Western World INSURANCE GROUP

Halfway Houses
Alcohol & Drug Rehab – Inpatient
General Liability and Professional Liability
Supplemental Application
(Complete in addition to ACORD)

1. Name of Applicant: _____

   Website: _____

FACILITY TYPE

2. **Type of Halfway House (check all that apply):**

   ☐ For-Profit Annual Gross Sales: $ _____

   ☐ Non-Profit Annual Budget: $ _____

   ☐ State-Sponsored ☐ Court-Mandated ☐ Lock-down facility

   ☐ Crisis center (rape, domestic violence, etc.)
   ☐ Foster care (children or adults)
   ☐ Mental health disorders – psychiatric care
   ☐ Non-violent criminal release program
   ☐ Primary detox facility
   ☐ Reintegration of persons recently released from prison or jail
   ☐ Other (give details): _____
   ☐ Residents hoping to achieve parole after prison term
   ☐ Sex crime offenders
   ☐ Sober living-no active aftercare rehab or support
   ☐ Substance abuse-active rehab
   ☐ Violent criminal release program

3. How are residents referred to your facility? _____

SERVICES PROVIDED

4. Provide details of all professional services, treatment and counseling provided to residents: _____

5. Provide details of all activities offered: _____

6. Do you provide birth control, pregnancy or abortion counseling? ☐ Yes ☐ No
7. Do you provide drug or alcohol testing? ☐ Yes ☐ No
8. Do you provide workshops? ☐ Yes ☐ No

   If yes, please provide details: _____
9. Do you offer outpatient counseling for non-residents? ☐ Yes ☐ No

   If yes, what are your annual gross sales derived from outpatient counseling? $ _____
10. Does your facility prescribe medicine or administer any prescription drugs or medications? ☐ Yes ☐ No
11. Does your facility dispense methadone? ☐ Yes ☐ No

    If yes, is methadone allowed to be taken off your premises? ☐ Yes ☐ No

DETAILS OF RESIDENTS

12. Provide details of residents:
    a. Current number of occupied beds: _____
    b. Average length of stay: _____
    c. Average number of adult residents: _____
    d. Average number of ambulatory residents: _____
    e. Average number of non-ambulatory residents: _____
    f. Average number of restrained residents: _____ Describe type of restraint: _____
    g. Average number of residents under the age of 18: _____
    h. Average number of residents over the age of 65: _____
13. Do residents pay rent? ☐ Yes ☐ No
14. Do you allow residents who are minors? ☐ Yes ☐ No

15. What are your criteria for admission? _____

_____

a. What types of residents will not be accepted? _____

b. Who makes the decision to discharge? _____

16. Are children/minors that reside at shelter required to be accompanied by a parent or legal guardian? ☐ Yes ☐ No

STAFF

17. Indicate number and type of staff members below:

Type of Staff	1st Shift		2nd Shift		3rd Shift	
	Contracted	Employed	Contracted	Employed	Contracted	Employed
MDs						
RNs						
LPNs						
Nurses Aides						
Psychologists						
Psychiatrists						
Licensed Therapists						
Licensed Counselors						
Social Workers						
Other (specify):						

18. Are any of the above personnel required to maintain their own professional coverage? ☐ Yes ☐ No
Limits required: $ _____ / _____

19. Is there always an awake staff member on duty 24 hours a day? ☐ Yes ☐ No

20. Please indicate staff-to-resident ratio: _____ / _____

21. Do you use armed security guards? ☐ Yes ☐ No

22. Do you use volunteers? ☐ Yes ☐ No
If yes, please describe their duties and in-house training provided: _____

_____

23. Are background checks made with all prior employers and educational institutions? ☐ Yes ☐ No
a. Does background check include police record? ☐ Yes ☐ No
b. Does background check include drug screening? ☐ Yes ☐ No

24. Do you want employees covered as additional insureds? *There is a premium charge.* ☐ Yes ☐ No
(NOTE: The policy already protects you for the acts of your employees.)

OPERATIONS AND PROCEDURES

25. Is your facility owned by a physician or a psychiatrist? ☐ Yes ☐ No
If yes, indicate their duties: ☐ Administrative only ☐ Diagnose ☐ Treatment ☐ Prescriptions

26. Are you engaged in, owned by, associated with or involved in any other enterprise? ☐ Yes ☐ No
If yes, provide details: _____

27. Is your facility run by an outside management company? ☐ Yes ☐ No
If yes, describe contractual relationship: _____

28. Do you provide consulting management services for any other facilities? ☐ Yes ☐ No
If yes, describe: _____

29. Who has access to confidential files and documents? ☐ All workers ☐ Only those whose positions require access

30. Are residents clearly informed of house rules and the potential consequences of violating those rules? ☐ Yes ☐ No

31. Are residents required to sign in and out when leaving and returning to your facility? ☐ Yes ☐ No

32. If guests are allowed, are they required to sign in and out? ☐ Yes ☐ No

LICENSING

33. Are you licensed? ☐ Yes Lic. Number: _____ ☐ No If no, explain: _____
    If yes, please answer questions **a.** through **d.**
    a. What type of license do you hold? _____
    b. Has your license ever been revoked or suspended? ☐ Yes ☐ No
    c. If yes, give details: _____
    d. Licensed bed capacity: _____
34. Has your shelter passed the most recent state inspection? **(Please attach a copy.)** ☐ Yes ☐ No

BUILDING

35. a. Type of building: ☐ Residential house ☐ Larger structure designed to house multiple occupants
    b. Number of buildings: _____ Number of stories: _____
    c. What is the total square footage of the building(s)? _____
    d. Construction type: _____
    e. Is building sprinklered? ☐ Yes ☐ No ☐ Fully or ☐ Partially spinklered?
    f. If partially sprinklered, what percentage? _____%
    g. Has an emergency evacuation plan been prepared? ☐ Yes ☐ No
    h. Are all rooms and halls equipped with smoke detectors? ☐ Yes ☐ No
    i. Type of fire protection, detection or suppression devices: _____
    j. Is smoking permitted? ☐ Yes ☐ No
    k. Are there designated smoking areas? ☐ Yes ☐ No
    l. Distance to the nearest fire station? _____ Nearest hydrant? _____
    m. Is the building equipped with a security alarm system? ☐ Yes ☐ No
    n. Are bathtubs and showers equipped with non-skid surfaces? ☐ Yes ☐ No

IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS 36 THROUGH 40.
If not desired, please sign application at bottom of page.

36. Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? ☐ Yes ☐ No
    If yes, provide details: _____

37. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
    If yes, provide details: _____

38. Has any facility that you have been associated with in the past ever had a molestation allegation or claim brought against it while you were there? ☐ Yes ☐ No
    If yes, provide details: _____

39. Does your facility do background checks on all employees and volunteers? ☐ Yes ☐ No
    Describe types of checks done (prior employer, police, etc.): _____

40. Sexual Molestation sub-limit wanted:
    ☐ $25,000/50,000 ☐ $50,000/100,000

_____ _____
Applicant's Signature Date

_____ _____
Title Producing Agent