Residential Care Provider Professional and General Liability Insurance Application

Name on License_____

DBA_____

Contact Person _____ Phone # _____ Fax #_____

Email Address _____ Website_____ Preferred Method of Contact_____

Mailing Address_____

Number of Years in Business _____ FEIN_____ Effective Date Requested ___/___ /_____

Type of Entity ☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ Non-Profit ☐ LLC ☐ LLP ☐ Other_____

Location Address (complete a separate sheet for any additional locations)	Number of Licensed Beds	Facility Type
1		
2		
3		

There will be no coverage for operations at locations owned, leased, or operated by the insured that are not listed on the schedule above.

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

Are any of the above locations Independent Living? ☐ Yes ☐ No If yes, how many units? _____ Loc ____

Are any of the above locations Adult Daycare? ☐ Yes ☐ No If yes, how many participants? _____ Loc ____

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 following questions, provide a detailed explanation on a separate page)
Has a fact, circumstance, event, or incident occurred at any location (or any location listed above) 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? ☐ 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 of care?

_____

Do you use a Negotiated Risk Agreement? (Not applicable in DE, IN, NJ, OH, WI, and 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 Census (if more than 3 locations, complete this section separately for additional locations)

(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	Location #1	Location #2	Location # 3
Number of Dementia/ Alzheimer's residents			
Number of developmentally disabled (or other) residents			
Number of fully mentally functional residents			
Total number of occupied beds			

(The total of all independently ambulatory, ambulate with assistance, confined to wheelchair, and bedridden residents must equal the total of occupied beds in each column)

Residents' Physical Capacity	Location #1	Location #2	Location # 3
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? ☐ Yes ☐ No

Do you document all resident falls? ☐ Yes ☐ No

Does your fall procedure include communication with family and medical personnel (doctor, hospital, etc.) 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 (if more than 3 locations, complete this section separately for additional locations)

Staffing Totals	Location # 1	Location # 2	Location# 3
Number of staff during the day			
Number of staff overnight			

Do you conduct Criminal Background Checks on all new employees? ☐ Yes ☐ No
Do you conduct Reference Checks on all new employees? ☐ Yes ☐ No
If you or any of your staff are RN's or LPN's, are you providing professional medical services to the residents? ☐ Yes ☐ No

If yes, does the RN or LPN have their own Nurses Professional Liability Insurance?

☐ 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? _____

If yes, do you get a Certificate of Insurance naming your facility as an additional insured from the staffing agency? ☐ Yes ☐ No

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

Are the staff members that administer medications trained in proper medication administration and handling?

☐ Yes ☐ No

Do you have a visiting RN, MD, or Home Health agency come in to provide professional medical services?

☐ Yes ☐ No

If yes, is their contract with the resident, the facility, or the State? ☐ Resident ☐ Facility ☐ State

If the contract is with the facility, do you obtain a Certificate of Liability naming your facility as an additional insured? ☐ Yes ☐ No

Building and Grounds at all locations

Are all exit doors alarmed? ☐ Yes ☐ No

Are there any firearms on the premises? ☐ Yes ☐ No If yes, how are they secured? _____

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

Are smoke detectors properly maintained? ☐ Yes ☐ No

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

How many fire extinguishers do you have? _____

What date were the fire extinguishers last serviced? _____

What is the distance to the nearest responding fire company in miles? _____ Hospital or EMT? _____

Is there a swimming pool on the premises? ☐ Yes ☐ No

Are residents permitted to use the pool? ☐ Yes ☐ No

If yes, are residents only permitted to use the pool with supervision? ☐ Yes ☐ No

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

Is there an alarm on the pool access? ☐ Yes ☐ No

Additional Coverage Options (consult your agent for questions on these coverage options)

Do you currently have a Commercial Auto policy in place? ☐ Yes ☐ No (If yes, this coverage is not applicable)

If no, do you want Excess Hired & Non-owned Auto Liability coverage? ☐ Yes ☐ No

If yes, how many employees use their personal automobile for business purposes? _____

What limit of Hired & Non-Owned Auto Liability do you want? ☐ $300,000 ☐ $500,000 ☐ $1,000,000

Do you live in the home? ☐ Yes ☐ No Do you have a Commercial Property Policy? ☐ Yes ☐ No

If yes, do you want Personal Liability coverage? ☐ Yes ☐ No

Who is listed as the named insured(s) on the Commercial Property Policy? _____

Is Employer's Contingent Liability Coverage needed? (WA, OH, WV, NV, ND, WY Only) ☐ Yes ☐ No

If yes, how many employees? _____

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: PCALIC, LLC

Agency Address: P.O. Box 933, Hanover, PA 17331 Email Address: _____

How did you hear about us? _____Association _____Mailer _____Internet Search _____Referral