Halfway House General Liability and Professional Liability Application

Applicant's Name \ Agent Name	
Mailing Address Address	
Location PROPOSED EFFEC	
Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture	<u></u>
LIMITS OF LIABILITY REQUESTED	PREMIUMS
General Aggregate \$	Premises/Operations
Products & Completed Operations Aggregate \$	\$
Personal & Advertising Injury \$	Products/Completed Operations
Each Occurrence \$	\$
Fire Damage (any one fire) \$	Other
Medical Expense (any one person) \$	\$
Professional Liability Each Occurrence \$	Other
Aggregate \$	\$
Other Coverages, Restrictions, and/or Endorsements Sexual and/or Physical Abuse: \$25,000/\$50,000 \$50,000 \$100,000 \$100,000/\$300,000	Total
Deductible \$	\$
 Applicant operates as: Profit Nonprofit Number of years in operate. How long under present management? (If fewer than five principals in the firm do not have a health care background, then also include the for hiring, screening and monitoring the work activities of your employees.) Is facility owned by physician(s)? Yes No Type of operation: Outpatient aftercare and support program (AA, Al-Anon, etc.) 	years, attach principals' resumes.
 ☐ Outpatient altercare and support program (AA, Ar-Anon, etc.) ☐ Outpatient counseling or guidance center ☐ Crises centers (rape, domestic violence, etc.) ☐ Non-medical drug and alcohol rehabilitation center ☐ Homeless shelters ☐ Mission or settlement house Describe type of operation and services provided (attach brochure and/or adversed)	ticing material if available):

4.	4. Operations conducted in the following s								
		d with state? Yes		License #:					
	State: License	d with state? ☐ Yes		License #:					
_				License #:					
_	5. Has license ever been revoked? Yes								
6.	6. Name all subsidiary companies/location	Name all subsidiary companies/locations and others coming under applicant's control (if none, please state):							
7.		Has the applicant sold, acquired or discontinued any operations in the last five years? ☐ Yes ☐ No If yes, please explain:							
8.	8. Is at least one of the principals or an Ada ☐ Yes ☐ No	Is at least one of the principals or an Administrator/Director involved in the operation on a full-time basis?							
9.		•							
	a. Construction of building: b. Number of floors:								
	Square foot area occupied by the applic		. ,						
	c. Year built:								
	· · · · · · · · · · · · · · · · · · ·	Yes No	_	_					
	Equipped with fire alarm?			al station					
	Equipped with smoke detectors?			ny on each floor?					
	e. Number of fire extinguishers on premise	_		of fire escapes:					
		Yes No	□ No	nere is it permitted?					
	g. Is there a swimming pool, hot tub/spa ofh. Was building originally built for this type	•		0					
10.									
10.	 a. Do you have a written Emergency Evac 	uation Plan? ☐ Yes	□ No						
	b. Does your plan include advance agreen			orarv shelter? ☐ Yes ☐ No					
	c. Are evacuation procedures posted in all			•					
	d. How often are drills conducted?								
11.	1. State patients'/residents' ages—from: _	(youngest) t	to	(oldest) Average age:					
12.	2. Physicians on premises, if any, are:								
	☐ Private practitioners (personal physicians	s of the resident)							
	☐ Employees of the applicant	☐ Employees of the applicant							
	☐ Contracted physicians through written co	• •							
	If contracted physician, are certificates (evid ☐ Yes ☐ No	ence) of professional	liability ins	urance required and kept on file?					
13.	3. Do services provided include Infusion T	nerapy? 🗌 Yes 📗] No						
	Does treatment process involve the adminis	tration of methadone	or other dr	rugs? 🗌 Yes 🔲 No					
14.	4. Are employees authorized to use their p	Are employees authorized to use their personal vehicles to transport residents or patients? \square Yes \square No							
15.	5. Are residents/patients placed in applicat	Are residents/patients placed in applicant's facility by court order? Yes No							
16.	Any involvement in medical detoxification? Yes No								
17.	7. Does facility accept prisoners on work r	elease or rehabilitat	ion progr	ams? 🗌 Yes 🔲 No					

