RESIDENTIAL SUPPLEMENT
CORRECTIONAL LIABILITY INSURANCE

INSTRUCTIONS:

A separate and distinct Residential Supplement is to be completed for **every** Residential Location owned and/or operated by the Applicant. Please answer all questions fully. If space is insufficient to answer any question fully, attach a separate sheet. **This application must be submitted in conjunction with the General Application.**

I. GENERAL INFORMATION

1. Applicant: _____
2. Name of Residential Location: _____
3. Address of Residential Location: _____
4. Type of Facility: ☐ Prison ☐ Jail ☐ Boot Camp ☐ Restitution Center ☐ Halfway House ☐ Community Corrections Center ☐ Other (describe): _____
5. Age of Occupants: ☐ Adult ☐ Juvenile
6. Occupant's Status: ☐ Convicted Felon ☐ Convicted Misdemeanor ☐ Pre-Trial Detainees ☐ INS Detainees ☐ US Marshall Detainees ☐ Other (describe):
7. Is the Facility public or private? _____

8. Show the percentage of services at prisons with the following security levels (should equal 100%)

Supermax Security	%
Maximum Security	%
Close Security	%
Medium Security	%
Minimum Security	%

9. What is your patient population's sex? (should equal 100%)

Male	%
Female	%

10. What is your patient population's age? (should equal 100%)

Under 20	%
20-30	%
31-40	%
41-50	%
50+	%

11. Please advise percentage of occupants directed to you facility by the criminal justice system: _____ %

12. Do you hold a greater than fifty percent (50%) interest in this operation? ..... ☐ Yes ☐ No

13. Is the location accredited by the NCCHC? ..... ☐ Yes ☐ No

14. Is the location accredited by the American Correctional Association (ACA)? ..... ☐ Yes ☐ No

15.

Facility Information			
Total square footage		Year built	
Certified capacity		Year of most recent renovation	
Number of Cells		Number of Beds	
Average Length of Stay		Average Daily Population	

16. If Juvenile, are occupants permitted to leave the premises unescorted by facility personnel? ..... ☐ Yes ☐ No

17. If Adult, are occupants permitted to leave the facility unescorted? ..... ☐ Yes ☐ No

18. Please advise the number of escapees during the last five (5) years:

19. Do you have the right to reject a potential occupant? ☐ Yes ☐ No

20. Number of incidents during the last five (5) years:

ASSAULTS, INCLUDING SEXUAL	
Description	**Number**
Occupant against occupant	
Occupant Against Staff	
Staff Against Occupant	

DEATHS	
Description	**Number**
Occupant	
Staff	
Visitor	

CAUSE OF DEATH			
Cause	**Number**	**Cause**	**Number**
Suicide		Illness	
Violence		Other	

21. Number of occupant <u>attempted</u> suicides during the last five (5) years: _____

22. Number of allegations regarding excessive or inappropriate force was utilized during last five (5) years: _____

23. Number of allegations of sexual misconduct during the last five (5) years: _____

24. a. Are medical records of all occupants obtained within 24 hours of admittance? ..... ☐ Yes ☐ No

b. If No, please advise procedure and timeframe for obtaining all such medical records: _____

_____

25. a. Are you regularly responsible for transporting occupants? ..... ☐ Yes ☐ No

b. If Yes, please complete the Offender Transportation Addendum.

26. a. Is this location currently, or has it been during the last five (5) years, operating/operated under a court order or consent decree? ..... ☐ Yes ☐ No

b. If Yes, have there been any repeat violations of any such order or decree? ..... ☐ Yes ☐ No

II. PERSONNEL (AT THIS LOCATION)

1. Please identify all personnel by indicating number of personnel in each applicable category:

	EMPLOYEES		CONTRACTORS	
	Full Time	**Part Time**	**Full Time**	**Part Time**
CLASS A				
Facility Administrator, Warden, Asst. Warden				

Correctional Office, Guard				
CLASS B				
Registered Nurses				
Licensed Practical Nurses				
Physicians				
Physicians Assistants				
Pharmacists				
Dentists				
Certified Nurse Assistants				
Residents				
Interns				
Psychiatrists				
Psychologists				
CLASS C				
Clerical Staff, Maintenance, Cooks				
Other:				

2. a. Do any of the individuals in identified as Class B Personnel above carry their own errors and omissions insurance coverage? ..... ☐ Yes ☐ No

   b. If Yes, please identify: _____

_____

III. HEALTH CARE (AT THIS LOCATION) ☐ Not Applicable

1. Please check the classification that best describes the health care services you provide:

   ☐ Clinic, Dispensary or Infirmary ☐ Mental or Psychopathic Treatment Center ☐ Medical or Surgical Facility

