Physicians' Reciprocal Insurers

Healthcare Facility
Social Service Agencies Application

IMPORTANT: Processing of this application will be delayed if it is not completed in its entirety and the requisite attachments are not included.

1800 Northern Blvd
Roslyn, New York 11576
Telephone: (516) 365-6690 Fax: (516) 775-4224

PHYSICIANS' RECIPROCAL INSURERS
HEALTHCARE FACILITY/SOCIAL SERVICE AGENCIES APPLICATION

All questions must be fully and completely answered. If there is not enough room in the section provided, a separate page(s) may be attached. Please mark "N/A" for any question that does not apply to your operation.

Part I. GENERAL INFORMATION

1. Name of Facility: _____

2. Address: _____

3. City/State/Zip: _____

4. Phone Number: _____ **5.** Fax Number: _____

6. Email: _____

7. Number of Years in Business: _____ **8.** Number of years under current management _____

9. Facility Tax I.D. Number: _____

10. Additional locations to be covered: _____

Are there plans to add on to the present location or add other locations within the next 3 years?
If "Yes", please describe:_____
_____

11. List all subsidiaries (attach list if more space is required):

Name of Subsidiary	Type of Operation	% of Ownership	Date Acquired	Coverage Requested? Domestic of Foreign

Do you wish coverage to include all subsidiaries? ☐ Yes ☐ No
If yes, include complete list of Directors and Officers of each subsidiary for which coverage is requested.

12. Operating as: ☐ For Profit ☐ Non-Profit ☐ Government ☐ Other: (Describe) _____

13. Type of ownership:
☐ Partnership ☐ Corporation ☐ Sole Proprietorship ☐ P.C.
☐ Other (Describe) _____

14. Annual Budget: _____ **15.** Years Operational: _____

16. Please provide a breakdown of funding sources. Please indicate the percentage that is restricted versus non-restricted (Must equal 100%)
_____

17. Please describe the purpose of the organization: _____

18. Are you licensed by the state or local authorities? ☐ Yes ☐ No

If yes, name the authority: _____

PLEASE ATTACH COPY OF ALL LICENSES HELD AND ATTACH LATEST HEALTH DEPARTMENT INSPECTION.

Part II. CONTACT INFORMATION

Please provide contact information for the following:

	Risk Manager	Claims Contact	Billing Contact
Name:			
Title:			
Telephone Number:			
Email Address:			
Mailing Address:			

Part III. INSURANCE INFORMATION

1. Requested Liability Limit and Deductible Options

a. Primary ☐
Excess ☐

b. Claims Made ☐ Coverage Period _____ Retroactive Date: _____
Occurrence ☐ Coverage Period _____

c. Requested Liability Limits:

FACILITY: Per Occurrence: _____ Aggregate: _____

PHYSICIANS (If coverage is being requested for employed physicians under the facility policy):

Shared Limit Option ☐ Yes ☐ No

Individual Limit option with a **total policy basket aggregate** of:
$6,000,000 ☐
$9,000,000 ☐
$12,000,000 ☐
$15,000,000 ☐

2. Requested Deductible (Check only one):

☐ No Deductible ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000
☐ Other: _____

***Failure to complete will delay the processing of the application*.**

3. Insurance Profile (Five Years) - Primary Professional Liability

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability	Premium
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$

4. Insurance Profile (Five Years) - Excess Professional Liability Coverage

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability	Premium
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$

5. Has the Applicant's policy or coverage ever been declined, cancelled or non-renewed during the past five (5) years?
If yes, please explain: _____

6. Supplemental information.

Please list all additional insured and their addresses, check coverage required and their insurable interest.

