ALLIED HEALTH & SOCIAL SERVICES SUPPLEMENTAL

Complete with CWCO-SUP-CORE and ACORD 125/126. CWCO-SUP-ABUSE is required for every submission in this class. Attach CWCO-SUP-HNOA or CWCO-SUP-AUTO if clients are transported. Must b

APPLICANT NAME	EFFECTIVE DATE REQUESTED	DATE ESTABLISHED

MAILING ADDRESS	CITY	STATE / ZIP	PHONE

WEBSITE	INSPECTION CONTACT	YEARS UNDER CURRENT MANAGEMENT	EMAIL

A ENTERPRISE & SERVICES

Type of enterprise:

- ☐ Corporation
- ☐ Individual
- ☐ Partnership
- ☐ Joint venture
- ☐ Non-profit
- ☐ For profit

FULL DESCRIPTION OF SERVICES RENDERED

Service lines provided (check all that apply):

- ☐ Home health care
- ☐ Temporary staffing agency
- ☐ Assisted living facility
- ☐ Adult group home
- ☐ Independent living
- ☐ Skilled nursing
- ☐ Mental health outpatient
- ☐ Alcohol / drug rehab
- ☐ Medical detox
- ☐ Halfway house
- ☐ Foster care — adult
- ☐ Foster care — child
- ☐ Adult day care
- ☐ Child day care
- ☐ Sheltered workshop
- ☐ Partial hospitalization
- ☐ Counseling / private practice
- ☐ Methadone clinic
- ☐ Emergency shelter
- ☐ Employee assistance program
- ☐ Hotline / referral service
- ☐ Non-emergency medical transport
- ☐ Emergency transport
- ☐ Other (describe above)

ACTUAL RECEIPTS / OPERATING BUDGET — PAST 12 MONTHS ($)	ESTIMATED RECEIPTS — NEXT 12 MONTHS ($)	ESTIMATED PAYROLL — NEXT 12 MONTHS ($)

B LOCATIONS & OPERATIONS VOLUME

LOC #	ADDRESS, CITY, STATE, ZIP	TYPE OF SERVICES PROVIDED	LICENSED CAPACITY

If more than four locations, attach a separate schedule.

OPERATION TYPE	MEASURE (BEDS / VISITS / CLIENTS / CALLS)	NUMBER	NOTES

Complete for each applicable line: number and type of beds (mental health inpatient, group home, alcohol/drug inpatient, shelters, detox, independent living, halfway house, foster care, apartments); annual out

B1 Are there any discontinued operations or programs? ☐ Yes ☐ No

IF YES, EXPLAIN

C STAFFING & CREDENTIALING

STAFF CATEGORY	FULL TIME	PART TIME	CONTRACTED	VOLUNTEER

Categories: administrators, MD/physicians, nurses, homemakers/nurse aides, psychologists, counselors, therapists, students or volunteers, other.

Hiring procedures used to screen applicants:

☐ Criminal background checks ☐ Reference checks ☐ Verification of certification or licensing
☐ Drug and alcohol screening ☐ Sexual abuse screening ☐ Abuse registry check
☐ Motor vehicle records ☐ Exclusion list (OIG / SAM) check ☐ None of these

C1 Are any physicians to be covered under this policy? ☐ Yes ☐ No

PHYSICIAN NAME & SPECIALTY	BOARD CERTIFIED	HOURS PER WEEK	VOLUNTEER / CONTRACTED / EMPLOYED	OWN MALPRACTICE?	LIMITS CARRIED

C2 Are all licenses, certifications and accreditations current for every staff member requiring one? ☐ Yes ☐ No

IF YES, EXPLAIN

C3 Has any license or accreditation ever been suspended, denied or revoked? ☐ Yes ☐ No

IF YES, EXPLAIN

PROFESSIONAL ASSOCIATIONS APPLICANT BELONGS TO

ANNUAL STAFF TURNOVER RATE (%)

D MEDICATION ADMINISTRATION

D1 Are any drugs or medications administered or prescribed? ☐ Yes ☐ No
IF YES, EXPLAIN

