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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

# RESIDENTIAL CARE RENEWAL

Applicant Name:_____
E-mail Address:_____ Website Address:_____
Annual Budget: $_____ Annual Payroll: $_____
Is the Applicant's organization more than 25% owned by a private equity fund structure? ☐ Yes ☐ No
If yes, provide name of private equity firm:_____
Risk Management Contact:_____ Risk Management's Phone:_____
Risk Management Email:_____

## REQUIREMENTS FOR RENEWAL

- Copy of the current license

## SECTION I – GENERAL INFORMATION

1. Has Applicant's license ever been suspended, revoked, or placed under conditional status? ☐ Yes ☐ No
2. Date of last state inspection:_____
   Any inspection violations/deficiencies noted? ☐ Yes ☐ No
   Provide date compliance completed:_____
3. Have there been any claims that allege negligence or failure to comply with any regulatory / license guideline? ☐ Yes ☐ No
   If yes, please explain on a separate sheet of paper.
4. Any mergers or operations planned for the next 2 years? ☐ Yes ☐ No
5. Are counseling services/therapy offered for the following target classes: Fire Starter? ☐ Yes ☐ No
   Sexual Offenders? ☐ Yes ☐ No Sexual Predators? ☐ Yes ☐ No

## SECTION II – MANAGEMENT PRACTICES

1. Service Level / Client to Staff Ratio Definitions (select all that apply):
   - ☐ These clients do not live in licensed residential care homes as they are very high functioning. Most hold jobs or attend day programs. (Level 1 – CA Only)
   - ☐ 6 to 1 staff ratio (6 residents to 1 staff person minimum). Residents want or need a little supervision – only reminders to do things. Supervision for safety reasons only. Most residents attend day programs or attend sheltered workshops. (Level 2 – CA Only)
   - ☐ 3 to 1 staff ratio. Behavior issues maybe involved (i.e. not listening, assistance with physical needs such as toileting, bathing). Most residents attend day programs or sheltered workshops. (Level 3 – CA Only)
   - ☐ Direct assistance needed for physical and/or behavioral issues. Most residents attend day programs or sheltered workshops. Care, supervision, and professionally supervised training for persons with deficits in self-help skills, and/or severe impairment in physical coordination and mobility, and/or severely disruptive or self-injurious behavior. Service level 4 subdivided into levels 4 (a) through 4(i), in which staffing levels are increased to correspond to escalating severity of disability levels. (Level 4 – CA Only)
     - ☐ Has a 3 to 1 staff ratio (additional hours may be required if over 3 residents in home (Level 4 (a-e) – CA Only)
     - ☐ Has a 2 to 1 staff ratio (Level 4 (f-i) – CA Only)

## SECTION III – RESIDENTIAL FACILITIES

(photocopy this section for each additional location)

| RESIDENTS | # BEDS | RESIDENTS | # BEDS | RESIDENTS | # BEDS |
|---|---|---|---|---|---|
| Acute Skilled Care | | Inpatients Crisis Center | | Respite Care | |
| Aged | | Low Income Housing | | Transitional Housing | |
| Group Home | | Shelter-Abuse Victims | | Youth Homes | |
| Hospice | | Shelter-Homeless | | Other (specify): | |
| Independent Living | | Shelter-Other: | | Other (specify): | |

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1. Annual number of clients by age group:
   Less than 18:_____ 18 - 35: _____ 36 - 65: _____ Over 65:_____
   Average Occupancy:_____
2. Annual number of clients by disability:
   24-hr Constant Care Required:_____ Alzheimer's/Dementia:_____ Blind:_____ Deaf:_____
   Developmental Disability:_____ Drug/Alcohol: _____ Emotional/Behavior: _____
   Intellectual Behavior:_____ Non-Ambulatory:_____ Traumatic Brain Injury:_____
3. Resident elopement/unauthorized leave prevention (check all that apply):
   ☐ Exit doors locked to residents ☐ Wristband sensor w/alarm ☐ Exit doors alarmed to residents
4. How often are residents checked or monitored to ensure that they are at the facility or have returned to the facility? _____
5. Specify number of: Male:_____ Female:_____ Co-ed:_____
6. Are residents separated? ☐ Yes ☐ No
   How are they separated?_____
7. Average length of stay:_____
8. Are residents primarily responsible for their own basic personal care including bathing, dressing, eating, and restroom aide? ☐ Yes ☐ No
9. What is the ratio of resident to staff: Day:_____ Night: _____
10. How many visits per month are made by a caseworker to a resident?_____
11. How often are rooms inspected?_____
    Who inspects the room?_____
    Does the Applicant have written procedures? ☐ Yes ☐ No
    Does the Applicant keep a checklist? ☐ Yes ☐ No
12. How often are bed checks done? ☐ Random ☐ Scheduled
13. Does the Applicant own or operate a Nursing Home or Assisted Living Facility? ☐ Yes ☐ No
    If yes, please explain:

