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

LOUISIANA 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?

Residential Care/Group Homes	Beds or Other[1]
☐ Adolescent/Child Residential Care	
☐ Adult Group Home	
☐ Developmental Disability/Residential Care	
☐ Substance Abuse Facility	

[1]**Beds:** 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? ____
    ____

NOTICES TO APPLICANT & FRAUD WARNINGS

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Insurer in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. The Application is on file with the Insurer, and shall be deemed to be attached to, and made a part of, and incorporated into the Policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the Policy, the Applicant will immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

NOTICE TO LOUISIANA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

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.

Save form first on your computer before emailing.