1. Name: _____
   Address: _____
   Insurance Interest (funding, landlord-if landlord provided location number)
   _____
   General Liability ☐ Professional Liability ☐

2. Name: _____
   Address: _____
   Insurance Interest (funding, landlord-if landlord provided location number)
   _____
   General Liability ☐ Professional Liability ☐

3. Name: _____
   Address: _____
   Insurance Interest (funding, landlord-if landlord provided location number)
   _____
   General Liability ☐ Professional Liability ☐

Part IV. STAFFING (If necessary, you may attach separate sheet)

1. **Schedule of Employees.**

	Number of Employees		Number of NON-Employees	
Profession	**Full Time**	**Part Time**	**Volunteers**	**Consultants**
Psychiatrist (MD's) *				
Other Physicians (MD's) *				
Psychologist (Doctoral Level)				
LEP / Master's Psychologist				
Social Worker				
Marriage & Family Therapist				
Residence Manager				
Administrative				
Paraprofessional				
Student				
Other				

* Please list names on separate sheet.

Please check all that apply:

Type	Pre-hire criminal background check	Educational Background or Residency	License Verification Suspension Revocation	OPMC/ OPD	OIG	Previous Employers and/or References	Sexual Offender Registry
Employees							
Contractors							
Volunteers							

1. Contractual Agreements

a. Do you contract with another facility for additional beds? ☐ Yes ☐ No

b. Are there contractual agreements in place, whereby the facility either receives or provides medical services? ☐ Yes ☐ No

IF YES, PLEASE PROVIDE A COPY OF EACH AGREEMENT.

c. Does the Applicant rent or lease the premises? ☐ Yes ☐ No

If yes, do you rent or lease any medical or therapeutic supplies and/or equipment to others? ☐ Yes ☐ No

d. Does the applicant do any fund raising/special events? ☐ Yes ☐ No

Describe events and amount of receipts:_____

Part V. QUALITY ASSURANCE/RISK MANAGEMENT

7. Risk Management

a. Who coordinates the facility's risk management program:

Name:		Title:	
Telephone #:		Email:	
Years of experience:		Reports to:	

b. Is there a formal written risk management plan?	☐ Yes ☐ No
c. Is there a formal written performance improvement/QA plan?	☐ Yes ☐ No
d. Are the national patient safety goals addressed in the RM or QA plans? If no provide details on separate sheet.	☐ Yes ☐ No
e. Is there a formal, documented peer review and credentialing process in place?	☐ Yes ☐ No
f. Is the risk manager solely accountable and responsible for risk management?	☐ Yes ☐ No
If **no,** explain other responsibilities:	
g. Does the risk manager have access to legal counsel to discuss risk issues not directly related to a claim?	☐ Yes ☐ No

h. Does the risk manager participate in or maintain the following:

Claims Management	☐ Yes ☐ No	IRB Committee	☐ Yes ☐ No
Contract Review and Evaluation	☐ Yes ☐ No	Patient Satisfaction Results	☐ Yes ☐ No
Disclosure	☐ Yes ☐ No	Policy and Procedure Development/Review	☐ Yes ☐ No
Staff Education	☐ Yes ☐ No	Risk Management Committee	☐ Yes ☐ No
Formal link to quality management	☐ Yes ☐ No	Patient Safety Program and Committee	☐ Yes ☐ No
Incident/Occurrence reporting	☐ Yes ☐ No	Sentinel Event Investigation	☐ Yes ☐ No
Infection Control Committee	☐ Yes ☐ No	Emergency Preparedness	☐ Yes ☐ No

PART VI. SERVICES PROVIDED

1. Does your agency or any of your employees provide any of the following services?

Psychiatric Counseling	☐ Yes ☐ No
Suicide or Crisis hotline	☐ Yes ☐ No
Vocational rehabilitation	☐ Yes ☐ No
Adoption / Foster care placement	☐ Yes ☐ No
Alternative incarceration home	☐ Yes ☐ No
Elderly / Aged Services	☐ Yes ☐ No
Child care	☐ Yes ☐ No
Crisis Center	☐ Yes ☐ No
Residential treatment Programs	☐ Yes ☐ No
Mental Health Services for Sex offenders	

or sexual addiction	☐ Yes ☐ No
In-home respite care	☐ Yes ☐ No
Embryonic placement	☐ Yes ☐ No

2. Outpatient Services

PROVIDE NUMBER OF ANNUAL CLIENT VISITS FOR EACH DESCRIPTION CHECKED

☐ Hospice (Outpatient) _____
☐ Mental Health Day Care _____
☐ Outpatient Counseling _____
☐ Sheltered Work Shop _____
☐ Mental Retardation (including ARC) and Cerebral Palsy Centers _____
☐ Crisis Center _____
☐ Day School _____
☐ Mental Health Day School _____
☐ Referral Agencies _____
☐ Big Brothers/Sisters (#of children) _____
☐ Crisis Hotline _____ # of calls annually
☐ Recreation Programs _____
☐ OTHER SERVICES – please describe and include number of # of clients VISITS: _____

a. Are there any age limitations on the above-captioned services? _____
b. Average age of clients. _____
c. Describe the types of problems treated in outpatient setting. _____
_____
d. If applicant provides a **recreation program**, please describe activities in full detail: _____
_____
e. If the applicant has a Big Brother / Big Sister Program, please describe or attach screening procedures:
_____
f. If the applicant provides **group therapy** sessions, answer the following:
   1. Average size of group: _____
   2. Average number of times the group meets per week: _____
   3. Indicate the types of problems treated in sessions: _____
g. If the applicant provides a **crisis hotline**, please answer the following:
   1. What types of problems are treated by the hotline? _____
   2. Do you use volunteers on the hotline? ☐ Yes ☐ No
   3. If volunteers are used as counselors, please describe the training they receive: _____
   _____
   4. Hours of operation for the hotline: _____

PLEASE ATTACH PROTOCOLS OUTLINING THE PROCEDURES FOR HANDLING A CRISIS HOTLINE CALL.

3. Adoption and Foster Care

☐ Adoption Placements:
_____ # of child /Adolescent Placements (Annual
_____ # of Adult Placements
_____ # of Aged / Elderly Placements

☐ Foster Care Placements:
_____ # of Child / Adolescent Placements (Annual)
_____ # of Adult Placements
_____ # of Aged / Elderly Placements

Foster Care:
a. What are the ages of children placed in foster homes? _____

b. How many foster homes do you utilize? _____

c. Are they licensed by applicable state and or local authorities? ☐ Yes ☐ No
If not, who licenses the foster homes? _____

d. Describe the process used to obtain foster homes: _____
_____

e. How often are children moved from one foster home to another? _____

f. How often does the applicant's employees visit the children in the foster homes? _____

g. Who compensates the foster parents? _____

h. How does the applicant handle allegations of child abuse (sexual or physical) in the foster homes?
_____

Adoption:

i. What are the ages of the children placed? _____

j. Outline the adoption procedures. _____
_____

k. Does the applicant have legal custody of the child? ☐ Yes ☐ No

l. Is a guardian appointed to ensure the child's welfare? _____

m. Do you provide International Placements? ☐ Yes ☐ No

4. Elderly / Aged Services

☐ Meals on Wheels _____ # of meals annually
☐ Agency for the aged/ seniors _____ # annual client contacts
☐ Adult Day Health Care _____ # annual client contacts
☐ Adult Day Care _____ # annual client contacts

Please describe the nature of the activities at the agency or senior center: _____
_____
_____

5. Substance Abuse Programs:

PLEASE INDICATE THE NUMBER OF ANNUAL CLIENT CONTACTS

☐ DUI Classes _____
☐ Methadone Maintenance _____
☐ Inpatient Detox # of beds _____
☐ Non-medical Detox (Secondary Stage) _____
☐ Alcohol / Drug Counseling (Outpatient) _____

a. Please describe the average age of clients utilizing these services: _____
_____
_____

b. Please describe all methods of detox, including medications utilized: _____
_____
_____

