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# Recovery Residences Application

## General Information

G1	Name of Applicant Mailing address City State Zip Email address Contact Name Phone # for inspection	Web address FEIN Management Agents phone #	Date est.
G2	Business Type: Individual    Corporation    Partnership    LLC    Non-profit Corp. Other    (Explain)		
G3	List all names which you or the corporation has operated under during the past 4 years, if different from above		N/A
G4	Description of Operations: If services are offered other than a recovery residence,    N/A explain fully the services offered		
G5	Is applicant engaged in, owned by, associated with or involved in any other enterprise?	Yes	No
	If yes, provide details		
G6	Is facility run by an outside management company?	Yes	No
	If yes, describe contractual relationship		
G7	Do you provide consultant services for or manage any other facilities?	Yes	No
	If yes, describe		
G8	<b>Current insurance coverage maintained</b>		
	Coverage	Insurer or "None"	Coverage Exp. Date
			Ann. Premium
			Insured since yr.
	General Liability Professional Liability Property Commercial Auto Workers Compensation		
	If currently insured, attach copies of currently valued (within last 3 months), hard copy company loss runs for the last 5 years if applicable.		
G9	State license not required for operations	State license required for operations and copy attached	
	If licensed, has license ever been revoked or suspended?	N/A	Yes    No
	Give details:		
G10	Is any facility certified?	N/A	Yes    No
	If applicable, who provides certification?		
G11	Accreditations and/or Association memberships	None	List:
G12	Are there any additional Interests in this insurance (mortgagee, loss payee or contracts requiring you to carry insurance)?	Yes	No
G13	Do you have written policies and procedures for tenants?	Yes	No
G14	Do you administer drug or alcohol testing of tenants?	Yes	No
G15	Do you have incident reporting procedures?	Yes	No
	If yes, is a written record kept?	Yes	No
G16	Do you allow guests/visitors to stay overnight?	Yes	No
G17	Do you allow residents to keep pets on premises?	Yes	No
G18	Any special events on any premises or off site?	Yes	No
	If so please describe		
G19	Has an emergency evacuation plan been prepared?	Yes	No

**Location Information: complete this section for each location**

L1	Location #	Location Address:		
L2	Is there a resident manager at location?		Yes	No
L3	Are all rooms and halls equipped with smoke detectors?		Yes	No
L4	Is building equipped with fire alarm?		Yes	No
	Is alarm Central Station connected to offsite monitoring company?	N/A	Yes	No
L5	Is smoking permitted?		Yes	No
	If so, are there designated smoking areas?	N/A	Yes	No
L6	Is building sprinklered?	If partially, what %?	Yes	No
L7	Are fire extinguishers located throughout the building?		Yes	No
L8	Is there a Burglar Alarm?		Yes	No
L9	Video Surveillance?		Yes	No
L10	Swimming Pool or Pools?		Yes	No
	If a single family home, is pool fenced with a self closing safety gate?	N/A	Yes	No
	Do all doors leading to pool area have child proof locks / controls?	N/A	Yes	No
L11	Jacuzzi/Hot Tub?		Yes	No
L12	Sauna?		Yes	No
L13	Exercise equipment?		Yes	No
L14	# of beds at this location			
L15	Total # of current residents			
	# under age 18?	# Women		
	# over age 18	# of Couples		
	# of Men	# Women & Children		
L16	Do you have of the following? Do not count same patient in more than one type			
	Seriously mentally impaired (e.g. Alzheimer's, senile)	Skilled Care		
	Somewhat mentally impaired (e.g. mentally challenged)	Intermediate Care		
	Aged but mentally and physically fully functional	Detox		
	Has a communicable disease (e.g. AIDS)			

**Totals (Totals must not exceed total number of residents.)**

**Facility Building information**

L17	Single Family Home	Apt. or Condo.	Other (Explain in Remarks)	Number of stories?
L18	What is the square footage of the building?		Year built?	
L19	Do you own this building?			Yes No
L20	If L19 is YES, is your current insurance endorsed to provide coverage as a Recovery Residence?	N/A		Yes No

**Complete the section below for Building, Bus. Pers. Prop and Lost Income coverage If more than one location, complete the property section for each location coverage is requested**

P1	Location #	Location Address:		
P2	Name of Current Property Insurer			Ann. Premium \$
P3	Do you want coverage on the Building?	Yes	No	Building Amt. \$
P4	Do you want coverage for contents?	Yes	No	Contents Amt. \$
P5	Do you want coverage for lost income?	Yes	No	Loss of Rents Amt \$
				Deductible: \$
P8	Construction type: (i.e. Frame, Masonry, Steel)			

**Please indicate all types of building updates in the last 15 years, when completed and description**

P9	Roof	Year Completed:	Description
P10	Plumbing	Year Completed:	Description
P11	Electrical	Year Completed:	Description
P12	Heating	Year Completed:	Description

**Personnel**

- G20 Indicate total number of employed personnel:
- G21 Total number and types of independent contractors? None
- G22 Do you currently have Worker's Compensation Insurance? Yes No
- G23 Please list the total of each type of Independent Contractor
- |              |                 |
|--------------|-----------------|
| MD's         | Psychologists   |
| RN's         | Therapists      |
| LPN's        | Counselors      |
| Nurses Aides | Other (specify) |
- G24 Are any independent contractors required to maintain their own professional liability coverage? N/A Yes No
- If question G24 is Yes, Limits required to be carried \_\_\_\_\_
- if G24 is Yes, How are coverage limits verified?
- G25 Are background checks made with all prior employers and educational institutions? Yes No
- G26 Does background check include police record? Yes No
- G27 Motor Vehicle Report? Yes No
- G28 Do you provide transportation for any clients? Yes No
- G29 Do you require all employees who transport tenants on your behalf to carry minimum personal auto liability insurance limits of \$1,000,000? Yes No N/A

For each employee who uses any vehicle to provide services to your clients please provide on a separate sheet: Full name as on drivers' license, DOB, State licensed, DL#

- G30 Are you named as an "additional Insured on your employees personal auto liability insurance? Yes No
- For all yes answers, please provide details on a separate sheet**
- G31 Have you or any controlled entities incurred any claims or legal actions of any type? Yes No  
If yes on a separate page please indicate the year of the claim, amounts paid or reserved, the insurance company and a description of the claim.
- G32 Is applicant, or any other persons for whom insurance is being requested, aware of any circumstances which may result in a claim? Yes No
- G33 Has applicant, or any other person for whom coverage is being requested, had any application for insurance denied? Yes No
- G34 Have you or any employee, volunteer or other person working for you ever been arrested or convicted of a crime? Yes No
- G35 Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? Yes No
- G36 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
- G37 Coverage Effective Dates Desired From: \_\_\_\_\_ To \_\_\_\_\_

**Indicate coverage requested and limits of insurance:**

- |   |                     |                         |
|---|---------------------|-------------------------|
| G38 General Liability coverage  | 1,000,000/2,000,000 | 1,000,000/3,000,000     |
| G39 Professional Liability  |                     | I decline this coverage |
| G40 Hired and Non Owned Auto Liability  |                     | I decline this coverage |
| G41 Abuse and Molestation (automatically included in some policies without option to decline) |                     | I decline this coverage |
| G42 Assault and Battery (automatically included in some policies without option to decline)   |                     | I decline this coverage |
| G43 Additional Coverage information/remarks/notes   |                     |                         |

**FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

Applicant's Signature:  
 Date:  
 Producing Agent:



Printed Name:  
 Title:  
 Date: