



United States Liability Insurance Group

COUNSELING AND REFERRAL SERVICES ADDENDUM

** NOTE: THIS PAGE ONLY NEEDS TO BE COMPLETED FOR COUNSELING/REFERRAL SERVICES OPERATIONS**

Name of Organization: _____

PROFESSIONAL LIABILITY:

(Note: The limit selected will apply separately for the General Liability, Professional and Abuse & Molestation.)

- | | Prohibited | Eligible |
|---|------------------------------|------------------------------|
| 1. Is the entity not-for-profit? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Are you licensed? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. If licensed, was the license ever suspended or revoked? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you provide 24 hour residential care? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you operate a shelter workshop? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you operate a camp? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. In the providing of services to your clients, do you employ the services of Physicians, Dentists, Psychiatrists, Pharmacists, Nurse Practitioners or any other similar type professionals? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. In the providing of services to your clients, do you employ the services of an Accountant, Lawyer, Banker or other similar type professionals? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Have you entered into any hold harmless agreements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Is the staff required to report all incidences that may result in a claim to the administrator? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 11. Are written records of all incidences kept by the administrator? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 12. Are all incidences reviewed? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 13. Do you operate a health care clinic? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Do you dispense medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Are you licensed to operate an adoption agency? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Are you involved in foster care or foster care placements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Do you operate a crisis/suicide hotline? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Are the staff members/volunteers properly trained and/or certified in the type of counseling they are doing? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 19. Are clients referred to specialists when appropriate? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 20. Are all files maintained to protect confidentiality of clients? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 21. Do you qualify each agency or operation to which you refer your clients? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 22. Do your services include the licensing, registering or inspecting of any residential facilities for which you refer your clients? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have there been any claims or suits or do you have knowledge of information that might give rise to a Professional Liability claim?
 Yes No If Yes, Provide Details of Each: _____

ABUSE & MOLESTATION:

- | | Prohibited | Eligible |
|---|-----------------------------|------------------------------|
| 1. Are there formal written procedures in place for staff hiring? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Prior employment and personal references verified prior to hiring? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Are licenses and other credentials verified prior to hiring? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Is there a formal orientation program for new hires that includes review of the company's written procedures including the sexual abuse policy? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Does your staff employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse related offenses? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 6. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients, both on and off premises? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Have there been any claims or suits or do you have knowledge of information that might give rise to a claim of sexual or physical abuse or molestation? Yes No

If Yes, Provide Details of Each: _____

STAFFING:

Position	# Full Time	# Part Time
Psychologists:	_____	_____
Nurses (RN, LPN):	_____	_____
Social Workers:	_____	_____
Counselors:	_____	_____
Teachers:	_____	_____
Nutritionists/Dietitians:	_____	_____

FRAUD STATEMENT: 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: _____
(Must be signed by the President, Chairperson or Executive Director)

Title: _____ Date: _____