



All questions must be answered and the application must be dated and signed before a quotation is given.

Allied World Insurance Company ("Insurer")

Return and make checks payable to: American Professional Agency, Inc. 95 Broadway, Amityville, NY 11701 (631) 691-6400 • (800) 421-6694

INPATIENT/RESIDENTIAL SUPPLEMENTAL APPLICATION FOR SOCIAL SERVICE AGENCY PROFESSIONAL LIABILITY INSURANCE COVERAGE

Offered through the Professional Counselors Purchasing Group, Inc.

APPLICANT INFORMATION

Applicant Name: \_\_\_\_\_

RESIDENTIAL CARE/GROUP HOME EXPOSURE

1. What type of residential care services are provided by the applicant?

Table with 2 columns: Residential Care/Group Homes, Beds or Other^1. Rows include Adolescent/Child Residential Care, Adult Group Home, Developmental Disability/Residential Care, Substance Abuse Facility.

^1Beds: Use the total number of occupied beds.

2. Is the Applicant accredited by CARF or Joint Commission? [ ] Yes [ ] No

3. Number of residents last calendar year: \_\_\_\_\_

4. Estimate number of residents during this calendar year: \_\_\_\_\_

5. Age limitations of residents: \_\_\_\_\_

6. Average age of residents: \_\_\_\_\_

7. Residents are: [ ] Male [ ] Female [ ] Both

8. Average length of stay by residents: \_\_\_\_\_

9. Number of beds the applicant maintains: \_\_\_\_\_

10. How many residences/locations are utilized by applicant for residential services? \_\_\_\_\_

*Please attach separate sheet listing locations.*

11. The applicant provides residential care for the following (check the boxes next to those you are involved in):

- Half-Way House for Handicapped
- Half-Way House for Convicts
- Crisis Shelter
- Half-Way House for Troubled Juveniles
- Orphanage
- Other (specify): \_\_\_\_\_

12. Indicate client/staff ratio: \_\_\_\_\_

13. Describe the security measures the applicant has placed at each residence: \_\_\_\_\_  
\_\_\_\_\_

14. How many employees or persons under contract\* with the applicant staff the residence after normal hours of operation? \_\_\_\_\_

**\*NOTE: This policy does not provide coverage to Independent Contractors/Consultants unless required by the insurance carrier. The Agency is always protected for their acts while doing work for the agency.**

15. Does the applicant own or lease the residences used for the residential care services? \_\_\_\_\_

16. The agency must present proof of Comprehensive General Liability Insurance in a minimum amount of \$100,000/\$300,000.

17. How does the applicant obtain the residents utilizing the applicant's services? \_\_\_\_\_  
\_\_\_\_\_

18. Indicate the minimum number of monthly visits to the residence by the caseworker? \_\_\_\_\_

19. What is the procedure utilized by the applicant to handle allegations of abuse (sexual or other) in the residential facility? \_\_\_\_\_  
\_\_\_\_\_

**FRAUD WARNING**

**NOTICE TO FLORIDA APPLICANTS:** "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

**APPLICANT SIGNATURE**

*I hereby acknowledge that the above information is complete and accurate to the best of my knowledge and belief.*

Print Name of Authorized Representative: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

*This Application must be completed, dated and signed by the CEO, CFO, Administrator, Executive Director or Risk Manager of the Applicant, who is authorized to sign on behalf of all proposed Insureds.*