HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

U.S. Risk Underwriters
Boston (617.342.7116)
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SUPPLEMENTAL APPLICATION FOR RESIDENTIAL FACILITIES, GROUP HOMES AND OTHER OVERNIGHT STAY (NON ELDERLY)

(CLAIMS MADE AND REPORTED BASIS)

Please email this application back to the underwriter with whom you are working.
For contact information please visit www.usrisk.com/healthcare.html

1. APPLICANT INFORMATION:

a. Complete name of applicant:_____

b. Address (if different from main application):_____
(Street) City)

_____
(State) (Zip) (County)

c. List locations of all facilities:

Location No.	Name and Location of Facility	**Type of facility:** Group Home: Halfway House; Inpatient; Contract Beds; Outpatient - Describe below in detail	**Type of Patient**: Mentally Retarded; Child/Adult/Aged; Ex-offender; Emotionally Disturbed; Physically Handicapped; Other - Please be specific	**(1)** No. of licensed Beds and **(2)** No. of occupied beds	**List all Services rendered** (e.g., alcohol or drug detoxification; confrontation, shock, rage, sex therapy; vocational rehab; hypnosis; surgery, types of counseling, etc.)
1	____sq. ft.			(1) No. (2) No.	
2	____sq.ft.			(1) No. (2) No.	
3	____sq.ft.			(1) No. (2) No.	
4	____sq.ft.			(1) No. (2) No.	

d. Are the facilities listed in Question (c) above licensed in accordance with all applicable local, state and federal laws and regulations? _____ ❑ Yes ❑ No
If no, attach separate explanation for each facility which is NOT licensed accordingly.

e. Range of client ages? _____ How many male? _____ How many female? _____

STAFF:

a. Number of professional employees, volunteers, and independent contractors

EMPLOYEES	1.	2.	3.	4.
MDs				
Psychologists				
Social Workers				
RNs				
LPNs/Nurse's Aides				
Pharmacists				
Nurse Practitioners				
Other (Describe qualifications & duties separately)				
Volunteers				
INDEPENDENT CONTRACTORS				
MDs				
Psychologists				
Social Workers				
RNs				
LPNs/Nurse's Aides				
Pharmacists				
Nurse Practitioners				
Other (Describe qualifications & duties separately)				

b. Are all of the above **employees** licensed in accordance with applicable and federal regulations? _____ ❑ Yes ❑ No
If no, attach explanation.

c. Do any of the above **employees** and **volunteers** carry their own professional liability insurance?_____ ❑ Yes ❑ No
If yes, advise limits: _____

OPERATIONS:

a. What precautions are taken to keep track of patients? _____

b. Do you use sign out procedures?_____ ❑ Yes ❑ No

c. Are alarms on doors to prevent clients from wandering from the residence?_____ ❑ Yes ❑ No

d. Do any residents attend school/workshops?_____ ❑ Yes ❑ No

e. Do any residents work full or part time? _____ ❑ Yes ❑ No

f. Does the applicant administer any methadone treatment? _____ ❑ Yes ❑ No
If yes, please describe treatment and controls used and indicate number of treatments during the last 12 months_____ Next 12 months _____

g. Is the applicant in the employ of any governmental entity?_____ ❑ Yes ❑ No
If yes, please attach explanation. Include details of your responsibilities.

h. Is the applicant under contract to any governmental entity?_____ ❑ Yes ❑ No
If yes, please attach explanation. Include details of your responsibilities.

i. Does the applicant perform or permit any corporal punishment? _____ ❑ Yes ❑ No
If yes, please provide separate explanation.

j. Please describe in detail any additional activities and/or procedures performed by the applicant, including any off premises exposure: _____

k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?_____ ❑ Yes ❑ No
If yes,
(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?_____ ❑ Yes ❑ No
(ii) Provide the name and title of the Applicant's Privacy Officer._____

GENERAL LIABILITY:

a. Answer questions below for each location.

QUESTIONS	1.	2.	3.	4.
Year Built				
Year Remodeled				
No. of Stories				
Construction:				
Exterior Walls				
Roof				
Floors				
Is the insured a: ❑ Building Owner ❑ Tenant ❑ General Lessee				
Age of wiring/update				
Number of fire extinguishers				
Number of fire escapes				
Distance to the nearest fire station				
Is the building sprinklered?				
Are handrails provided in hallways and bathrooms?				
Is the building equipped with:	**Yes No**	**Yes No**	**Yes No**	**Yes No**
At least 2 clearly-marked exits on each floor?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Self-closing fire doors on each floor?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Exit doors of at least 42" width from all sleeping, diagnostic & treatment rooms?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Automatic fire alarm system connected to local fire department?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Central station fire alarm?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Emergency electrical system?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Heat sensors?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Smoke detectors in all bedrooms/hallways?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Are handrails provided in hallways and bathrooms?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Is any new construction contemplated for the next 12 months? If yes, attach details including estimated contract costs, number of beds, sq. ft., planned use, date of completion, etc.	❑ ❑	❑ ❑	❑ ❑	❑ ❑

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Applicant's Signature Title Date