IGP Specialty | 14241 Dallas Parkway, Suite 850 | Dallas, Texas 75254

APPLICATION FOR RESIDENTIAL FACILITIES, GROUP HOMES AND OTHER OVERNIGHT STAY FACILITIES (NON-ELDERLY)
CLAIMS MADE AND REPORTED BASIS

Please email this completed application to the IGP Specialty underwriter you are working with.
For contact information, please visit our Healthcare Program webpage.

GENERAL INFORMATION

1. Complete name of applicant: _____
2. Mailing Address: _____
   City: _____ State: _____ County: _____ ZIP: _____
   Website URL: _____
3. Describe locations of all facilities (continued on next page; attach additional sheets if necessary):

FACILITY #1	Square Feet:
Name and Location	
Type of Facility (Group Home, Halfway House, Inpatient, Contract Beds, Outpatient, or Other). *Describe in detail.*	
Type of Patient (Mentally Retarded, Child/Adult/Aged, Ex-offender, Emotionally Disturbed, Physically Handicapped, or Other). *Be specific.*	
Number of Beds | Licensed Beds: _____ Occupied Beds: _____	
All services rendered (Alcohol or drug detoxification, confrontation, shock/rage/sex therapy, vocational rehab, hypnosis, surgery, types of counseling, etc.).	

FACILITY #2	Square Feet:
Name and Location	
Type of Facility (Group Home, Halfway House, Inpatient, Contract Beds, Outpatient, or Other). *Describe in detail.*	
Type of Patient (Mentally Retarded, Child/Adult/Aged, Ex-offender, Emotionally Disturbed, Physically Handicapped, or Other). *Be specific.*	
Number of Beds | Licensed Beds: _____ Occupied Beds: _____	
All services rendered (Alcohol or drug detoxification, confrontation, shock/rage/sex therapy, vocational rehab, hypnosis, surgery, types of counseling, etc.).	

FACILITY #3	Square Feet:
Name and Location	
Type of Facility (Group Home, Halfway House, Inpatient, Contract Beds, Outpatient, or Other). *Describe in detail.*	
Type of Patient (Mentally Retarded, Child/Adult/Aged, Ex-offender, Emotionally Disturbed, Physically Handicapped, or Other). *Be specific.*	
Number of Beds | Licensed Beds: _____ Occupied Beds: _____	
All services rendered (Alcohol or drug detoxification, confrontation, shock/rage/sex therapy, vocational rehab, hypnosis, surgery, types of counseling, etc.).	

FACILITY #4	Square Feet:
Name and Location	
Type of Facility (Group Home, Halfway House, Inpatient, Contract Beds, Outpatient, or Other). *Describe in detail.*	
Type of Patient (Mentally Retarded, Child/Adult/Aged, Ex-offender, Emotionally Disturbed, Physically Handicapped, or Other). *Be specific.*	
Number of Beds | Licensed Beds: _____ Occupied Beds: _____	
All services rendered (Alcohol or drug detoxification, confrontation, shock/rage/sex therapy, vocational rehab, hypnosis, surgery, types of counseling, etc.).	

4. Are the facilities listed in question 3 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.
5. Range of client ages: _____ How many male? _____ How many female? _____
6. Are you required to name your landlord or any other business as an additional insured? ☐ Yes ☐ No
   If yes, please list name and address of each and state interest. Use separate sheet if required:

Name	Address	Interest

7. State sources and amounts of actual and projected gross revenue:

Source	Amount this Fiscal Year	Amount Next Fiscal Year
a. Charitable Contributions	$	$
b. Government Funding	$	$
c. Fee for Service	$	$

OPERATIONS

1. What precautions are taken to keep track of patients?

2. Do you use sign-out procedures? ☐ Yes ☐ No
3. Are alarms on doors to prevent clients from wandering from the residence? ☐ Yes ☐ No
4. Do any residents attend school/workshops? ☐ Yes ☐ No
5. Do any residents work full-time or part-time? ☐ Yes ☐ No
6. 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:

   The next 12 months:

7. Is the applicant in the employ of any governmental entity? ☐ Yes ☐ No
   If yes, please attach explanation, including details of your responsibilities.
8. Is the applicant under contract to any governmental entity? ☐ Yes ☐ No
   If yes, please attach explanation. Include details of your responsibilities.
9. Does the applicant perform or permit any corporal punishment? ☐ Yes ☐ No
   If yes, please attach explanation.
10. Describe in detail any additional activities and/or procedures performed by the applicant, including any off-premises exposure:

11. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ☐ Yes ☐ No
    If yes:
    a. Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No
    b. Provide the name and title of the applicant's Privacy Officer: _____
12. Does your practice include prescribing of opioids? ☐ Yes ☐ No
    If yes, provide the following details:
    a. Specify the percentage of your practice derived from opioid prescriptions: _____ %
    b. Do you fully comply with the CDC Guideline for Prescribing Opioids? ☐ Yes ☐ No
    c. Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business? ☐ Yes ☐ No
    d. Do you also dispense the opioids? ☐ Yes ☐ No

HIRING PRACTICES

13. Do you require signed applications on all prospective employees? ☐ Yes ☐ No
14. Do you verify all professional qualifications, licenses and certifications? ☐ Yes ☐ No
15. Do you conduct a personal interview with prospective employees and non-employees? ☐ Yes ☐ No
16. Do you require professional and personal references on each employee? ☐ Yes ☐ No
17. Do you conduct a criminal background check? ☐ Yes ☐ No
18. Do you provide training and orientation for new employees? ☐ Yes ☐ No
19. Do you follow up on any pending license suspensions or revocations or any pending disciplinary actions? ☐ Yes ☐ No
20. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past? ☐ Yes ☐ No
21. Do you have written job descriptions? ☐ Yes ☐ No
22. Do you require drug/alcohol screening? ☐ Yes ☐ No

RISK MANAGEMENT/LOSS CONTROL

23. Is there a written, formalized Risk Management Program? ☐ Yes ☐ No
24. Is there a written, formalized Quality Assurance Program? ☐ Yes ☐ No
25. Do you have a standard system to handle a patient's complaints or suggestions? ☐ Yes ☐ No
26. Do you practice universal precautions? ☐ Yes ☐ No
27. Do you have a Quality Assurance Department? ☐ Yes ☐ No
28. In case of an emergency is management available 7 days a week, 24 hours a day? ☐ Yes ☐ No
29. Do you have policies and procedures in place regarding medications? ☐ Yes ☐ No
30. Are nursing charts maintained regularly? ☐ Yes ☐ No
31. Do you regularly check employees' licenses and certifications? ☐ Yes ☐ No
32. Does your staff employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse-related offenses? ☐ Yes ☐ No
33. Do you discuss at staff orientation elder and/or child abuse or sexual abuse? ☐ Yes ☐ No
34. Do you have a supervision plan in place that monitors staff in the daily relationships with clients? ☐ Yes ☐ No

RESIDENT INFORMATION

35. Are all residents screened for the below at-risk conditions prior to admission? Check all that apply.
    ☐ Fall ☐ Skin Conditions ☐ Psychiatric Conditions ☐ Mobility Limitations ☐ Cognitive Impairments ☐ Nutritional Status
    ☐ Prior Injuries ☐ Wandering/Elopement
36. Who completes assessments? ☐ Administrator ☐ RN/LPN ☐ Other: _____
37. How often are reassessments conducted on residents?
38. Do you accept residents with a primary psychiatric diagnosis? ☐ Yes ☐ Yes ☐ No
39. Do you have written policies/procedures for admission, discharge, and transfer criteria? ☐ Yes ☐ No
40. Do you have policies/procedures in place to identify those residents who may need a higher level of care? ☐ Yes ☐ No
41. Have you ever denied an admissions due to required level of care? ☐ Yes ☐ No
42. Do you have policies/procedures in place to identify those residents who may need a higher level of care? ☐ Yes ☐ No
43. Do third-party providers render services at any of your locations (examples: home health, hospice, mental health, or physical therapy)?
    ☐ Yes ☐ No
44. Do you require them to list you as additional insured on their insurance policy? ☐ Yes ☐ No
45. Does applicant have sexual/physical abuse reporting requirements in place? ☐ Yes ☐ No
46. Is there a formal risk management program in place for incident reporting? ☐ Yes ☐ No
47. Does facility have a back-up power source in place? ☐ Yes ☐ No

    If yes, provide details: _____

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MEDICATION ADMINISTRATION

48. Who is responsible for administering medications? Check all that apply.
☐ Licensed Staff ☐ Medication Aide ☐ Residents ☐ Self Administer ☐ Other: _____
49. How are drugs stored? ☐ Locked Room ☐ Locked Cabinet ☐ Locked Cart ☐ Other: _____
50. Is a unit dose medication system used by the facility? ☐ Yes ☐ No
51. Do you have a system to track, monitor and calculate medication errors? ☐ Yes ☐ No
52. What is your current medication error rate? _____ % Date of Evaluation: _____

