Social Services Agencies **Application**

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

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

Desired effective date: _____

1. GENERAL INFORMATION

Name of applicant: _____
Address: _____
City: _____ State: _____ County: _____ ZIP: _____
Contact Name: _____ Title: _____
Contact Email Address: _____ Phone: _____
Website URL: _____

List all subsidiaries (attach a list if more space is required):

Name	Type of Operation	Percentage of Ownership	Date Acquired	Domestic or Foreign?
Professional Liability		%		
General Liability		%		
Excess and/or Umbrella		%		

Applicant is:
☐ Not-for-Profit ☐ For-Profit ☐ Government ☐ Other (describe): _____

Annual budget: $ _____ Years operational: _____
Are you licensed by state or local authorities? ☐ Yes ☐ No
Please describe the purpose of the organization. _____
Percentage of services provided involving minors (persons under age 18): _____ %

2. STAFFING AND OPERATIONS

Please attach a copy of your employment application.

Profession	**Number of Employees**		**Number of Non-Employees**	
	Full-Time	Part-Time	Full-Time	Part-Time
Psychiatrists (M.D.)*				
Other Physicians (M.D.)*				
Psychologists (M.D.)*				
Social Workers				
Residence Managers				
Counselors				
Others (specify positions below)				

**Please list names on a separate sheet.*

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If Others, specify positions:

3. OUTPATIENT SERVICES

Provide number of annual client visits for each description checked.

Service	Number of Annual Visits	Service	Number of Annual Visits
☐ Hospice (outpatient)		☐ Day school	
☐ Mental health day care		☐ Mental health day school	
☐ Outpatient counseling		☐ Referral agencies	
☐ Mental retardation (including ARC) and/or cerebral palsy centers		☐ Big Brothers/Big Sisters Number of children:	
☐ Sheltered workshop			Number of Annual Calls
☐ Recreation programs		☐ Crisis phone hotline	
☐ Training (please describe and include number of clients)			
☐ Other services (please describe and include number of client visits):			

a. Age limitations on the above captioned services, if any: _____ Average age of clients: _____

b. Describe the types of problems treated in an outpatient setting:

c. If the applicant provides a recreation program, please describe activities in full detail:

d. If the applicant provides group therapy sessions, answer the following:
   i. Average size of the group: _____
   ii. Average number of times the group meets per week: _____
   iii. Types of problems treated in sessions: _____

e. If the applicant provides a crisis hotline, please answer the following:
   i. What types of problems are treated by the hotline? _____
   ii. Do you use volunteers on the hotline? ☐ Yes ☐ No
   ii. If volunteers are used as counselors, please describe the training they receive:
   iv. Hours of operation for the hotline: _____

4. ELDERLY/AGED (NON-RESIDENTIAL) SERVICES:

☐ Meals on Wheels Number of meals annually: _____

☐ Agency for the aged/seniors Number of annual client contacts: _____

☐ Elderly Residential Number of beds (see Residential Facility Supplement on page 6): _____

Please describe the nature of the activities at the agency or senior center:

5. SUBSTANCE ABUSE PROGRAMS

Please indicate the number of annual client contacts.

☐ DUI classes: _____ ☐ Non-medical detox (secondary stage): _____

☐ Methadone maintenance: _____ ☐ Alcohol/drug counseling (outpatient): _____

☐ Inpatient detox: _____ Number of beds: _____

6. RESIDENTIAL PROGRAMS

Please indicate the number of beds.

☐ Contracted beds: _____ ☐ Group home (3+ months): _____

☐ Group and residential home: _____ ☐ Halfway house: _____

☐ Home for the battered: _____ ☐ Inpatient mental health: _____

☐ Supervised living: _____ ☐ Residential treatment (MH/MR): _____

☐ Hospice: _____ ☐ Psychiatric hospital: _____

☐ Elderly: _____ ☐ Other: _____

If Other, please describe: _____

a. Are you a psychiatric hospital? ☐ Yes ☐ No

b. Are you an alternative to incarceration for youths or adults? ☐ Yes ☐ No

c. Do you provide assisted living services? ☐ Yes ☐ No
   If yes, what is the average age of the residents: _____ Are there any age limitations for residents?: _____

d. Residents are: ☐ Male ☐ Female ☐ Both
   If both, are they located in separate buildings or floors? ☐ Yes ☐ No

e. Average length of stay by residents: _____ How many residential locations are run by the applicant? _____

f. What is your client/staff ratio? _____

g. Are security measures in place for each residential facility? ☐ Yes ☐ No

h. Are monthly visits made by a caseworker to a resident? ☐ Yes ☐ No

7. PHYSICAL AND SEXUAL ABUSE QUESTIONS *(Complete if this coverage is desired.)*

a. Does your staff (paid and volunteer) employment application include questions about whether the individual has ever been convicted of any crime, including any sex-related or child-abuse related offense? ☐ Yes ☐ No

b. Does your state permit you to do criminal background investigations? ☐ Yes ☐ No

c. Do you verify employment related references? ☐ Yes ☐ No
   If yes, by phone or in person? ☐ Phone ☐ In person

d. Does your organization conduct personal interviews? ☐ Yes ☐ No

e. At staff orientation, do you discuss physical/sexual abuse, how to recognize the signs, and what to do if a client/child reports someone has abused/molested him/her? ☐ Yes ☐ No

f. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children? ☐ Yes ☐ No

g. Do you have a crisis management plan for dealing with the staff personnel, victim, parents, authorities, and media, if you have an incident of abuse/molestation? ☐ Yes ☐ No

ITEMS 9–13 MUST BE COMPLETED IN FULL.

