



PROFESSIONAL and GENERAL LIABILITY APPLICATION

ASSISTED LIVING FACILITIES and ADULT GROUP HOMES (Edition 06.2026)

Section 1: Applicant Information

1. Applicant Name: _____
2. Mailing Address: _____
3. Location Address: _____
(If multiple locations exist, please complete a separate application for each location)
4. Telephone Number: _____ Website: _____ Date Established: _____
5. Financial Information:
 - a) Gross Receipts (Past 12 Months): \$ _____
 - b) Estimated Gross Receipts (Next 12 Months): \$ _____

Section 2: Coverage Requested

6. Effective Date: _____
Liability Limits: \$ _____ / \$ _____
Deductible: \$ _____

Section 3: Facility Details

7. Entity Type and Bed Count:

<u>Facility Type</u>	<u>Number of Licensed Beds</u>	<u>Number of currently Occupied Beds</u>
Adult Family Home	_____	_____
Assisted Living Facility (Elderly)	_____	_____
Alzheimer's / Memory Care Facility	_____	_____
Group Home – Developmentally Disabled Adults	_____	_____
Group Home – Mentally Ill Adults	_____	_____
Independent Living Facility (Elderly)	_____	_____
Host Home	_____	_____
Other (Specify): _____	_____	_____

8. Resident Profile:
 - a) Number of Current Residents by Age: 18–39: _____ 40–59: _____ 60+: _____
 - b) Types of impairments affecting non-elderly residents ("non-elderly" meaning ages 18-59 years):

- c) Does the facility accept residents under 18 years old?

☐ Yes ☐ No

9. Does the applicant have any ancillary operations not stated above? ☐ Yes ☐ No

If Yes, please provide details: _____

If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 2 of this application? ☐ Yes ☐ No

10. Is the applicant engaged in, owned by, associated with, or controlled by any other businesses? ☐ Yes ☐ No

If Yes, please provide details: _____

If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 2 of this application? ☐ Yes ☐ No

Section 4: Staffing and Operations

11. a) Is the facility staffed 24/7 with residents never left alone? ☐ Yes ☐ No

b) Shift structure (Check one): ☐ Two 12-hour shifts ☐ Three 8-hour shifts

c) Staffing: Full-time: _____ Part-time: _____ Total Staff: _____

12. Employee and Independent Contractor Details by Shift:

a) List the **NUMBER** and type of **EMPLOYEES** by shift:

EMPLOYEES	1st Shift	2nd Shift	3rd Shift	EMPLOYEES	1st Shift	2nd Shift	3rd Shift
Administrator / Manager				Physician			
Caregiver / Home Health Aide				Nurse Practitioner / Physician Assistant			
CNA				Social Worker / Counselor			
Registered Nurse				Therapist			
LPN/LVN				All others (Describe):			

b) List the **NUMBER** and type of **INDEPENDENT CONTRACTORS** by shift: ☐ If None

INDEPENDENT CONTRACTORS	1st Shift	2nd Shift	3rd Shift	INDEPENDENT CONTRACTORS	1st Shift	2nd Shift	3rd Shift
Administrator / Manager				Physician			
Caregiver / Home Health Aide				Nurse Practitioner / Physician Assistant			
CNA				Social Worker / Counselor			
Registered Nurse				Therapist			
LPN/LVN				All others (Describe):			



13. Are all individuals listed on Q12 subject to licensing requirements properly licensed? ☐ Yes ☐ No
If No, explain: _____

14. Are you seeking coverage under this proposed insurance for the independent contractors? ☐ Yes ☐ No
If No, is coverage at equal or greater limits maintained by each independent contractor? ☐ Yes ☐ No

Section 5: Administration and Screening

15. Name of individual(s) responsible for the administration/management of the facility and their related years of experience:
Name: _____ Facility: _____ Years of Experience: _____

16. Does the owner/administrator reside at the facility? ☐ Yes ☐ No

17. Screening and Policies:

- a) Do you conduct pre-employment screening and investigation? ☐ Yes ☐ No
b) Do you have a written incident/occurrence reporting policy and procedures? ☐ Yes ☐ No

18. Check all the following that are collected, verified, and maintained for each staff member during the hiring process:
☐ Applications/Resumes ☐ Criminal Background Checks ☐ Drug Testing ☐ Education/Training/Competence

19. Are employees up to date on any training required by the state or other governing body, and is proof of this required training kept on file at the facility? ☐ Yes ☐ No

Section 6: Safety and Resident Profile

20. Are smoke detectors in all bedrooms/hallways? ☐ Yes ☐ No

21. Is a Resident Agreement signed by all residents upon entering the facility? (If Yes, attach a copy) ☐ Yes ☐ No

22. Does the facility complete and retain a pre-admission assessment for every resident? ☐ Yes ☐ No

23. Does the Administrator/Manager personally conduct all pre-admission assessments? ☐ Yes ☐ No
a) Are pre-admission assessments conducted in person? (If No, provide details) ☐ Yes ☐ No
b) How often do you formally reassess your residents?