ELOPEMENTS

53. Are residents allowed to leave premises unattended? ☐ Yes ☐ No
54. Does applicant have elopement/wandering risk assessments and prevention plan in place? ☐ Yes ☐ No
55. Are all exit doors alarmed or have delayed egress? ☐ Yes ☐ No
56. Are electronic devices used for those residents prone to wondering/memory care? ☐ Yes ☐ No
57. Number of resident elopements in the past 3 years: _____
If any, provide details: _____

STAFF INFORMATION

58. Number of professional employees, volunteers, and independent contractors:

Employees	Location 1	Location 2	Location 3	Location 4
MDs				
Psychologists				
Social Workers				
RNs				
LPNs/Nurse's Aides				
Pharmacists				
Nurse Practitioners				
Volunteers				
Other (describe qualifications and duties separately):				

continued on next page ▶

Number of professional employees, volunteers, and independent contractors *(continued):*

Independent Contractors	Location 1	Location 2	Location 3	Location 4
MDs				
Psychologists				
Social Workers				
RNs				
LPNs/Nurse's Aides				
Pharmacists				
Nurse Practitioners				
Other (describe qualifications and duties separately):				

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

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

61. Does the facility maintain 24-hour awake staff? ☐ Yes ☐ No

62. Please provide staff to resident ratio for shifts indicated below (required):

☐ 8-Hour Shift Schedule Used	Staff-to-Resident Ratio	☐ 12-Hour Shift Schedule Used	Staff-to-Resident Ratio
Day	____ : ____	Day/Evening	____ : ____
Evening	____ : ____	Evening/Awake	____ : ____
Awake	____ : ____		

continued on next page ▶

GENERAL LIABILITY

63. The insured is a: ☐ Building owner ☐ Tenant ☐ General lessee

64. Complete information below for each location:

	Location 1	Location 2	Location 3	Location 4
Year built				
Year remodeled				
Number of stories				
Construction type:				
Exterior walls				
Roofs				
Floors				
Age of wiring/update				
Number of fire extinguishers				
Number of fire escapes				
Distance to the nearest fire station				
Is the building equipped with:				
At least 2 clearly marked exits on each floor?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Self-closing fire doors on each floor?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Exit doors of at least 42" width from all sleeping, diagnostic and treatment rooms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Automatic fire alarm system connected to local fire department?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Central station fire alarm?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Emergency electrical system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Heat sensors?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Smoke detectors in all bedrooms/hallways?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Handrails in hallways and bathrooms?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sprinkler system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Attach a detailed explanation for any "yes" answers.

65. Is any new construction contemplated for the next 12 months? ☐ Yes ☐ No

If yes, attach details, including estimated contract costs, number of beds, square feet, planned use, date of completion, etc.

INSURANCE AND CLAIM INFORMATION

66. a. Do you currently carry Professional Liability Insurance? ☐ Yes ☐ No

If yes, list the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

Policy Period **FROM** MM/DD/YY	Policy Period **TO** MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
			$	$		$
			$	$		$
			$	$		$
			$	$		$
			$	$		$

If claims made, what is the retroactive date/prior acts date on your current policy? _____

b. Do you currently carry **Commercial General Liability Insurance?** ☐ Yes ☐ No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
		$	$		$

If claims made, what is the retroactive date/prior acts date on your current policy? _____

67. a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.
IF NO PRIOR COVERAGE, COMPLETE CLAIM SUPPLEMENT.

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No

If yes, provide full details:

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? ☐ Yes ☐ No

If yes, fully describe the circumstances and follow-up action taken:

NOTE: If yes to any questions above (66.a, 66.b or 66.c), please complete the **Supplemental Claim Information Form.**

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

1. Copy of prior five (5) years currently valued company loss run
2. Copy of the declaration page of your most recent professional liability policy
3. If a start-up firm, copy of the pro forma business plan
4. Copy of any advertising brochures or advertisements
5. Copy of a sample client contract
6. Resumes/CVs for all key personnel, principals, executives, medical directors and/or administrators

Limits of Liability desired for Professional Liability:

☐ $100,000/$100,000 ☐ $250,000/$250,000 ☐ $500,000/$500,000
☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/3,000,000
☐ Other: $ _____ / $ _____

Deductible desired:

☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other: $ _____

MINIMUM AND MAXIMUM DEDUCTIBLES WILL BE SUBJECT TO UNDERWRITING APPROVAL.

SIGNATURE PANEL

It is understood and agreed that if any such fact(s), incidents, act(s), circumstance(s) or occurrence(s) exists, whether or not disclosed, any claim or action subsequently arising or developing therefrom shall be excluded from coverage under any policy issued by U.S. Risk HealthcarePros.

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Notice applicable in most states: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

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

Applicant signature _____ Date _____

Typed or printed name: _____ Title: _____

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