   ☐ Drug or Substance Abuse Treatment Center ☐ Other (describe): _____

2. Describe the nature and type of health care you provide: _____

3. a. Number of Health Care Beds: _____ b. Square Footage of Health Care Facility: _____

4. Level of health care provided

			# Performed last year?	Comments
Medical Screening	☐ Yes	☐ No		
Diagnostic	☐ Yes	☐ No		
Treatment	☐ Yes	☐ No		
Referral	☐ Yes	☐ No		

Surgical ☐ Yes ☐ No

Psych Evaluation ☐ Yes ☐ No

5. Explain any specialized services

6. Are Physical Examinations provided to all inmates upon entrance to the facility? ☐ Yes ☐ No

7. Is security present at all times during service? ☐ Yes ☐ No Please provide details.

8. What are the reporting and documenting procedures for incidents and claims? Provide copy of incident log.

9. Does applicant operate an Intensive Care Unit? ☐ Yes ☐ No Please provide details.

10. What are the protocols for releasing a patient out of the health ward?

11. Please provide inmate intoxication protocols (i.e. Drunk Tank).

12. Do inmates participate in work release programs? ☐ Yes ☐ No
If yes, please describe nature, locations, and frequency. Please also describe how inmates are cleared for work release.

IV. HEALTHCARE ADMINISTRATION AND STAFF ☐ N/A

Provide information for the Medical Director providing services at applicant's facility. Attach additional sheet if necessary.

Medical Director	Specialty Board Certification	Ins. Carrier, Policy Number, and Limits	State of Licensure	License Number	Employee/ Contractor	Hours/ Month

Provide information for the physician/surgeon providing services at applicant's facility. Attach additional sheet if necessary.

Physicians/ Surgeons	Specialty Board Certification	Ins. Carrier, Policy Number, and Limits	State of Licensure	License Number	Employee/ Contractor	Hours/ Month

1. Are physicians and licensed independent practitioners credentialed? ☐ Yes ☐ No
2. Is credentialing and privileging formalized? ☐ Yes ☐ No
3. Is new technology included in the delineation of privileges? ☐ Yes ☐ No
4. Does the applicant require employed or contracted physicians and surgeons to carry professional liability insurance?

   ☐ Yes, in by-laws ☐ Yes, in contract ☐ No (If no, please explain) _____
5. Indicate minimum professional liability insurance limits required for:

   Employed/Contracted Physicians/Surgeons $ _____ per claim $ _____ aggregate
6. How often do you verify Professional Liability Insurance? _____
7. Has there **ever** been any review by a state medical board or other federal, state, or non-governmental oversight entity of any health care professional with privileges at the applicant's facility? ☐ Yes ☐ No
8. Has any health care professional with privileges in the applicant's facility **ever** had their license suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No
9. Has any health care professional with privileges in the applicant's facility **ever** had their DEA license suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No
10. Have any limitations or conditions **ever** been imposed on any health care professional's privileges? ☐ Yes ☐ No

V. RISK MANAGEMENT/QUALITY ASSURANCE

1. Does the applicant utilize a formal written Quality Improvement? ☐ Yes ☐ No
2. Does the applicant utilize a formal written Risk Management Program? ☐ Yes ☐ No
3. Does the governing body periodically review the program for effectiveness and approve necessary changes? ☐ Yes ☐ No
4. Is there a peer review process in place? ☐ Yes ☐ No

MEDICAL/PATIENT RECORDS

1. Are records stored: ☐ Electronically ☐ Paper Files ☐ Both
2. How long are records stored? _____
3. If electric, how often are backups made? _____
4. If paper, where are records stored? ☐ On site ☐ Off site
5. Do the buildings in which paper records are stored contain sprinklers? ☐ Yes ☐ No
6. Who has the overall responsibility for Risk Management & Quality Assurance?

   Name: _____

   Title: _____

   Telephone Number: _____

VI. LIFE SAFETY MEASURES/RISK MANAGEMENT (AT THIS LOCATION)

1. Number of stories: _____
2. Construction: ☐ Frame ☐ Masonry ☐ Non Combustible ☐ Fire Resistive ☐ Masonry Non Combustible
3. Are all doors and windows alarmed? ..... ☐ Yes ☐ No

