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Limit of liability	Premium	Effective Dates	Claims-made or Occurrence?

What is the most recent retroactive date?_____

3. Claims History:

a. Have any claims been made or accidents reported during the past five years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? [ ] Yes [ ] No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

_____

_____

_____

_____

b. Does any proposed insured have any knowledge of an event, circumstance, or accident 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 Diamarc Underwriters, LLC, 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 dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

_____

Applicant Signature

_____

Title

_____

Date