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Other (Describe): _____

24. Does the facility have the right to transfer out / discharge residents whose needs exceed the services of the facility? ☐ Yes ☐ No

25. Does the facility have written guidelines that determine when a resident no longer qualifies for the services provided at the facility? ☐ Yes ☐ No

26. Do all residents have a current care plan and physician evaluation on file dated within the past 12 months? ☐ Yes ☐ No

27. How many people are in a wheelchair most of or all of the day? _____

28. a) How many residents are bedridden? _____ b) Of these, how many are on hospice care? _____

29. Do any residents currently have, or are being evaluated for, Dementia or Alzheimer's? ☐ Yes ☐ No



Level		Description	Number of Residents NOT on Hospice	Number of Residents ON Hospice
1	Normal Adult	No functional decline.		
2	Normal Older Adult	Personal awareness of some functional decline.		
3	Early Dementia or Alzheimer's	Noticeable deficits in demanding job situations.		
4	Mild Dementia or Alzheimer's	Requires assistance in complicated tasks such as handling finances, planning parties, etc.		
5	Moderate Dementia or Alzheimer's	Requires assistance in choosing proper attire.		
6	Moderately Severe Dementia or Alzheimer's	Requires assistance dressing, bathing, and toileting. Experiences urinary and fecal incontinence.		
7	Severe Dementia or Alzheimer's	Speech ability declines to about a half-dozen intelligible words. Progressive loss of abilities to walk, sit up, smile, and hold head up		

30. Does the facility admit or retain residents with any of the following conditions or behavioral histories?
(Check Yes/No and provide count)

Resident Count:

Bedsore / Pressure Ulcers	☐ Yes ☐ No	_____
Mobility limitations	☐ Yes ☐ No	_____
Requires Assistance	☐ Yes ☐ No	_____
Confusion / Disorientation	☐ Yes ☐ No	_____
Current Medications	☐ Yes ☐ No	_____
Exit Seeking / Wandering Risk	☐ Yes ☐ No	_____
Cognitive Impairment	☐ Yes ☐ No	_____
Violent and/or combative behaviors	☐ Yes ☐ No	_____
Mental Health / Psychiatric History	☐ Yes ☐ No	_____
Suicidal or Self-harming behaviors	☐ Yes ☐ No	_____

31. If the facility accepts or retains residents with a documented history of injuries or falls, please provide a detailed description of the risk mitigation measures, safety protocols, and monitoring procedures currently in place:

32. Are all residents screened prior to admission for suicidal, self-harm, or harm-to-others behaviors, and are such individuals not admitted or transferred if these behaviors arise?

☐ Yes ☐ No

If No, please provide details: _____

33. Does the facility admit or retain any residents with a history of convictions for sexual or violent crimes?

☐ Yes ☐ No

34. Do you have residents who currently have bedsores
If Yes, please complete the following chart:

☐ Yes ☐ No

Stage	Admitted with Condition	Condition Developed at the Applicant's Facility
I		
II		
III		
IV		

35. a) Who is responsible for providing bedsore / pressure ulcer care? _____
b) Do they carry their own Professional Liability Insurance? ☐ Yes ☐ No
If yes, at what limits? \$ _____ / \$ _____
36. Will residents with non-improving pressure ulcers be transferred to an appropriate care setting, with supporting documentation maintained? ☐ Yes ☐ No
37. Are all medical, nursing, and clinical services provided to residents exclusively by third-party providers, such as licensed home health agencies, hospice agencies, or independent contractors, with no such services provided directly by facility employees? ☐ Yes ☐ No
38. Are all exit doors at all locations alarmed?
a) If Yes, are alarms kept in working order at all times and never disabled or turned off? ☐ Yes ☐ No
☐ Yes ☐ No
b) If No, does the facility agree not to admit or retain residents with Alzheimer's or dementia above GDS Level 3, or those who are wander or exit-seeking risks? ☐ Yes ☐ No
39. Have there been any incidents within the past three (3) years in which a resident eloped (left the premises without staff knowledge or authorization)? ☐ Yes ☐ No
40. Inspection Details:
a) Date of last on-site state or local inspection/survey/review: _____/_____/_____
b) Was this inspection the initial pre-licensing review? ☐ Yes ☐ No
c) If any inspection, survey, or review has occurred, list all identified deficiencies, complaints, or violations:

41. Are all services provided exclusively at the location listed in Question 3? ☐ Yes ☐ No
If No, provide details including types of off-site locations, percentage of time spent off-site, duration and frequency of trips, staff-to-resident ratios during off-site activities, and any water or sporting events involved.

Section 7: Regulatory and Inspection

42. Disclosure of Disciplinary or Legal History:
Attach a detailed explanation for any **YES** answers below:
Has the applicant or have any of the employees:
a) Ever been subject to disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No
b) Ever been convicted of any act committed in violation of any law or ordinance (other than traffic offenses)? ☐ Yes ☐ No
c) Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, accepted only on special terms, or voluntarily surrendered?

☐ Yes ☐ No

Section 8: Insurance History

Currently valued loss runs for all prior coverage are required.

43. Professional Liability Coverage – Last 5 Years: (if none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

44. General Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

Section 9: Claims and Incidents

45. Has any insurer canceled or refused to renew similar insurance in the past 5 years?
(If Yes, attach details)

☐ Yes ☐ No

46. Has any claim been made against the insured or its employees that would be covered by this policy in the past 5 years?

☐ Yes ☐ No

If Yes, please attach a completed Huntersure Claims Supplement (one for each claim or incident reported)

47. Is the applicant aware of any circumstances that may result in a claim against the insured or its employees that would be covered under this policy? (If Yes, attach details)

☐ Yes ☐ No



48. Have any of the following occurred in the past 5 years?

- a) Death of a patient or resident other than from natural causes?
- b) Incident resulting in hospitalization or transfer of a patient/resident?
- c) Injury to a patient, resident, or visitor requiring medical care?
- d) Alleged or actual abuse, molestation, or improper contact?
- e) Formal complaint or notice from a state or federal licensing board?
- f) Injury or complications resulting from medication errors?

☐ Yes	☐ No
☐ Yes	☐ No
☐ Yes	☐ No
☐ Yes	☐ No
☐ Yes	☐ No
☐ Yes	☐ No

If Yes to any of the above, please provide details:

Signature and Attestation

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: 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 act, which is a crime.

ELECTRONIC SIGNATURE: If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date, time stamp, and originating email address.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)