4. How many miles from the facility is the nearest fire station? _____

5. Are there heat sensors on each floor? ☐ Yes ☐ No

6. Are there smoke sensors on each floor? ☐ Yes ☐ No

7. a. Is there a ventilation system servicing all offender areas with high exhaust capacity? ☐ Yes ☐ No

   b. Does ventilation system have heat sensors? ☐ Yes ☐ No

   c. Does ventilation system have smoke sensors? ☐ Yes ☐ No

   d. Are at least two vents accessible from every floor? ☐ Yes ☐ No

8. a. Is the facility sprinklered? ☐ Yes ☐ No

   b. Is the sprinkler system specifically configured to address all high exposure areas (i.e., laundry, storage closets, kitchen areas, etc.)? ☐ Yes ☐ No

   c. Is the sprinkler system inspected and tagged annually? ☐ Yes ☐ No

9. a. Is there an automatic, dry chemical fire suppression system over all cooking surfaces? ☐ Yes ☐ No

   b. Is the system inspected and tagged annually? ☐ Yes ☐ No

10. Is there a conspicuously labeled fire hose cabinet on every floor with sufficient hose to reach all points on that floor? ☐ Yes ☐ No

11. a. Is there at least one fire alarm sending station per floor and/or wing that is connected to a central station? ☐ Yes ☐ No

    b. Does the fire alarm signal a distinct sound in the control room? ☐ Yes ☐ No

    c. Are the fire alarms connected with the smoke detectors? ☐ Yes ☐ No

12. Are there a sufficient number of marked fire blanket containers with fire blankets? ☐ Yes ☐ No

13. Are all storage closets fitted with at least one-hour fire doors? ☐ Yes ☐ No

14. Are all designated fire doors equipped with automatic closing devices? ☐ Yes ☐ No

15. Do all doors open in the direction of a primary fire exit? ☐ Yes ☐ No

16. Are facility exits marked with illuminated exit signs? ☐ Yes ☐ No

17. Is there outside access to all floors in the event of an emergency? ☐ Yes ☐ No

18. a. Are any flammable liquids are handled at the facility? ☐ Yes ☐ No

    b. If Yes, what liquids? _____

19. a. Do offenders have access to flammable liquids? ☐ Yes ☐ No

    b. If Yes, please describe: _____

20. a. Are there designated smoking areas in the facility? ☐ Yes ☐ No

    b. If Yes, please describe: _____

21. a. Are any combustibles stored in offender areas? ☐ Yes ☐ No

    b. If Yes, please describe: _____

22. Is all of the bedding in offender areas fabricated of fire retardant and non-toxic materials? ☐ Yes ☐ No

23. Is smoking allowed in offender bed areas? ☐ Yes ☐ No

24. Are electric flameless wall lighters used? ☐ Yes ☐ No

25. Are all trashcans constructed of durable metal? ☐ Yes ☐ No

26. Are all offender areas equipped with flush mounted, tamper proof security lights? ☐ Yes ☐ No

27. Does facility have self-contained oxygen masks located in all critical areas? ☐ Yes ☐ No

28. Is all electrical wiring of a three phase grounded type? ☐ Yes ☐ No

29. Is all electrical wiring protected by conduit with no open runs? ☐ Yes ☐ No

30. Is there a backup and/or auxiliary electrical system? ☐ Yes ☐ No

31. Is there a master-lock system that could open all of the offender cell doors simultaneously in the event of an emergency? ☐ Not Applicable ☐ Yes ☐ No

32. Surveillance Systems:

Booking Area	☐ Audio	☐ Video	☐ None
Cell Areas	☐ Audio	☐ Video	☐ None
Sally Port	☐ Audio	☐ Video	☐ None

33. In the event of an evacuation, is a temporary housing plan in place? ☐ Yes ☐ No

34. Who (name and title) is responsible for the implementation and monitoring of emergency and life safety programs at the facility?

_____

35. What formal training or expertise does the above individual have in regard to emergency situations?

_____

_____

36. Are all employees instructed on actions to be taken in the event of a life safety emergency? ☐ Yes ☐ No

37. Is there a log kept on all reported life safety incidents? ☐ Yes ☐ No

38. a. Are specific personnel assigned to regularly inspect all life safety or fire protection equipment? ☐ Yes ☐ No

b. Are defective conditions noted during inspections always corrected within thirty (30) days of notation? ☐ Yes ☐ No

39. Is facility staffed with at least one (1) full time employee responsible for building maintenance? ☐ Yes ☐ No

40. Is the facility regularly inspected by:

a. State Corrections Officials? ☐ Yes ☐ No Date of last inspection: _____

b. Fire Inspectors? ☐ Yes ☐ No Date of last inspection: _____

c. Department of Health? ☐ Yes ☐ No Date of last inspection: _____

d. OSHA ☐ Not Applicable ☐ Yes ☐ No Date of last inspection: _____

41. **Please attach a current copy of the resume of the individual in charge of the facility.**

_____

Applicant's Authorized Signature (of Principal, Partner or President) | Title | Date