18	3. C	Does facility provide pregnancy and/or abortion counseling services? Yes No							
19		Does facility, if an inpatient facility, accept children under the age of 18? ☐ Yes ☐ No If yes, does applicant also require the child's guardian to be in residence at the same facility? ☐ Yes ☐ No							
20). I	s facility a foster	home	or foster care facility? [] Yes	☐ No			
21	. [oes facility prov	/ide in	patient services for eithe	er of th	e following:			
		a. Developmentally Disabled—Adults or children able to care for themselves despite their disability or mental retardation. Examples of this category include Downs Syndrome, autism, and brain injuries. This category does not include individuals whose primary diagnosis is an emotional or mental illness. Yes No							
	i.	b. Mentally Disabled —Adults or children able to care for themselves (with substantial numbers able to hold jobs). Behavior is controlled through medication and monitored by their personal physician. This category would include individuals whose primary diagnosis is an emotional or mental illness including but not limited to schizophrenia, psychopathic and sociopathic diagnosis. Yes No							
22	2. C	oes the application	nt prov	ide bed and board facili	ties? [☐ Yes ☐ No	o If yes, num	ber of beds: _	
	L	.ength of stay: fror	m	(shortest) to		(longest) Ave	rage:	
23		. Does the applicant provide outpatient services? ☐ Yes ☐ No If yes, number of annual outpatient visits:							
24	. E								
25	a b	As part of hiring/screening of new employees, does applicant: a. Obtain copies of their professional licenses/certifications?							
26	i. 1	Total number of employees:							
27	'. C								
28	3. C								
29				y contractual agreemen		rein applicant	t assumes the	liability of oth	ners?
	_] Yes □ No		,				,	
		If yes, please attach a list of each entity that has requested to be named as an additional insured and the type of service(s) applicant provides.							
30	Any other premises or operations exposures not stated in this application? ☐ Yes ☐ No If yes, attach a complete description and underwriting/rating information.								
		SCHEDULE OF HAZARDS							
	Drawium Pagasi								
	Loc.	Classification	Class.	ss. (s) Gross Sales (p) Payroll	Terr.	Rate		Premium	
	No.	Ciassilication	Code		Ten.	Prem./ Ops.	Products/ Comp. Ops.	Prem./ Ops.	Products/ Comp. Ops.

	ed malpracti		ve any claims bee stake or premises					
		If yes, date: _		Ple	ase explain: _			
			s any company car					
			.) 🗌 Yes 🔲 No					
Previous	Insurer: Indi	cate premiun	n and losses for pas	st three years.				
YEAR	COMPANY	POL.#	OCCURRENCE OR CLAIMS MADE	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION	
			cant nor the Company ntract should a policy be	•	insurance, but	it is agreed that t	the information con-	
APPLICAB	BLE IN THE STA	ATE OF NEW Y	ORK:					
statement fact materi	of claim contain	ning any materi imits a fraudule	ent to defraud any insu ally false information, c ent insurance act, which e of the claim for each s	or conceals for the h is a crime, and	e purpose of mi	isleading, informa	ation concerning any	
FRAUD W	ARNING:							
statement	of claim contai	ning any mater	ent to defraud any insu ially false information o t insurance act, which i	or conceals for the	e purpose of mi	sleading, informa	ation concerning any	
NAME AN	ND TITLE							
APPLICA	NT'S SIGNAT	URE			D	ATE		
AGENT NAMEAG					GENT LICENSE NUMBER			
Name and	d Phone Numl	ber of individu	al to contact for inspe	ection/audit				
			IMPORT	ANT NOTICE -				
		general reputation	procedure, a routine inquir , personal characteristics a the nature and scope of the	y may be made to c nd mode of living. U	btain applicable in pon written reques	t, additional informat	- 1	

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE NOT APPLICABLE