Residential Care Provider Professional and General Liability Insurance Application

Name on License(s): _____

DBA(s): _____

Mailing Address: _____

Contact Person: _____ Phone #: _____ ☐ Check if Mobile

Email Address: _____ Website: _____

Number of Years in Operation: _____ FEIN: _____ Effective Date Requested: _____

Type of Entity: ☐ Individual ☐ LLC ☐ Corporation

☐ Partnership/Joint Venture ☐ Other:

Location Name	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 a 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 (no med. assistance or care provided)? ☐ Yes ☐ No

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

Do any of the above locations provide adult day care to persons not living at the location? ☐ 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

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

Do you expect to sell or change the management of any facility in the next twelve months? ☐ Yes ☐ No

Are all locations managed and operated by the licensee or employees of the licensee? ☐ Yes ☐ No
If "No", attach copy of the management agreement/contract and complete Management Company Addendum.

Are any businesses that are seeking coverage under the Policy not currently in good standing with their licensing and corporate registration?	☐ Yes ☐ No
Has (1) an unexpected death; **or** (2) a fact, circumstance, event, or incident that might result in a claim on liability insurance occurred at any location in the past 3 years?	☐ Yes ☐ No
Has any license ever been denied, revoked, or suspended; or has any location ever been voluntarily closed in response to a regulatory action?	☐ Yes ☐ No
Has any fine, condition, restriction, or stop placement been imposed 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
Do you provide services other than assistance with daily living?	☐ Yes ☐ No
(If "Yes" to any of the above questions, provide a detailed explanation on a separate page)	

LEGAL\72200838\4

PCALIC
CARING FOR THOSE WHO CARE
A TANGRAM PROGRAM

Do you or your owners/members own or operate any residential care facilities, independent living facilities, or similar businesses not listed on this application? ☐ Yes ☐ No
If "Yes", provide the name, address, and type of business for all businesses on a separate page.

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

How often are residents reassessed by a medical professional? _____

Do you have a written contract/agreement for your services with each one of your residents or their legal representative/Power of Attorney (POA)? ☐ 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 legal representative/POA sign a release for emergency medical treatment? ☐ 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 legal representative/POA? ☐ Yes ☐ No

Do you accept new residents who are already receiving hospice care/services? ☐ 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 cognitive decline or memory loss annually? ☐ Yes ☐ No

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

Do you provide any off-site activities or excursions to the residents? ☐ Yes ☐ No

If "Yes", describe all off-site activities or excursions: _____

Resident Censuses

(For each location, the "Total of above lines" must be equal to the total number of residents currently at that location)

Residents' Mental Capacity	**Loc. #1**	**Loc. #2**	**Loc. #3**	**Loc. #4**	**Loc. #5**
Number of dementia/Alzheimer's residents					
Number of developmentally disabled residents 55 & under					
Number of developmentally disabled residents over 55					
Number of mentally ill residents					
Number of fully mentally functional residents					
Total of above lines					

(For each location, the "Total of above lines" must be equal to the total number of residents currently at that location)

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 of above lines					

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

PCALIC
CARING FOR THOSE WHO CARE
A TANGRAM PROGRAM

Do you have written policies and procedures regarding care and treatment of residents that are easily accessible by your staff? ☐ Yes ☐ No

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

Please describe your patient record-keeping system: _____

_____

Do you follow current infection prevention and control measures? ☐ Yes ☐ No

If "Yes", from what trusted source? ☐ Municipal ☐ State ☐ Federal ☐ Other: _____

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					

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

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

Do you conduct reference checks on all new employees? ☐ Yes ☐ No

Do you conduct background checks on all new employees? ☐ Yes ☐ No

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

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

Do you or your staff provide services at your facility requiring a professional license, or do third-parties provide services at your facility requiring a professional license? ☐ Yes ☐ No

If "Yes," what services are provided at your facility which require a professional license, and who provides them? Please check all that apply and explain the services provided below.				
Skilled Nursing Care	☐ You/Staff	☐ Contracted with you	☐ Contracted by Resident	☐ No
Medical Doctor	☐ You/Staff	☐ Contracted with you	☐ Contracted by Resident	☐ No
Hospice, Physical Therapy, Wound Care	☐ You/Staff	☐ Contracted with you	☐ Contracted by Resident	☐ No
Other professional services by you/staff:		Other professional services offered by contractor:		
Please explain:				

Did 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 rifles, pistols or guns on the premises? ☐ Yes ☐ No
If "Yes", complete Rifles, Pistols or Guns 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

Do any of the locations have a swimming pool? ☐ Yes ☐ No
If "Yes", complete Pools section of the Residential Care Provider Supplemental Application.

Do you or the owner of the premises carry property insurance on each building? ☐ Yes ☐ No

Do you own or rent the building(s) for each location? ☐Rent ☐Own

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

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 based on reasonable inquiry. I declare 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.

This application does not guarantee approval for insurance. PCH reserves the right to decline coverage. This application requires the following attachments:

- Copy of state license for each location
- Copy of the last state inspection with plans of correction for each location
- Copies of any citations or notices of deficiency within the last 12 months and all related plans of correction
- 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 a new venture, supply 3 years of relevant job experience or resume

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

Producer Name: _____ Agency: _____

Agency Address: _____ Email Address: _____

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

LEGAL\72200838\4

PCALIC
CARING FOR THOSE WHO CARE
A TANGRAM PROGRAM