Residential Care Provider Professional and General Liability Insurance Application

Name on License: _____

DBA: _____

Mailing Address: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Address: _____

Website: _____ Preferred Method of Contact: _____

Number of Years in Operation: _____ FEIN: _____ Effective Date Requested: __/__/____

Type of Entity: ☐ Sole Proprietor ☐ LLC ☐ Corporation

Location Address	# of Licensed Beds	Facility Type
1.		
2.		
3.		
4.		
5.		

If more than 5 locations, complete a second application for additional locations. There will be no coverage for operations at locations owned, leased, or operated by the insured that are not listed on submitted application.

Limits of Insurance Requested (Per Claim/Aggregate):

☐ $50,000/200,000 ☐ $100,000/300,000 ☐ $500,000/500,000 ☒ $500,000/1,000,000
☐ $1,000,000/1,000,000 ☐ $1,000,000/2,000,000 ☐ $1,000,000/3,000,000 ☐ $2,000,000/4,000,000

General Information for all locations

Are any of the above locations independent living? ☐ Yes ☒ No

If "Yes", how many units? _____ Which location(s)? _____

Are any of the above locations adult day care? ☐ Yes ☐ No

If "Yes", how many participants? _____ Which location(s)? _____

Do you offer any offsite home health or non-medical home care services? ☐ Yes ☐ No
If "Yes", you will need to complete a Home Health application. Please contact your agent/broker

Do you accept any residents under the age of 18? ☐ Yes ☐ No

Do you provide any other services? ☐ Yes ☐ No If "Yes", please explain: _____

(If "Yes" to any of the below questions, provide a detailed explanation on a separate page)	
Has a fact, circumstance, event, or incident occurred at any location in the past 3 years that might result in a claim on liability insurance?	☐ Yes ☐ No
Has any license ever been denied, revoked, or suspended; or a fine been imposed by the state in the past 3 years?	☐ Yes ☐ No
Have you had any elopements (residents that have left the facility without your knowledge/permission) in the past 3 years?	☐ Yes ☐ No

Is a medical assessment by a medical professional obtained prior to admission? ☐ Yes ☐ No

How often are residents reassessed? _____

How do you identify when a resident needs to be transferred to another degree or level of care? _____

_____

Do you have a written contract for your services with each one of your residents? ☐ Yes ☐ No

Do you use a Negotiated Risk Agreement? (not applicable in DE, IN, NJ, OH, WI, & WA) ☐ Yes ☐ No

Do you require a signed release in order to release records pertaining to resident? ☐ Yes ☐ No

Does the resident or Power of Attorney sign a release for emergency medical treatment of resident? ☐ Yes ☐ No

Have you had any new residents within the past 90 days? ☐ Yes ☐ No If "Yes", how many? _____

Do you conduct a tour of the facility and review procedures with new residents and/or their Power of Attorney? ☐ Yes ☐ No

Do you accept wanderers? ☐ Yes ☐ No If "Yes", are identification armbands used? ☐ Yes ☐ No

Do you conduct a wandering risk assessment upon admission? ☐ Yes ☐ No

Are all residents assessed by a medical professional for memory loss annually? ☐ Yes ☐ No

Are restraints used other than those ordered by a doctor? ☐ Yes ☐ No

Describe off-site activities or excursions offered to the residents: _____

Resident Censuses

(The total of all Alzheimer's, dementia, developmentally disabled (other), and fully functional residents must equal the total of occupied beds in each column)

Residents' Mental Capacity	**Loc. #1**	**Loc. #2**	**Loc. #3**	**Loc. #4**	**Loc. #5**
Number of Dementia/Alzheimer's residents					
Number of developmentally disabled (or other) residents					
Number of fully mentally functional elderly residents					
Total number of occupied beds					

(The total of all Alzheimer's, dementia, developmentally disabled (other), and fully functional residents must equal the total of occupied beds in each column)

Residents' Physical Capacity	**Loc. #1**	**Loc. #2**	**Loc. #3**	**Loc. #4**	**Loc. #5**
Number of Independently Ambulatory residents					
Number of residents who ambulate only with assistance					
Number of residents confined to a wheelchair					
Number of bedridden residents					
Total number of occupied beds					

If any location above has bedridden residents, can they bear weight? ☐ Yes ☐ No

Policies and Procedures at all locations

Does the facility have a written plan for missing residents (missing resident protocol)? ☐ Yes ☐ No

Does the facility have a sign out policy in place? ☐ Yes ☐ No

Does the facility have a written physical and sexual abuse prevention policy? ☐ Yes ☐ No

