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?

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? _____
    _____

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.

Email Form **Print Form**

Save form first on your computer before emailing.