8. RECORD OF EXISTING INSURANCE

Coverage	Company	Limits	Premium	Effective Date	Retro Date Claims Made
Professional Liability					
General Liability					
Excess and/or Umbrella					

9. If no insurance exists, is this a new venture? ☐ Yes ☐ No

10. Is expiring professional liability coverage on a claims made policy? ☐ Yes ☐ No
Retroactive Date: _____
If yes, do you desire prior acts coverage? ☐ Yes ☐ No

11. Is expiring general liability coverage on a claims made policy? ☐ Yes ☐ No
Retroactive Date: _____
If yes, do you desire prior acts coverage? ☐ Yes ☐ No

12. Does this policy provide Physical/Sexual Abuse Coverage? ☐ Yes ☐ No
Is this a sub-limit? ☐ Yes ☐ No Limit: $ _____

13. CLAIMS HISTORY

Has the applicant had **any** Professional Liability or General Liability claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past 5 years? ☐ Yes ☐ No

If yes, please describe in detail date claim reported, date of loss, allegations, amount reserved/paid, and current status (open or closed).

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

1. Employment application
2. Five year currently valued loss runs
3. Copies of state licenses
4. Health department inspections
5. Most recent financial statement (balance sheet and P&L)

APPLICATION MUST BE SIGNED BY APPLICANT.

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

NOTE: *Application must be signed and dated by* ***both applicant and agent,*** *but not by the agent for the applicant.*

APPLICANT SIGNATURE PANEL

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____

AGENT/BROKER SIGNATURE PANEL

Authorized signature _____ Date _____

Typed or printed name: _____ Name of Agency: _____

RESIDENTIAL FACILITY SUPPLEMENT ▶

Residential Facility **Supplement**

The following supplement must be completed for each residential facility operated by the Applicant.

LOCATION NUMBER: _____

Number of beds at this location: _____

1. a. Name of Facility: _____
   b. Address: _____

2. Information that concerns this facility:
   a. Year of construction: _____
   b. Number of stories in building: _____
   c. Number of stories occupied by applicant: _____
   d. Protective Devices
      - ☐ Automatic sprinklers
      - ☐ Heat sensors
      - ☐ Smoke detectors
   e. Number of fire escapes: _____
   f. Swimming pool? ☐ Yes ☐ No
   g. Enter year of updates in: Construction: _____ Plumbing: _____ Wiring: _____
   h. ☐ Owned ☐ Leased

3. This location operates as: _____ Average length of stay: _____

4. Problems treated at this facility:
   ☐ Alcohol ☐ Drug ☐ Mental Retardation ☐ Mentally Ill ☐ Aged

5. Is facility **room and board only**? ☐ Yes ☐ No
   If no, describe treatment methods and approach:

6. Is this a lock-up facility for residents? ☐ Yes ☐ No

7. Are any of the above beds, medical or non-medical detoxification beds? ☐ Yes ☐ No

8. **OPERATIONAL AND PREMISES INFORMATION**
   a. Are you leasing/sub-leasing to others any portion of the locations listed? ☐ Yes ☐ No
      If yes, please describe occupancy:
   b. Do you require that your tenant carry liability insurance for their occupancy? ☐ Yes ☐ No
   c. Are you always added as an Additional Insured to the tenant's liability policy? ☐ Yes ☐ No
   d. Are there any pools on the premises? ☐ Yes ☐ No
      Are pools used exclusively for clients? ☐ Yes ☐ No
      Is pool secured when not in use? ☐ Yes ☐ No
      Are clients supervised? ☐ Yes ☐ No

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Are there certified lifeguards used at all times? ☐ Yes ☐ No
Do you utilize off-premises swimming facilities? ☐ Yes ☐ No
Are pool depths marked? ☐ Yes ☐ No
Staff trained in water safety? ☐ Yes ☐ No
Minimum age allowed in water: _____
Is the pool area fenced? ☐ Yes ☐ No
Is there a self-locking gate? ☐ Yes ☐ No
Is the walking surface around pool in good condition? ☐ Yes ☐ No
Any slides or diving boards? ☐ Yes ☐ No
Is the storage of pool chemicals secure? ☐ Yes ☐ No

e. Is there a playground and/or playground equipment? ☐ Yes ☐ No
Is the playground fenced? ☐ Yes ☐ No
Are there any trampolines? ☐ Yes ☐ No
Is playground equipment properly inspected and maintained on a specified schedule? ☐ Yes ☐ No
Does the play equipment and toys meet the consumer safety code requirements? ☐ Yes ☐ No

f. Do you provide medical services? ☐ Yes ☐ No

g. Is transportation provided to clients? ☐ Yes ☐ No