    _____

## SECTION IV – PROFESSIONAL LIABILITY / STAFF

1. What is the staff turnover ratio for the last twelve (12) months?_____
2. Annual Staffing – Employees, Independent Contractors and Volunteers
   Total number of: Full time employees:_____ Part Time Employees:_____ Volunteers:_____
   Contracted Intellectually/ Developmentally Disabled (IDD) Shared Living- Host Homes:_____

| Staffing | # of Employees | | # of Contracted | | Total Annual Volunteer Hours Worked |
|---|---|---|---|---|---|
| | FT | PT | FT | PT | |
| Psychologist | | | | | |
| Medical Director (Admin Only) | | | | | |
| Nurse Practitioner | | | | | |
| Physician Assistant | | | | | |
| Pharmacist | | | | | |
| Paramedic EMT | | | | | |
| Psychiatrist | | | | | |
| Physician-Hospice | | | | | |
| Pediatrician | | | | | |
| Physician-No Surgery | | | | | |
| Dentist | | | | | |
| Optometrists/Ophthalmologist | | | | | |
| Licensed Social Worker | | | | | |
| Sociologist | | | | | |
| Registered Nurse (RN) | | | | | |
| Licensed Practical Nurse (LPN) | | | | | |
| Physical Therapist | | | | | |
| Optician | | | | | |

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| Staffing | # of Employees | | # of Contracted | | Total Annual Volunteer Hours Worked |
|---|---|---|---|---|---|
| | FT | PT | FT | PT | |
| Orthotics & Prosthetics (O&P) Certified Practitioner | | | | | |
| Counselor (Guidance, Vocational) | | | | | |
| Social Worker | | | | | |
| Occupational Therapist | | | | | |
| Speech Therapist | | | | | |
| Clergy / Rabbi / Pastor | | | | | |
| O&P Certified Technician | | | | | |
| Teacher | | | | | |
| Nutritionist / Dietician | | | | | |
| Residential Manager | | | | | |
| Home Health Aide | | | | | |
| IDD In-Home Companion Care Provider | | | | | |
| Day Care Worker | | | | | |
| O&P Certified Fitter | | | | | |
| O&P Certified Assistant | | | | | |
| Adoptions | | | | | |
| Foster Care | | | | | |
| *Other (describe):_____ | | | | | |
| *Other (describe):_____ | | | | | |

F/T = Full Time – over 20 hours per week/ P/T = Part Time – up to 20 hours per week.
*Please describe "other" staff positions not listed in the above chart in the provided area.

3. **If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.**
4. **If the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians carry their own medical malpractice insurance, we may provide vicarious medical professional coverage for the entity as respects to the professional services rendered on the insured's behalf. Coverage for the entity will require the following: The Professional's name, medical license number, medical specialty and proof that the professional carries adequate limits of insurance (at least $1million limit of liability). Proof of insurance may be satisfied by submitting a copy of the professional's declaration page and/or certificate of insurance.**

## SECTION V - CONSULTANTS/INDEPENDENT CONTRACTORS

1. Are there written agreements with independent contractors? ☐ Yes ☐ No
2. Are certificates of malpractice/liability insurance obtained and maintained for all contracted service providers (independent contractors)? ☐ Yes ☐ No
3. Please indicate the limits of liability: $_____

## SECTION VI – ABUSE & MOLESTATION ☐ N/A

1. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? ☐ Yes ☐ No
2. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if the Applicant has incident of abuse? ☐ Yes ☐ No
3. Are there written complaint procedures and are they displayed prominently? ☐ Yes ☐ No
   If yes, explain:

   _____
4. Is there a written supervision plan that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ Yes ☐ No
5. Are formal written procedures in place for hiring? ☐ Yes ☐ No

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6. Do volunteers work directly with clients? ☐ Yes ☐ No
7. Is there formal staff training on child/sexual abuse, including how to recognize the signs? ☐ Yes ☐ No
8. What procedures are in place to make sure no relationship occurs between staff and clients?

9. Are there procedures prohibiting closed door one-on-one meetings / counseling? ☐ Yes ☐ No
10. Is there more than one person responsible for the welfare of any single patient? ☐ Yes ☐ No
11. Have any incidents resulted in an allegation of sexual abuse? ☐ Yes ☐ No
    Was the case settled? ☐ Yes ☐ No Was the case taken to trial? ☐ Yes ☐ No
    Amount paid for damages to the victim: $_____
12. Does the Applicant run criminal background checks on employees? ☐ Yes ☐ No
13. Does the Applicant run criminal background checks on volunteers? ☐ Yes ☐ No

## SECTION VII - AUTOMOBILE ☐ N/A

1. Does the Applicant run MVRs on employees? ☐ Yes ☐ No If yes, how often?_____
2. Does the Applicant have a driver safety training program? ☐ Yes ☐ No
3. Are all drivers at least 21 years of age? ☐ Yes ☐ No
4. Does the Applicant transport clients/consumers for other private or government agencies? ☐ Yes ☐ No
   If yes, please explain:

   If yes, for a fee? ☐ Yes ☐ No
5. Does the Applicant's organization utilize GPS fleet telematics devices? ☐ Yes ☐ No
   If yes, please check off the fleet telematics being utilized:
   ☐ Plug in ☐ Hard wired ☐ Mobile Phone ☐ Other:_____
6. What percentage of the Applicant's fleet is provided with these fleet telematics devices?_____%

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## FRAUD STATEMENT AND SIGNATURE SECTIONS

**The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.**

**The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.**
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company**

**VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.**

### FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PA, RI, TN, VA, WA AND WV).**

**APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV:** ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

**APPLICABLE IN COLORADO:** IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

**APPLICABLE IN FLORIDA AND OKLAHOMA:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

**APPLICABLE IN KANSAS:** AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

**APPLICABLE IN KENTUCKY:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

**APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**APPLICABLE IN PENNSYLVANIA:** 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 FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**APPLICABLE IN VERMONT:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

**APPLICABLE IN 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 CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

**SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT**

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)