Does the facility have a written procedure for resident falls which includes communication with family and medical personnel and written documentation of this action? ☐ Yes ☐ No

Is your documentation for recording falls, monitoring medications, and changes in condition computer-based or written? ☐ Computer-based ☐ Written

Staffing at all locations

Staffing Totals	Loc. #1	Loc. #2	Loc.#3	Loc. #4	Loc. #5
Number of staff during the day					
Number of staff overnight					

Do you conduct the following on all new employees? ☐ Background checks ☐ Reference checks

Do you complete regular drug screenings of all employees? ☐ Yes ☐ No

Are overnight staff awake at all times? ☐ Yes ☐ No

If "No", how are sleeping overnight staff made aware of emergencies? _____

What is the average length of employment for all employees with you? _____

Do you use a staffing agency to obtain your employees? ☐ Yes ☐ No If "Yes", how many staff? _____

Do you have an employee training program? ☐ Yes ☐ No

Are the staff members that administer medications trained in proper medication administration, handling, and safe-keeping? ☐ Yes ☐ No

Are you or any of your staff (including contractors) licensed medical professionals providing professional medical services to your residents? ☐ Yes ☐ No

If "Yes", what professional medical services are you providing? _____

Do you obtain a Certificate of Liability Insurance from all licensed medical professionals? ☐ Yes ☐ No

Building and Grounds at all locations

Are all exit doors alarmed? ☐ Yes ☐ No

Are there any firearms (rifles, handguns, etc.) on the premises? ☐ Yes ☐ No
If "Yes", complete Firearms section of the Residential Care Provider Supplemental Application.

Are properly maintained smoke detectors located in all bedrooms and halls? ☐ Yes ☐ No

Do you have a fire inspection completed by a local fire company annually? ☐ Yes ☐ No

Location-specific Building Information	Loc. #1	Loc. #2	Loc.#3	Loc. #4	Loc. #5
Number of fire extinguishers					
Date of last fire extinguisher servicing					
Distance to the nearest responding fire company					
Distance to the nearest responding hospital or EMT					

Do any of the locations have a swimming pool? ☐ Yes ☐ No If "Yes", which locations? _____

Is pool use only permitted with supervision? ☐ Yes ☐ No

Is the pool fenced with a locked gate? ☐ Yes ☐ No

Are all doors leading to the pool alarmed? ☐ Yes ☐ No

Additional Insureds

(Complete this schedule if any Additional Insured's need to be named on your policy.)

Name and Mailing Address of Additional Insured	Interest	Loc.

Additional Coverage Options

PCH Mutual offers several additional coverages to meet your needs. Coverages can be reviewed on the Additional Coverage Options section of the Residential Care Provider Supplemental Application. Please consult your agent/broker with any questions on these coverages.

Do you desire any of the coverages shown on the Additional Coverage Options section of the Residential Care Provider Supplemental Application? ☐ Yes ☐ No

If "Yes", attach the completed Residential Care Provider Supplemental Application.

The application for this policy is incorporated and warranted as part of this policy. This insurance policy is being issued in reliance on the accuracy, truthfulness, and completeness of the application. Any inaccuracy, falsity, or omission, regardless of the nature, shall entitle us to rescind the policy.

I declare that the information provided in this application is accurate, true, and complete and that each location currently complies and will comply with the rules and regulations set by state and federal law. I understand that if I willfully do not comply with these rules and regulations that coverage is null and void and any claims may be denied and premium returned.

If the information supplied on the application changes between the date of the application and the effective date of the insurance, I will immediately notify PCH of any changes. In the event of any changes, PCH may withdraw or modify any outstanding quotations and/or agreement to bind the coverage. I must notify PCH of any changes in the operation of this business during the policy period, and failure to do so may result in cancellation of the coverage or denial of a claim.

I hereby authorize PCH to obtain information necessary for the evaluation in determining acceptability, including, but not limited to, physical inspections and inquiries with the state licensing departments.

Signature Printed Name and Title Date

This application does not guarantee approval for this liability insurance program. PCH reserves the right to decline coverage. We will attempt to provide you with an approval or declination within 48 hours of receiving this form and the supporting documents in our office. Please email or fax these items to 717-630-1188.

This application requires the following attachments:

- Copy of State license for each location
- Copy of last State inspection for each location
- Copy of your current insurance policy(ies) if applicable
- 3 years of currently valued loss runs from existing and previous insurance companies for each location if applicable or No known losses letter
- If new venture, supply 3 years of relevant job experience or resume

Producer Name: _____ Agency: _____

Agency Address: _____ Email Address: _____

How did you hear about us? ☐ Association ☐ Mailer ☐ Internet Search ☐ Referral