6. Residential Programs

PLEASE INDICATE THE NUMBER OF BEDS

Contracted Beds	_____	Group Home (3+ months)	_____
Group & Residental Home	_____	Halfway House	_____
Home for the Battered	_____	Inpatient Mental Health	_____
Supervised Living	_____	Residential Treatment MH/MR	_____
Hospice	_____	Psychiatric Hospital	_____

Other Services – Please describe and include # of client VISITS: _____
_____

a. Are you a psychiatric hospital? ☐ Yes ☐ No
b. Are you an alternative to incarceration for youths or adults? ☐ Yes ☐ No
c. Do you provide assisted living services? ☐ Yes ☐ No
d. Is there any age limitations of residents? _____
e. Average age of residents: _____
f. Residents are: ☐ Male ☐ Female ☐ Both
If both, how are they separated? _____
g. Average length of stay by residents? _____
h. How many residential locations are run by the applicant? _____
i. Indicate Client / Staff ratio: _____
j. Describe the security measures for each residential facility: _____
k. How does the applicant obtain the residents utilizing the applicant's services? _____
l. How many visits are made per month by caseworker to a resident? _____
m. How does the applicant handle allegations of child abuse (sexual or physical) in the residential facilities? _____

7. Child Care

Type of Facility:

☐ Commercial Center ☐ In-Home ☐ 24 Hour Drop-In ☐ Family Child Care

Capacity: _____ Building #1 _____ Building #2 _____ Building #3

Enrollment:

Licensed for Ages	# of Children	# of Teachers
☐ 0 – 17 months	_____	_____
☐ 18 months to 30 months	_____	_____
☐ 30 months to 4 years	_____	_____
☐ Pre-School	_____	_____
☐ After School	_____	_____

Maximum age accepted in enrollment: _____

Time: ☐ Daytime Care ☐ Night Care
☐ Customary School Day ☐ Half day _____ A.M. _____ P. M.

Licensing:

Is the Center licensed? ☐ Yes ☐ No
If yes, a copy of the license must be attached.
Has a license to operate ever been denied, suspended or revoked? ☐ Yes ☐ No

If yes, please provide details.

Have you ever been brought up for a compliance hearing? ☐ Yes ☐ No

If yes, please provide details.

8. Policies and Procedures

a. Are there any children enrolled at the Center who are emotionally or physically handicapped or who require special treatment due to existing medical problems? ☐ Yes ☐ No
If yes, please describe disability, age of child and special care provided by the Center. _____
_____

b. Are there any children enrolled at the Center who require a special diet? ☐ Yes ☐ No
If yes, please describe dietary needs. _____
_____

c. Is a minimum of one staff member certified in First Aid present at all times? ☐ Yes ☐ No

d. Do you have a child release policy? ☐ Yes ☐ No
If yes, please describe: _____
_____

e. Are all employees and volunteers trained regarding the Center's child release policy? ☐ Yes ☐ No

f. Is a file maintained on each child containing the following information? ☐ Yes ☐ No

1. Immunization records of the children having been immunized successfully and updated annually? ☐ Yes ☐ No
2. Records for each child indicating unusual condition the child has? ☐ Yes ☐ No
3. Signed releases for emergency medical treatment/disposing of medications obtained from parents? ☐ Yes ☐ No

g. Is dispensing of children's medication also subject to written instructions from a physician? ☐ Yes ☐ No

9. Equipment

a. Is there a playground? ☐ Yes ☐ No
b. Is the playground fenced? ☐ Yes ☐ No
c. Describe playground surfaces and depths: _____
d. Are there any trampolines? ☐ Yes ☐ No
e. Is the playground equipment properly maintained and checked on a specific schedule? ☐ Yes ☐ No
f. Does the play equipment and toys meet the consumer safety code requirements? ☐ Yes ☐ No

10. Representations

b. Please provide a claims history for ALL contracted or employed physicians.

c. Do employee / non-employee psychiatrists, physicians, psychologist maintain individual medical malpractice coverage? ☐ Yes ☐ No

