Quaker Special Risk

a division of Quaker Agency, Inc.
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SOCIAL SERVICES
PROFESSIONAL LIABILITY APPLICATION
for RESIDENTIAL FACILITIES

INSTRUCTIONS: ANSWER ALL QUESTIONS; IF THE ANSWER IS NONE, STATE NONE; IF THE QUESTION 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

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 an ___ Employee ___ Student ___ Sole Practitioner

___ B. The **APPLICANT** is a:
___ Sole Proprietorship ___ Partnership ___ Corporation
___ Other - Describe _____

1.9 Entity is ___ For Profit ___ Not-for-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 twelve months - $_____
last twelve months - $_____

1.12 Annual Payroll or Remuneration: Estimated next twelve months - $_____
last twelve 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
___Other:_____
___Home for Retarded
___Hospice
___Partial Hospitalization Program
___Temporary Shelter
___Youth Home / Orphanage

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 Prgm, how many licensed client spaces**? _____

2.2 **Patient Census**

RESIDENTS AGES

Under 13	13 - 18	18 - 25	26 - 54	55 - 64	65 +

DAY PATIENTS / PARTICIPANTS 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 Alzheimers Disease or Dementia? _____ / None_____

2.4 If facility 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; and 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 decription:_____
_____

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 exist 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 6).

2.24 Any activities or events for patients/clients conducted or sponsored __ Yes __ No
away from applicants? IF YES, describe_____

2.25 Any swimming pools, exercise facilities, or athletic activities? __ Yes __ No
IF YES, please describe (for pool give info re pool use rules, life guard, fencing, depth)_____

_____

2.26 Describe any "fund raising" 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 employees to report all incidents (accidents)? __ Yes __ No
Are records of such reports kept on file by the facility? __ Yes __ No
If no, explain:_____

3.2 Are precautions taken to prevent residents leaving premises or "wandering" without applicant's knowledge, such as exit alarms, etc.? ____ Yes ____ No 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 (i.e. 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	__	__	Psychiatrist *
__	__	Physician * / Dentist *	__	__	Speech Therapists
__	__	Nurse Practitioner	__	__	RN's / LVN's
__	__	Physician Assistant	__	__	Other:_____

Complete the following for each Physician, including Medical Director, Dentist, Chiropractor, Podiatrist, Psychiatrist, Nurse Practitioners, Physician Assistants, Anesthetist, Midwife.
* 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?___ Yes ___ No IF YES, explain on separate sheet.

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, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Form Yes or No
1.					
2.					

3._____
4._____
5._____

If claims-made form, 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, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Claims-Made Form Eff.Date	Claims-Made Form Yes or No
1.						
2.						
3.						
4.						
5.						

If claims-made form, 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?

___ 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)._____

_____

_____

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?

___ Yes ___ No

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 Mid-Continent General Agency, 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 that applicant has not withheld any 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 <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

_____ _____

Date Applicant/Title