Rice Insurance LLC
1400 Broadway
Bellingham, WA 98225
Phone- 360-734-1161 | **FAX- 360-734-1173.** roger@riceinsurance.com

Fax

TO:	Roger Chamberlin	FROM:	
FAX:	360-734-1173	PAGES:	
PHONE:		DATE:	
RE:	AFH Insurance-	CC:	

☐ Urgent ☐ For Review ☐ Please Comment ☒ Please Reply ☐ Please Recycle

Attached please find the following renewal documents:

Checklist:

_____ completed APPLICATION

_____ copy of my most recent DSHS inspection including the letter of deficiencies

_____ copy of my AFH license

Thank you,

Roger Chamberlin- roger@riceinsurance.com

HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

U.S. Risk Underwriters
Boston (617.342.7116)
Dallas (800.232.5830)
Houston(800.833.8803)

RESIDENTIAL FACILITIES, GROUP HOMES AND OTHER OVERNIGHT STAY FACILITIES APPLICATION (NON-ELDERLY) PROFESSIONAL AND GENERAL LIABILITY APPLICATION

(CLAIMS MADE AND REPORTED BASIS)

Please email this application back to the underwriter you are working with.
For contact information please visit www.usrisk.com/healthcare.html

Effective date desired:_____

1. Complete name of applicant : _____
   Address: _____
   City: _____ State:_____ Zip:_____ County: _____
   Contact name: _____ Title:_____ Email address: _____
   Phone: _____ Web site Address: _____ Fax: _____
2. Applicant is: a. ❑ Individual ❑ Partnership ❑ Corporation ❑ Professional Association ❑ Other: _____
   b. ❑ Not-for-profit ❑ For-profit ❑ Both
3. Date established: _____ /_____
4. Current accreditations or associations: ❑ NAHC ❑ TAHC ❑ JCAHO ❑ CHAP ❑ NHPCO ❑ Other: _____
5. Is the firm engaged in, owned by or associated with or controlled by any other business? ❑ Yes ❑ No
   If yes, give details (use an additional sheet of paper if necessary): _____
   _____
   _____
6. Does the applicant anticipate any facility expansions within the next year? ❑ Yes ❑ No
   If yes, please describe: _____
   _____
7. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered? ❑ Yes ❑ No
   If yes, give details: _____
   _____
8. Hold Harmless (Indemnification) Agreements: -
   (a) In favor of the applicant: - if the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained: _____
   _____
   (b) In favor of others: - has the applicant agreed to indemnity (hold harmless) others under written contract? ❑ Yes ❑ No
   If yes, please submit a copy of the agreement.
9. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule? ❑ Yes ❑ No
   If yes,
   (i) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? ❑ Yes ❑ No
   (II) Provide the name and title of the Applicant's Privacy Officer. _____

10. List locations of all facilities

Location No.	Name and Location of Facility	**Type of facility:** Group Home: Halfway House; Inpatient; Contract Beds; Outpatient - Describe below in detail	**Type of Patient**: Mentally Retarded; Child/Adult/Aged; Ex-offender; Emotionally Disturbed; Physically Handicapped; Other - Please be specific	**(1)** No. of licensed Beds and **(2)** No. of occupied beds	**List all Services rendered** (e.g., alcohol or drug detoxification; confrontation, shock, rage, sex therapy; vocational rehab; hypnosis; surgery, types of counseling, etc.)
1	____sq. ft			(1) No. (2) No.	
2	____sq.ft			(1) No. (2) No.	
3	____sq.ft			(1) No. (2) No.	
4	____sq.ft			(1) No. (2) No.	

11. Are the facilities listed 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.

12. Range of client ages _____ How many male? _____ How many female? _____

13. State sources and amounts of actual and projected gross revenue below:

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

14. Please state the number of professional employees, volunteers, and independent contractors below.

EMPLOYEES	1.	2.	3.	4.
MDs				
Psychologists				
Social Workers				
RNs				
LPNs/Nurse's Aides				
Pharmacists				
Nurse Practitioners				
Other (Describe qualifications & duties separately)				
Volunteers				
INDEPENDENT CONTRACTORS				
MDs				
Psychologists				
Social Workers				
RNs				
LPNs/Nurse's Aides				
Pharmacists				
Nurse Practitioners				
Other (Describe qualifications & duties separately)				

15. Are all the above individuals above licensed in accordance with applicable state and federal regulations? ❑ Yes ❑ No
If no, attach an explanation

16. Does the applicant have any independent contractors? ❑ Yes ❑ No
If yes, list the number and type of independent contractors who provide professional services on behalf of the applicant:

_____

_____

17. Do any of the above employees or volunteers carry their own professional liability insurance? ❑ Yes ❑ No
If yes, please advise policy limits: _____

18. Is continuing education or staff development required for your employees? ❑ Yes ❑ No

19. Name of medical director, if any: _____
(i) Is coverage provided for the medical director under any other insurance policy? ❑ Yes ❑ No
(ii) If yes, please provide type of policy and name of carrier: _____

HIRING PRACTICES

20. a. Do you conduct a criminal background check? ❑ Yes ❑ No
b. Do you require signed applications on all prospective employees? ❑ Yes ❑ No
c. Do you verify all professional qualifications, licenses and certifications? ❑ Yes ❑ No
d. Do you require professional and personal references on each employee? ❑ Yes ❑ No
e. Do you provide training and orientation for new employees? ❑ Yes ❑ No
f. Do you verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities? ❑ Yes ❑ No
g. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past? ❑ Yes ❑ No
h. Do you have written job descriptions? ❑ Yes ❑ No
i. Do you require drug/alcohol screening? ❑ Yes ❑ No