Required Limits: _____

d. Do you discuss at staff orientation, child/sexual abuse, how to recognize the signs, and what to do if a client/child reports someone molested/abused him or her? ☐ Yes ☐ No

e. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients/children? ☐ Yes ☐ No

f. Do you have a crisis management plan for dealing with staff personnel, victim, parents, authorities and media if you have an incident of abuse? ☐ Yes ☐ No

g. Is coverage desired for non-employed consultants? ☐ Yes ☐ No
IF COVERAGE IS DESIRED, PLEASE LIST NAMES AND TITLES ON A SEPARATE SHEET

h. Are any medications prescribed by the Applicant? ☐ Yes ☐ No
IF YES, ATTACH A LIST ADVISING WHAT MEDICATIONS ARE PRESCRIBED, BY WHOM, FOR WHAT PURPOSE AND HOW THE MEDICATIONS ARE SECURED.

i. Is ANYONE applying for insurance under this policy aware of any state, federal, local code or professional violations, unethical misconduct, incompetence or negligence? ☐ Yes ☐ No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

j. Is ANYONE applying for insurance under this policy aware of any circumstances involving sex or sexual abuse/molestation with any patients, former patients or relative thereof? ☐ Yes ☐ No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

k. Does ANYONE applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate? ☐ Yes ☐ No
IF YES, PLEASE DESCRIBE ON A SEPARATE SHEET.

l. Does the applicant enlist the services of volunteers (a volunteer is someone who does work or provides services for the applicant, but is not an employee and includes unpaid consultants and board member)? ☐ Yes ☐ No
If yes,
    1. Do they go through the same screening process as employees? ☐ Yes ☐ No
    2. Please provide the estimated number of annual volunteer days for all locations: _____

Part VII. ADDITIONAL INFORMATION AND DOCUMENTS TO ACCOMPANY APPLICATION

1. Copy of the most recent Department of Health survey, including the Plan of Correction.
2. Complete copy of the most recent JCAHO or AAAHC accreditation report.
3. Copy of current state license.
4. Copies of Certificates of Insurance for physicians covered under individual policies.
5. If applicable, completed PRI applications for all physicians to be covered under the facility policy.
6. Copies of any contracts with independent physician groups.
7. Current annual audited financials.
8. Public relations materials, brochures, etc.
9. Copies of any hold harmless agreements.
10. Copy of Certificate of Incorporation (Articles of Organization).
11. Copy of loss runs for the last ten (10) years.

APPLICATION IS NOT ACCEPTED WITHOUT SIGNATURE ON THE NEXT PAGE

PHYSICIANS' RECIPROCAL INSURERS
HEALTHCARE FACILITY/SOCIAL SERVICE AGENCIES APPLICATION

NOTICE

Applicants considering claims-made coverage must take note of the following:

A claims-made policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the retroactive date stated in the policy.

The policy covers claims actually made against the insured and incidents reported while the policy remains in effect and all coverage under the policy ceases upon the termination of the policy, except for the mandatory automatic extended reporting period of sixty (60) days, unless the insured purchases additional extended reporting period coverage which will provide coverage for an unlimited time period without any gap in coverage.

The rates for extended reporting period coverage will be based on the rates in effect at the time of termination of coverage and such rate may be subject to substantial increase over the rates currently in effect. The average statewide percentage changes, and the effective dates, of each rate revision which PRI has implemented in this State during the five (5) year period immediately preceding the effective date of the policy will be provided upon the written request of the insured. Such past changes may or may not be indicative of future rate changes.

Unless the insured purchases extended reporting period coverage in addition to the mandated automatic extended reporting period of sixty (60) days, there will be no coverage provided for claims-made or incidents reported after such period of sixty (60) days.

During the first few years of coverage on a claims-made basis, the annual rate is comparatively lower than occurrence rates, however, such annual rate increases significantly, independent of overall rate level increases, until the claims-made relationship reaches maturity.

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 ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signature: _____

Name (please print): _____

Title: _____

Date: _____