



PROFESSIONAL and GENERAL LIABILITY APPLICATION RESIDENTIAL FACILITIES (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: _____ 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>
Halfway House / Transitional Living	_____	_____
Sober Living (Non-Medical)	_____	_____
Drug & Alcohol Rehabilitation – Non-Detox	_____	_____
Drug & Alcohol Rehabilitation – Detox	_____	_____
Shelter / Homeless	_____	_____
Low-Income Housing (Elderly)	_____	_____
Other (Specify): _____	_____	_____

8. Resident Profile:
 - a) Number of Current Residents by Age: 0-17: _____ 18-59: _____ 60+: _____
 - b) Does the facility accept residents under 18 years old? ☐ Yes ☐ No
9. Full description of services provided: _____

10. 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

11. 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

12. 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: _____

13. 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 (Patient contact)			
Facility Manager				Physician (Medical Director only)			
Residential Assistant				Social Worker			
Nurses (RN, LPN, LVN)				Therapist / Counselor			
Behavioral Health Technician				Nurse Practitioner / Physician Assistant			
Case Manager				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 (Patient contact)			
Facility Manager				Physician (Medical Director only)			
Residential Assistant				Social Worker			
Nurses (RN, LPN, LVN)				Therapist / Counselor			
Behavioral Health Technician				Nurse Practitioner / Physician Assistant			
Case Manager				All Others (Describe):			

14. Are all individuals listed on Q13 subject to licensing requirements properly licensed? ☐ Yes ☐ No
(If No, attach details)

15. Do you require employed physicians providing direct patient care to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No
If Yes, provide required limits: \$_____ / \$_____

16. 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

17. Name of individual(s) responsible for the administration/management of the facility and their related years of experience:
 Name: _____ Facility: _____ Years of Experience: _____
18. Does the owner/administrator reside at the facility? ☐ Yes ☐ No
19. Name of Medical Director: _____
 a) Direct Patient Care: ☐ Yes ☐ No *If Yes, please attach a copy of the Medical Director's COI.*
 b) Years Serving as Medical Director: _____ Status: ☐ Employed ☐ Contracted
 c) Length of Time at Facility: _____ Schedule: ☐ Full-Time ☐ Part-Time
20. Screening and Policies:
 a) Do you conduct pre-employment screening and investigation? ☐ Yes ☐ No
 b) Are employees required to actively participate in continuing education? ☐ Yes ☐ No
 c) Do you prepare job descriptions and instructional manuals for your staff? ☐ Yes ☐ No
 d) Do you have a written incident/occurrence reporting policy and procedures? ☐ Yes ☐ No
21. 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
22. 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

23. Are smoke detectors in all bedrooms/hallways? ☐ Yes ☐ No
24. Is a Resident Agreement signed by all residents upon entering the facility? (If Yes, attach a copy) ☐ Yes ☐ No
25. Does the facility complete and retain a pre-admission assessment for every resident? ☐ Yes ☐ No
26. Does the Administrator/Manager personally conduct all pre-admission assessments?
 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): _____
27. Does the facility have the right to transfer out / discharge residents whose needs exceed the services of the facility? ☐ Yes ☐ No
28. Does the facility have written guidelines that determine when a resident no longer qualifies for the services provided at the facility? ☐ Yes ☐ No
29. Are all residents pre-screened for current or past suicidal, self-harm, or harm-to-others thoughts prior to acceptance? ☐ Yes ☐ No
30. If an applicant or resident is identified as having current or past suicidal, self-harm, or harm-to-others thoughts, are they denied admission or immediately transferred when such behaviors arise? ☐ Yes ☐ No
 If No to either question above, please provide details: _____



31. Are all exit doors at all locations alarmed? ☐ Yes ☐ No
a) If Yes, are alarms kept in working order at all times and never disabled or turned off? ☐ Yes ☐ No
32. 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
If Yes, 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. 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:

35. 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

36. 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.

37. 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: _____

38. 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

39. Has any insurer canceled or refused to renew similar insurance in the past 5 years?
(If Yes, attach details) ☐ Yes ☐ No

40. 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)

41. 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

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

- a) Death of a patient or resident other than from natural causes? ☐ Yes ☐ No
- b) Incident resulting in hospitalization or transfer of a patient/resident? ☐ Yes ☐ No
- c) Injury to a patient, resident, or visitor requiring medical care? ☐ Yes ☐ No
- d) Alleged or actual abuse, molestation, or improper contact? ☐ Yes ☐ No
- e) Formal complaint or notice from a state or federal licensing board? ☐ Yes ☐ No
- f) Injury or complications resulting from medication errors? ☐ 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)