GREENHILL
INSURANCE SERVICES

Mailing Address:
1707 Post Oak, Suite 279
Houston, Texas 77056
WWW.GRNHLL.COM

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 (including dba's): _____

Tax ID: _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (_____)_____ Fax (_____)_____

Email: _____

Website: _____

1.6 Person to contact for Survey: Name: _____Title: _____

Email: _____Telephone Number: (_____)_____

1.7 Year entity established: _____

1.8 The Applicant is (Please check and complete A) or B) below:

☐ A. The **APPLICANT** is an: ☐ INDIVIDUAL ☐ Employee ☐ Student ☐ Sole Practitioner

☐ B. The **APPLICANT** is a: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability

☐ Other –Please Describe _____

1.9 Entity is: ☐ For Profit ☐ Non-Profit

Please describe source of funds: _____

_____

1.10 **Proposed Effective Date:** _____

1.11 Requested Limits of Liability (if available): $ _____/$ _____

1.12 Annual Gross Receipts: Estimated next twelve months - $_____

Last twelve months - $_____

1.13 Annual Remuneration: Estimated next twelve months - $_____

Last twelve months - $_____

1.13 Type of Facility: (Licensed? ☐ Yes ☐ No If NO, Explain_____

Please check one:

☐ Alcohol/Drug Rehabilitation ☐ Home for Mentally Disabled

☐ Halfway House ☐ Hospice

☐ Home for Alzheimer Patients ☐ Partial Hospitalization Program

☐ Home for Disabled ☐ Temporary Shelter

☐ Home for Mentally Ill ☐ Youth Home / Orphanage

☐ Other:_____

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?

If NO, please explain:_____ ☐ Yes ☐ No

PART II. EXPOSURES

2.1 Facility is **licensed for how many beds**?_____ Average Occupancy? ____Length of Stay? _____

If **Day Care / Partial Hospitalization Program, 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 Mentally Disabled, are residents/patients mentally disabled 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 mentally disabled 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, please provide detailed description:_____

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**?

If YES, the application for Sheltered Workshops for Mentally Disabled 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, please 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, please 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? If YES, how many shifts per day? _____ ☐ Yes ☐ No

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, please list names and frequency:_____

_____

Are medications stored in a secure manner? ☐ Yes ☐ No

If NO, please 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, please 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 (RESIDENT FACILITIES - SURVEY SUPPLEMENT)

2.24 Any activities or events for patients/clients conducted or sponsored away from applicants? ☐ Yes ☐ No

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, please 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, please 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, and 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?
If YES, explain on separate sheet. ☐ Yes ☐ No

3.9 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 Yes	Claims-Made No
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date? _____

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	Eff. Date	Claims-Made Yes	Claims-Made No
1.							
2.							
3.							
4.							
5.							

If claims-made, 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 QUESTION 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, please 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 Greenhill Insurance Services, 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

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 DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date	Applicant	Title

Complete Survey Supplement attached, and include photo.

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Resident Facilities - Survey Supplement

PROPERTY SURVEY SUPPLEMENT	BUILDING 1	BUILDING 2	BUILDING 3
A. Describe Use			
B. Year Built			
C. Number of Stories			
Any residents above ground floor?			
If Yes, how many? All ambulatory?			
D: Construction including type roof			
E. Total Square Footage			
F. Located in City Limits (circle one)	Yes No	Yes No	Yes No
G. Does Building meet all local codes? (circle one)	Yes No	Yes No	Yes No
H. Distance to nearest fire hydrant			
I. Distance to fire station			
J. NFPA Protection Class			
K. Built for present use? (circle one)	Yes No	Yes No	Yes No
If not, original purpose			
If not, year converted			
Age and type of heating system			
Age and type of wiring			
L. Is the building sprinklered? (circle one)	Yes No	Yes No	Yes No
Entirely or partially?			
M. Automatic fire or sprinkler alarm connected to local fire department or monitoring company? (circle one)	Yes No	Yes No	Yes No
N. Automatic extinguishing system in stove hood?	Yes No	Yes No	Yes No
O. Number of fire extinguishers			
P. Number of fire escapes			
Q. At least 2 clearly marked exits on each floor?	Yes No	Yes No	Yes No
R. Exits free of obstruction and equipped with panic hardware?	Yes No	Yes No	Yes No
S. Self-closing fire doors on each floor?	Yes No	Yes No	Yes No

T. Smoke detectors in all rooms?	Yes No	Yes No	Yes No
U. Emergency lighting system?	Yes No	Yes No	Yes No
V. Emergency Generator?	Yes No	Yes No	Yes No

Date Applicant Title