



# General Liability and Professional Liability Supplemental Application For Shelters

(Complete in addition to ACORD)

1. Name of Applicant: \_\_\_\_\_  
 Website: \_\_\_\_\_

2. Type of shelter and residents (check all that apply):
- |  |  |
|--|--|
| <input type="checkbox"/> Battered women's shelter<br><input type="checkbox"/> Foster care (children or adults)<br><input type="checkbox"/> Halfway house<br><input type="checkbox"/> Homeless shelter<br><input type="checkbox"/> Medical clinic<br><input type="checkbox"/> Mission / Settlement<br><input type="checkbox"/> Primary detox facility<br><input type="checkbox"/> Other (give details): _____ | <input type="checkbox"/> Psychiatric care facility<br><input type="checkbox"/> Rehab – drug<br><input type="checkbox"/> Rehab – alcohol<br><input type="checkbox"/> Sexual offenders<br><input type="checkbox"/> Violent criminals<br><input type="checkbox"/> Non-violent criminals |
|--|--|

3. Provide details of all professional services, treatment and counseling provided to residents: \_\_\_\_\_

4. Provide details of all activities offered: \_\_\_\_\_

5. Do you have any residents under the age of 18 or over the age of 65?  Yes  No

6. Are you engaged in, owned by, associated with or involved in any other enterprise?  Yes  No  
 If yes, provide details: \_\_\_\_\_

7. Is your facility run by an outside management company?  Yes  No  
 If yes, describe contractual relationship: \_\_\_\_\_

8. Do you provide consulting services for, or manage any other facilities?  Yes  No  
 If yes, describe: \_\_\_\_\_

9. Are you licensed?  Yes Lic. Number: \_\_\_\_\_  No If no, why not? \_\_\_\_\_

If yes, please answer questions a. through h.

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b. Has your license ever been revoked or suspended?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: \_\_\_\_\_

e. Bed occupancy: \_\_\_\_\_

f. Average number of adult residents: \_\_\_\_\_

g. Average number of child residents: \_\_\_\_\_

h. Average number of non-ambulatory residents: \_\_\_\_\_

10. Indicate number and type of staff members below:

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

11. Are any of the above required to maintain their own professional coverage?  Yes  No

Limits required: \$ \_\_\_\_\_

12. Do you use volunteers?  Yes  No  
 If yes, please describe their duties and in-house training provided: \_\_\_\_\_
- 
13. 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
14. Is there always an awake staff member on duty 24 hours a day?  Yes  No
15. 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.)
16. Have all staff members and volunteers been trained to handle a confrontation with a potentially violent abuser who may show up to see their domestic partner?  Yes  No
17. What is your client privilege policy? \_\_\_\_\_
- 
18. Who has access to confidential files and documents?  
 All workers  Only those whose positions require access
19. What are your criteria for admission? \_\_\_\_\_  
 a. What types of residents will not be accepted? \_\_\_\_\_  
 b. Who makes the decision to discharge? \_\_\_\_\_
20. Are children/minors that reside at shelter required to be accompanied by a parent or legal guardian?  Yes  No
21. Does your facility prescribe medicine or administer any prescription drugs or medications?  Yes  No
22. Does your facility use restraints?  Yes  No
23. Does your facility operate a victim hotline?  Yes  No  
 a. If yes, are phone lines manned by trained counselors?  Yes  No  
 b. Average number of hotline calls per year: \_\_\_\_\_
24. What is the average length of stay? \_\_\_\_\_  
 a. How are residents referred to your facility? \_\_\_\_\_  
 b. Are residents clearly informed of house rules and the potential consequences of violating those rules?  Yes  No
25. Has your shelter passed the most recent state inspection?  Yes  No

**BUILDING INFORMATION**

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

**IF SEXUAL MOLESTATION COVERAGE IS DESIRED, PLEASE COMPLETE QUESTIONS 27 THROUGH 31.  
If not desired, please sign application at bottom of page.**

27. 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: \_\_\_\_\_
28. 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: \_\_\_\_\_
29. 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: \_\_\_\_\_
30. Does your facility do background checks on all employees and volunteers?  Yes  No  
Describe types of checks done (prior employer, police, etc.): \_\_\_\_\_
31. Sexual Molestation sub limit wanted:  
 \$25,000/50,000       \$50,000/100,000       \$100,000/300,000

**FRAUD WARNING: A NY 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 IS GUILTY OF INSURANCE FRAUD. THIS IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.  
(FOR NEW YORK INSURED: AN ACT OF INSURANCE FRAUD SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Producing Agent