

Residential Care Provider Professional and General Liability Insurance Application

Name on License _____

DBA _____

Contact Person _____ Phone # _____ Fax # _____

Email Address _____ Mailing Address _____

Number of Years in Business _____ FEIN _____ Effective Date Requested ___/___/___

Type of Entity Corporation Sole Proprietor Partnership Non-Profit LLC LLP Other _____

Limits of Insurance Requested (Per Claim/Aggregate)

\$50,000/\$200,000 \$100,000/\$300,000 \$500,000/\$500,000 \$500,000/\$1,000,000

\$1,000,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000 \$2,000,000/\$4,000,000

Location Address (complete a separate sheet for any additional locations)	Number of Licensed Beds	Facility Type
1		
2		
3		

There will be no coverage for operations at locations owned, leased, or operated by the insured that are not listed on the schedule above.

Are any of the above locations Independent Living? Yes No If yes, how many units? _____ Loc _____

Are any of the above locations Adult Daycare? Yes No If yes, how many participants? _____ Loc _____

Do you offer any home health or non-medical home care services? Yes No

If yes, you will need to complete a Home Health application. Please contact your Agent/Broker.

Do you accept any residents under the age of 18? Yes No

Do you provide any other services? Yes No If yes, please explain _____

(If yes to any of the following questions, provide a detailed explanation on a separate page)	
Has a fact, circumstance, event, or incident occurred at any location (or any location listed above) in the past 3 years that might result in a claim on liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any license ever been denied, revoked, or suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any elopements (residents that have left the facility without your knowledge/permission) in the past 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is a medical assessment by a medical professional obtained prior to admission? Yes No

How often are residents reassessed? _____

How do you identify when a resident needs to be transferred to another degree of care?

Do you use a Negotiated Risk Agreement? Yes No

Do you require a signed release in order to release records pertaining to resident? Yes No

Does the resident or Power of Attorney sign a release for emergency medical treatment of resident? Yes No

Have you had any new residents within the past 90 days? Yes No If yes, how many? _____

Do you conduct a tour of the facility and review procedures with new residents and/or their Power of Attorney?

Yes No

Do you accept wanderers? Yes No If yes, are identification armbands used? Yes No

Do you conduct a wandering risk assessment upon admission? Yes No

Are all residents assessed for memory loss annually? Yes No

Are restraints used other than those ordered by a doctor? Yes No

Describe off-site activities or excursions offered to the residents: _____

Resident Census (if more than 3 locations, complete this section separately for additional locations)

(The total of all Alzheimer's, dementia, developmentally disabled (other), and fully functional residents must equal the total of occupied beds in each column)

Residents' Mental Capacity	Location #1	Location #2	Location # 3
Number of Alzheimer's residents			
Number of residents diagnosed with dementia			
Number of developmentally disabled (or other) residents			
Number of fully mentally functional residents			
Total number of occupied beds			

(The total of all independently ambulatory, ambulate with assistance, confined to wheelchair, and bedridden residents must equal the total of occupied beds in each column)

Residents' Physical Capacity	Location #1	Location #2	Location # 3
Number of Independently Ambulatory residents			
Number of residents who ambulate only with assistance			
Number of residents confined to a wheelchair			
Number of bedridden residents			
Total number of occupied beds			

If any location above has bedridden residents, can they bear weight? Yes No

Policies and Procedures at all locations

Does the facility have a written plan for missing residents (If someone wanders)? Yes No

Does the facility have a sign out policy in place? Yes No

Does the facility have a written physical and sexual abuse prevention policy? Yes No

Does the facility have a written procedure for resident falls? Yes No

Do you document all resident falls? Yes No

Does your fall procedure include communication with family and medical personnel (doctor, hospital, etc.) and written documentation of this action? Yes No

Is your documentation for recording falls, monitoring medications, and changes in condition computer based or written? Computer-based Written

Staffing at all locations (if more than 3 locations, complete this section separately for additional locations)

Staffing Totals	Location # 1	Location # 2	Location# 3
Number of staff during the day			
Number of staff overnight			

Do you conduct Criminal Background Checks on all new employees? Yes No

Do you conduct Reference Checks on all new employees? Yes No

Are you or any of your staff RN's or LPN's providing professional medical services to the residents? Yes No