Who is responsible for administering medications:
☐ Licensed staff ☐ Medication aide ☐ Residents self-administer ☐ Not applicable

D2 Is a unit-dose medication system used by the facility? ☐ Yes ☐ No
IF YES, EXPLAIN

D3 Are controlled substances stored under double lock with a written count log? ☐ Yes ☐ No
IF YES, EXPLAIN

DESCRIBE HOW DRUGS ARE STORED, LOGGED, AND RECONCILED, AND THE PROCEDURE FOLLOWED WHEN A MEDICATION ERROR OCCURS

E RECREATION & PHYSICAL EXPOSURES

E1 Are there any camp, adventure, wilderness, ropes course or recreational programs? ☐ Yes ☐ No
IF YES, EXPLAIN

If yes to E1, submit a brochure or detailed narrative of activities.

E2 Are there any swimming or boating activities? ☐ Yes ☐ No
IF YES, EXPLAIN

E3 Is any pool or spa fenced with a self-locking gate? ☐ Yes ☐ No

E4 Is there a diving board, slide, or trampoline? ☐ Yes ☐ No
IF YES, EXPLAIN

E5 Is there other recreation equipment, such as climbing walls? ☐ Yes ☐ No
IF YES, EXPLAIN

E6 Are clients transported in any vehicle? (attach CWCO-SUP-HNOA or CWCO-SUP-AUTO) ☐ Yes ☐ No
IF YES, EXPLAIN

E7 Does the applicant provide overnight or residential care? ☐ Yes ☐ No
IF YES, EXPLAIN

F COVERAGE REQUESTED & CURRENT INSURANCE

Coverages requested:
☐ General liability ☐ Professional liability ☐ Abuse & molestation
☐ Property ☐ Auto ☐ Workers' compensation

Limits requested:
☐ $100,000 / $100,000 ☐ $300,000 / $300,000 ☐ $100,000 / $300,000
☐ $1,000,000 / $1,000,000 ☐ $1,000,000 / $2,000,000 ☐ Other

Abuse & molestation limits requested:
☐ $25,000 / $50,000 ☐ $50,000 / $100,000 ☐ $100,000 / $300,000 ☐ Other / higher

COVERAGE	CURRENT CARRIER	POLICY TERM	PREMIUM	LIMITS	DEDUCTIBLE	RETRO DATE

Complete rows for general liability, professional liability, and abuse & molestation.

G CLAIMS HISTORY

Attach currently-valued loss runs for the last 5 years.

G1 During the past five years, have any claims been presented to a current or prior carrier, or directly to the applicant? ☐ Yes ☐ No

DATE OF LOSS	DESCRIPTION OF LOSS	PAID ($)	RESERVED ($)	STATUS

G2 Is the applicant, or any person for whom insurance is requested, aware of any circumstance that may result in a claim? ☐ Yes ☐ No

IF YES, EXPLAIN

G3 Has the applicant ever been cancelled or non-renewed in the past three years? ☐ Yes ☐ No

IF YES, EXPLAIN

H ADDITIONAL INFORMATION

ANYTHING ELSE AN UNDERWRITER SHOULD KNOW — ACCREDITATION, STATE SURVEY RESULTS, OR PLANNED CHANGES

I REPRESENTATIONS & SIGNATURE

The undersigned declares that the statements and answers given in this supplemental are true, complete and correct to the best of their knowledge, and that no material fact has been withheld or misstated. The applicant agrees that this supplemental, together with all ACORD applications and attachments, forms the basis of any submission to insurers and may be relied upon by them. Signing this supplemental does not bind coverage. This supplemental must be signed by an owner, partner or officer not earlier than 45 days before the proposed effective date.

FRAUD NOTICE: 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 such person to criminal and civil penalties. (State-specific fraud warnings apply; see state amendatory notice.)

APPLICANT / AUTHORIZED SIGNATURE (TYPE FULL NAME)	TITLE	DATE

PRODUCER — CORY WASHINGTON & CO. LLC	PRODUCER SIGNATURE (TYPE FULL NAME)	DATE