OPERATIONS

21. What precautions are taken to keep track of patients?
22. Do you use sign out procedures? ❑ Yes ❑ No
23. Are alarms on doors to prevent clients from wandering from the residence? ❑ Yes ❑ No
24. Do any residents attend school/workshops? ❑ Yes ❑ No
25. Do any residents work full or part time? ❑ Yes ❑ No
26. 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_____ Next 12 months _____

27. Is the applicant in the employ of any governmental entity? ❑ Yes ❑ No
If yes, please attach explanation. Include details of your responsibilities.
28. Is the applicant under contract to any governmental entity? ❑ Yes ❑ No
If yes, please attach explanation. Include details of your responsibilities.
29. Does the applicant perform or permit any corporal punishment? ❑ Yes ❑ No
If yes, please provide separate explanation.
30. Please describe in detail any additional activities and/or procedures performed by the applicant, including any off premises exposure: _____

31. a. Is there a written, formalized Quality Assurance Program? ❑ Yes ❑ No
b. Is there a written, formalized Risk Management Program? ❑ Yes ❑ No
c. Do you have a standard system to handle a patient's complaints or suggestions? ❑ Yes ❑ No
d. In case of an emergency, is management available 7 days a week, 24 hours a day? ❑ Yes ❑ No

GENERAL LIABILITY:

32. Answer questions below only if General Liability coverage for Locations in 1(c) is requested.

QUESTIONS	1.	2.	3.	4.
Year Built				
Year Remodeled				
No. of Stories				
Construction:				
Exterior Walls				
Roof				
Floors				
Is the insured a: ❑ Building Owner ❑ Tenant ❑ General Lessee				
Age of wiring/update				
Number of fire extinguishers				
Number of fire escapes				
Distance to the nearest fire station				
Is the building sprinklered?				
Are handrails provided in hallways and bath-rooms?				
Is the building equipped with:	**Yes No**	**Yes No**	**Yes No**	**Yes No**
At least 2 clearly-marked exits on each floor?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Self-closing fire doors on each floor?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Exit doors of at least 42" width from all sleeping, diagnostic & treatment rooms?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Automatic fire alarm system connected to local fire department?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Central station fire alarm?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Emergency electrical system?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Heat sensors?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Smoke detectors in all bedrooms/hallways?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Are handrails provided in hallways and bath-rooms?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Is there a swimming pool on the premises?	❑ ❑	❑ ❑	❑ ❑	❑ ❑
What pool security measures are in place?				
Is any new construction contemplated for the next 12 months? If yes, attach details including estimated contract costs, number of beds, sq. ft., planned use, date of completion, etc.	❑ ❑	❑ ❑	❑ ❑	❑ ❑

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

INSURANCE AND CLAIM INFORMATION

33. **Do you currently carry the following:**

a. **Professional Liability Insurance?** ❑ Yes ❑ No

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	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. **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 Occur-rence?	Premium

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

CLAIMS HISTORY:

34. 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 ATTACHED 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: _____

_____

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.

_____/_____ _____

Applicant's Signature **Title** **Date**

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

1. COPY OF 5 YEAR CURRENTLY VALUED HARD COPY COMPANY LOSS RUNS
2. COPY OF THE DECLARATION PAGE OF YOUR MOST RECENT PROFESSIONAL LIABILITY POLICY
3. IF A START UP FIRM, COPY OF THE PROFORMA BUSINESS PLAN
4. COPY OF ANY ADVERTISING BROCHURES OR ADVERTISEMENTS
5. COPY OF A SAMPLE CLIENT CONTRACT
6. RESUMES/CV'S 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.

YOU SHOULD SECURE PROOF OF MEDICAL MALPRACTICE INSURANCE FOR ALL PHYSICIANS, DENTISTS, SURGEONS AND NURSE ANESTHETISTS

Adult Family Home **Resume**

Name: _____ Primary Phone: _____
Home Address: _____
(Street, City, State & Zip Code)

Personal Data:

Date of Birth: _____ Marital Status: _____
Social Security #: _____ Spouse's Name: _____

Education:

Did you graduate High School? ☑ Yes ☐ No
College: _____ to _____ Name of School: _____
Courses Studied: _____
Special education relating to your AFH Business: _____
_____
_____

Business & Professional Experience:

Years with current Employer: _____ Years of Care-giving Experience: _____

Prior Employment:
(Indicate Firm Name, Length of Time Employed, Occupation/Position, Reason for Leaving)

From _____ / _____ to _____ / _____ Position: _____ Reason for Leaving: _____	Company: _____ Responsibilities: _____ _____
From _____ / _____ to _____ / _____ Position: _____ Reason for Leaving: _____	Company: _____ Responsibilities: _____ _____
From _____ / _____ to _____ / _____ Position: _____ Reason for Leaving: _____	Company: _____ Responsibilities: _____ _____
From _____ / _____ to _____ / _____ Position: _____ Reason for Leaving: _____	Company: _____ Responsibilities: _____ _____

Management experience/ Transferable business skils:

_____
_____
_____
_____