If yes, does the medical professional have their own Professional Liability Insurance? Yes No

Are overnight staff awake at all times? Yes No

If no, how are sleeping overnight staff made aware of emergencies? _____

What is the average length of employment for all employees with you? _____

Do you use a staffing agency to obtain your employees? Yes No If yes, how many? _____

If yes, do you get a Certificate of Insurance naming your facility as an additional insured from the staffing agency? Yes No

Do you have an employee training program? Yes No

Are the staff members that administer medications trained in proper medication administration and handling?
 Yes No

Do you have a visiting RN, MD, or Home Health agency come in to provide professional medical services?
 Yes No

If yes, is their contract with the resident or the facility? Resident Facility

If the contract is with the facility, do you obtain a Certificate of Liability naming your facility as an additional insured? Yes No

Building and Grounds at all locations

Are all exit doors alarmed? Yes No

Do you have an emergency evacuation plan posted? Yes No

Are smoke detectors located in all bedrooms and halls? Yes No

Are smoke detectors properly maintained? Yes No

Do you have a fire inspection completed by a local fire company annually? Yes No

How many fire extinguishers do you have? _____

What date were the fire extinguishers last serviced? _____

What is the distance to the nearest responding fire company in miles? _____

What is the distance to the nearest Hospital, EMT, or Paramedic in miles? _____

Is there a swimming pool on the premises? Yes No

Are residents permitted to use the pool? Yes No

If yes, are residents only permitted to use the pool with supervision? Yes No

Is the pool fenced with a locked gate? Yes No

Is there an alarm on the pool access? Yes No

Are there any firearms on the premises? Yes No If yes, how are they secured? _____

Additional Coverage Options (consult your agent for questions on these coverage options)

Do you currently have a Commercial Auto policy in place? Yes No (If yes, this coverage is not applicable)

If no, do you want Excess Hired & Non-owned Auto Liability coverage? Yes No

If yes, how many employees use their personal automobile for business purposes? _____

What limit of Hired & Non-Owned Auto Liability do you want? \$300,000 \$500,000 \$1,000,000

Do you live in the home? Yes No Do you have a Commercial Property Policy? Yes No

If yes, do you want Personal Liability coverage? Yes No

Who is listed as the named insured(s) on the Commercial Property Policy? _____

Is Employer's Contingent Liability Coverage needed? (WA, OH, WV, NV, ND, WY Only) Yes No

If yes, how many employees? _____

The application for this policy is incorporated and warranted as part of this policy. This insurance policy is being issued in reliance on the accuracy, truthfulness, and completeness of the application. Any inaccuracy, falsity, or omission, regardless of the nature, shall entitle us to rescind the policy.

I declare that the information provided in this application is accurate, true, and complete and that each location currently complies and will comply with the rules and regulations set by state and federal law. I understand that if I willfully do not comply with these rules and regulations that coverage is null and void and any claims may be denied and premium returned.

If the information supplied on the application changes between the date of the application and the effective date of the insurance, I will immediately notify PCH of any changes. In the event of any changes, PCH may withdraw or modify any outstanding quotations and/or agreement to bind the coverage. I must notify PCH of any changes in the operation of this business during the policy period, and failure to do so may result in cancellation of the coverage or denial of a claim.

I hereby authorize PCH to obtain information necessary for the evaluation in determining acceptability, including, but not limited to, physical inspections and inquiries with the state licensing departments.

Signature

Printed Name and Title

Date

This application does not guarantee approval for this liability insurance program. PCH reserves the right to decline coverage. We will attempt to provide you with an approval or declination within 48 hours of receiving this form and the supporting documents in our office. Please email or fax these items to 717-630-1188.

This application requires the following attachments:

- Copy of State license for each location
- Copy of last State inspection for each location
- Copy of your current insurance policy(ies) if applicable
- 3 years of currently valued loss runs from existing and previous insurance companies for each location if applicable

Producer Name: _____ Agency: _____

Agency Address: _____ Email Address: _____

How did you hear about us? _____ Association _____ Mailer _____ Internet Search _____ Referral