ALLIED HEALTHCARE SOCIAL SERVICES 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. Applicant Name:_____

2. Mailing Address:_____

_____

3. Location Address(es):_____

_____

4. Date Established:_____

5. The applicant is:
   [ ] Sole Practitioner
   [ ] Sole Proprietorship
   [ ] Partnership
   [ ] Corporation
   [ ] Other; Describe:_____

6. Gross Annual Receipts: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

7. Entity is: [ ] For Profit [ ] Non-Profit
   Describe source of funds:_____

PART II. EXPOSURES

1. Type of Facility:

_____ Adoption Agency
_____ Child Day Care
_____ Day Care (Senior Citizens)
_____ Forster Care
_____ Hotline (Phone crisis service)
_____ Meals on Wheels
_____ Nanny Service
_____ Employee Assistance Program
_____ Referral Agency
_____ Other:_____

2. Describe the nature of insured's operation including types of services rendered and activities conducted:

_____

_____

3. Total number of patient/client visits last year? _____

   Estimated next year? _____

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

   If no, explain:_____

5. Does facility provide "Day" services? [ ] Yes [ ] No
   If yes, what is the number of "day patients" (include "independent living" persons): Maximum # ____ Average #____

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

   If no, explain:_____

7. 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? _____

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

   _____

9. Are any services specifically concerned with sexual response/dysfunction of individual patients/clients:_____

   _____

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

    If yes, how many shifts per day? _____

11. Is any medication prescribed? [ ] Yes [ ] No

    If yes, list names and frequency prescribed:_____

    _____

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

    If no, explain:_____

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

    If yes, please describe:_____

    _____

14. Any swimming pools, exercise facilities, or athletic activities? [ ] Yes [ ] No
    If yes, please describe (information re: pool use rules, lifeguard, fencing, and depth):_____

    _____

    _____

15. Describe any "fundraising" or other special events activities conducted:_____

    _____

    _____

16 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.

17. List memberships in professional organizations: _____

PART III. RISK MANAGEMENT

1. Total number of staff: _____

2. Total payroll last year: _____

Total payroll next year: _____

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

E	C		E	C	
_____	_____	Case Managers	_____	_____	Psychiatrists*
_____	_____	Dieticians/Nutritionists	_____	_____	Psychologists/Psychotherapists
_____	_____	Marriage/Family Counselors	_____	_____	Respiratory Therapists
_____	_____	Nurse Practitioners	_____	_____	RNs/LVNs/LPNs
_____	_____	Occupational Therapists	_____	_____	School Counselors
_____	_____	Pharmacists	_____	_____	Social Workers
_____	_____	Physician Assistants	_____	_____	Speech Therapists
_____	_____	Physicians*/Dentists	_____	_____	Teachers
_____	_____	Physiotherapists/Physical Therapists	_____	_____	Other:_____

12. Complete the following for each Physician, including Medical Director, Dentist, Chiropractor, Podiatrist, Psychiatrist, Nurse Practitioners, and Physician Assistants:

* Complete Physician Supplement when applicable.

Name	Professional Status	E, C, or I (E = Employee C = Contract I = Independent)	Maintains malpractice insurance	Limit of Liability	Certificate of Insurance Obtained

3. 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: _____

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

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

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

7. 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

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

Explain any exceptions: _____

_____

_____

_____

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

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

Please describe: _____

_____

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

12. State the frequency of fire drills: _____

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

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

_____

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

If yes, attach explanation.

13. Has the applicant or have any 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.

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

Name	Title	Experience/Training	Association Membership

PART IV. FOSTER CARE (Complete for coverage for these operations)

1. Annual number of foster care placements:_____

Who pays the foster parents?_____

How many foster homes are utilized?_____

Total number of beds available:_____

Maximum number of children per home:_____

Age range of foster children:_____

2. How does the agency recruit foster homes?_____

Are the foster homes licensed?_____

Does the agency certify the foster homes?_____

Criteria upon which a foster home is rated and accepted:_____

3. Does acceptance procedure include background/reference checks? [ ] Yes [ ] No

Screening for Criminal Record? [ ] Yes [ ] No

4. Foster care placements are:

Well Child: _____ % Mentally Retarded: _____%

Emotionally Disturbed: _____% Other: _____%

Describe:_____

5. Percentage of children who are removed from their parents' homes involuntarily:_____%

Under what authority?_____

_____

6. How often do social workers visit a foster home?_____

7. Annual number of adoptions:_____ Annual number of related counseling sessions:_____

From what source (e.g., agencies, private parties) does the agency receive adoptive children?

_____

PART V. HISTORY

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

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

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	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

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. 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 MarketScout, 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