

# PROFESSIONAL LIABILITY APPLICATION FOR SOCIAL SERVICES

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: \_\_\_\_\_
- 1.2 Mailing Address: \_\_\_\_\_
- 1.3 Location Address(es): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 1.4 County (parish) of each location: \_\_\_\_\_
- 1.5 Telephone Number: Office \_\_\_\_\_ / \_\_\_\_\_ Fax \_\_\_\_\_ / \_\_\_\_\_
- 1.6 Person to contact for survey: Name: \_\_\_\_\_ Title: \_\_\_\_\_
- 1.7 Proposed **Effective Date**: \_\_\_\_\_ Year Entity Established: \_\_\_\_\_
- 1.8 The Applicant is (Please check and complete A) or B) below:  
\_\_\_ A. The **APPLICANT** is an **INDIVIDUAL**:  
    IF SO, the **INDIVIDUAL** is an \_\_\_ Employee \_\_\_ Student \_\_\_ Sole Practitioner  
\_\_\_ B. The **APPLICANT** is a:  
    \_\_\_ Sole Proprietorship \_\_\_ Partnership \_\_\_ Corporation  
    \_\_\_ Other - Describe \_\_\_\_\_
- 1.9 Entity is \_\_\_ For Profit \_\_\_ Not-for-Profit. Describe source of funds: \_\_\_\_\_
- 1.10 Requested Limits of Liability (if available):  
    Professional Liability \$ \_\_\_\_\_ each medical incident/\$ \_\_\_\_\_ aggregate  
    General Liability \$ \_\_\_\_\_ each occurrence/\$ \_\_\_\_\_ general aggregate
- 1.11 Annual Gross Receipts or Budget: Estimated next twelve months - \$ \_\_\_\_\_  
    last twelve months - \$ \_\_\_\_\_
- 1.12 Annual Payroll or Remuneration: Estimated next twelve months - \$ \_\_\_\_\_  
    last twelve months - \$ \_\_\_\_\_

1.13 Type of Facility: (Licensed? \_\_Yes \_\_No If NO, Explain: \_\_\_\_\_)

Check One, or describe:

- |  |   |
|--|---|
| <input type="checkbox"/> Adoption Agency *               | <input type="checkbox"/> Meals on Wheels                            |
| <input type="checkbox"/> Child Day Care *                | <input type="checkbox"/> Nanny Services                             |
| <input type="checkbox"/> Day Care (Senior Citizens) *    | <input type="checkbox"/> Employee Assistance Program                |
| <input type="checkbox"/> Day Care (Senior Citizens) *    | <input type="checkbox"/> Referral Agency * (Consultants Supplement) |
| <input type="checkbox"/> Foster Care *                   | <input type="checkbox"/> Sheltered Workshop *                       |
| <input type="checkbox"/> Hotlines (Phone Crisis Service) | <input type="checkbox"/> Other: _____                               |

\* Applicable supplemental questionnaire must be completed

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? \_\_Yes \_\_ No If No, Explain: \_\_\_\_\_

## **PART II. EXPOSURES**

2.1 Does facility provide "Day" services? \_\_\_\_Yes \_\_\_\_ No If Yes, what is the Number of "day patients" (include "independent living" persons) Maximum # \_\_\_\_ Average # \_\_\_\_

2.2 Do you conduct a **Sheltered Workshop**? \_\_\_\_ Yes \_\_\_\_ No If Yes, the application for Sheltered Workshops for Retarded and Developmentally Disabled Persons must be completed.

2.3 Are all patients fully ambulatory (including use of cane or walker)? \_\_\_\_ Yes \_\_\_\_ No  
If not, explain: \_\_\_\_\_

2.4 What was your total number of outpatient/client visits last year? \_\_\_\_ Estimated next year? \_\_\_\_

2.5 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? \_\_\_\_

2.6 Describe any physical contact which may occur between you and any patients/clients or between two or more patients/clients at your direction. \_\_\_\_\_

2.7 Describe any services specifically concerned with sexual response/dysfunction of individual patients/clients: \_\_\_\_\_

2.8 Is there a Registered Nurse on duty? \_\_ Yes \_\_ No If Yes, how many shifts per day? \_\_\_\_

2.9 Is any medication prescribed? \_\_ Yes \_\_ No If Yes, list names and frequency: \_\_\_\_\_

Are medications stored in a secure manner? \_\_ Yes \_\_ No

If No, explain in detail: \_\_\_\_\_

- 2.10 Do you enter into any contractual agreements ? \_\_ Yes \_\_ No  
 IF YES, enclose copies of all such contracts including those contracts for use with patients/clients.
- 2.11 Enclose a copy of all brochures or advertising materials distributed by you.
- 2.12 Any activities or events for patients/clients conducted or sponsored \_\_ Yes \_\_ No  
 away from applicants? IF YES, describe \_\_\_\_\_
- 2.13 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) \_\_\_\_\_
- 2.14 Describe any "fund raising" or other special events activities conducted. \_\_\_\_\_
- 2.15 Do you have any other premises or operations not stated in this application? \_\_ Yes \_\_ No  
 IF YES, 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, explain: \_\_\_\_\_
- 3.2 Are precautions taken to prevent patients/clients 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 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)

<u>E</u>	<u>C</u>		<u>E</u>	<u>C</u>	
—	—	Dietitians/Nutritionists	—	—	Physiotherapists/Physical Therapists
—	—	Occupational Therapists	—	—	Psychologists/Psychotherapists
—	—	Pharmacists	—	—	Psychiatrist *
—	—	Physician * / Dentist *	—	—	Speech Therapists
—	—	Nurse Practitioner	—	—	RN's / LVN's / LPN's
—	—	Physician Assistant	—	—	Respiratory Therapists
—	—	Social Workers	—	—	Case Managers
—	—	Marriage/Family Counselors	—	—	School Counselors
—	—	Teachers	—	—	Other: _____

Complete the following for each Physician, including Medical Director, Dentist, Chiropractor, Podiatrist, Psychiatrist, Nurse Practitioners, Physician Assistants

\* 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?  Yes  No IF YES, explain on separate sheet.

3.10 Name, qualification and number of years of experience of the Medical Director, all managers and supervisors:

Name	Title	Experience/Training	Association Membership

3.11 Does Applicant have written screening and hiring policies and procedures for all prospective employees, independent contractors/consultants and volunteers?  Yes  No

**If yes, please provide copies of the procedures, including samples of employment applications.**

3.12 Are there written guidelines regarding sexual misconduct?  Yes  No

**If yes, please provide copies of all policies and procedures including training materials.**

**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 Form Yes or No
1.					
2.					
3.					
4.					
5.					

If **claims-made form**, what is the most recent retroactive date? \_\_\_\_\_

**NOTE:** If prior acts coverage is needed, complete **Prior Acts** Supplemental application.

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 Form Yes or No
1.					
2.					
3.					
4.					
5.					

If **claims-made form**, 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). \_\_\_\_\_

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4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 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, describe the event and indicate the reason for anticipation of a claim.

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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 **The Solutions Group** 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