Flood and Peterson Care Association
RESPITE, COMMUNITY ACCESS, IN-HOME SERVICES FAMILY CARE GIVER, APPLICATION

SECTION 1: Name and Mailing Information

FULL NAME: (Not your consumer's name)			
Trade Name if Applicable:			
Mailing Address:	City:	State:	Zip:
Home Phone Number:	Cell Phone Number:		
Email Address:			
PLEASE LIST THE AGENCY(S) YOU ARE CONTRACTED WITH:			
Primary Phone Number of the Agency(s) that you are contracted with:			

Section 2: Underwriting Questions (CIRCLE ANSWERS)

Question		
1. Do you have EMPLOYEES, or do you pay anyone to do services for you? **(If you pay employees, you do not qualify for this program.)**	**Yes**	**No**
2. Do you work for a HOME HEALTH CARE Agency or an ASSISTED LIVING Facility for the elderly? **(If you work for a Home Health Agency or Assisted Living facility for the elderly you do not qualify for this program.)**	**Yes**	**No**
3. Are all your clients developmentally disabled?	**Yes**	**No**
Check the age groups that you work with: Under 18 ☐ 18 to 64 ☐ 65 Years Old and Older ☐		
4. Do you provide overnight respite in your client's home?	**Yes**	**No**
5. Do you provide overnight respite in your own home?	**Yes**	**No**
• **If you do provide overnight respite, do you have homeowners or renters' insurance? (Homeowner or Renters Insurance is required for you to provide overnight respite in your home)**	**Yes**	**No**
6. Do you provide in-home support or community access support and services?	**Yes**	**No**
• **If you provide in-home support services, do you provide ANY SKILLED MEDICAL CARE? (If you provide any SKILLED MEDICAL care, you do not qualify for this program.)**	**Yes**	**No**
7. Has the organization completed a background check on you and anyone living in your home that is 18 years of age or older? **(This is a requirement)**	**Yes**	**No**
8. Have you ever had an allegation of **Mistreatment, Abuse, Neglect** or **Exploitation?** **(IF YES, did it result in substantiated** Mistreatment, Abuse, Neglect or Exploitation? **Please describe:**	**Yes**	**No**

Flood and Peterson Care Association

9. Have you had a lawsuit filed against you as a Respite Provider? **(If yes please give a brief description)**	**Yes**	**No**
10. Has any insurance company cancelled or non-renewed similar insurance coverage?	**Yes**	**No**
Describe any training and/or certification you have received to qualify as a provider: **FIRST AID: ___ CPR: ___ ABUSE/NEGLECT TRAINING: ___ ALL OTHER APPLICABLE TRAINING: ___**		

General & Professional Liability Insurance Premium Due: **$399.86***

***($388.21 premium plus $11.65 Surplus Lines Tax)**

Make Check or Money Order Payable to Care Association

Mail to: **PO BOX 578, Greeley, Colorado 80632**

THE APPLICANT DECLARES THE ABOVE STATEMENTS AND REPRESENTATIONS ARE TRUE AND CORRECT AND THAT NO FACTS HAVE BEEN SUPPRESSED OR MISSTATED. THE COMPLETION OF THIS APPLICATION DOES NOT BIND THE COMPANY TO SELL NOR THE APPLICANT TO PURCHASE THIS INSURANCE, BUT ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPEPRESENTATIONS MADE IN THIS APPLICATION AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.

THE APPLICANT UNDERSTANDS THAT ANY COVERAGE PROVIDED PURSUANT TO THIS APPLICATION WILL BE PART OF A MASTER INSURANCE PROGRAM WITH A $1,000,000 LIMIT OF LIABILITY PER CLAIM AND A MAXIUMUM POLICY AGGREGATE LIMIT OF $5,000,000 (THEREFORE, IT IS POSSIBLE THAT CLAIMS ASSOCIATED WITH OTHER HOST HOMES MAY PARTIALLY REDUCE OR ENTIRELY ELIMINATE LIMITS OF LIABILITY AVAILABLE TO YOU.

THE POLICY UNDER THIS PROGRAM IS A CLAIMS-MADE POLICY WHICH PROVIDES LIABILITY COVERAGE ONLY IF A CLAIM IS MADE DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD.

THE CONTRACT UNDER THIS PROGRAM IS DELIVERED AS A SURPLUS LINES COVERAGE UNDER THE "NONADMITTED INSURANCE ACT". THE INSURER ISSUING THE CONTRACT IS NOT LICENSED IN COLORADO BUT IS AN ELIGIBLE NON-ADMITTED INSURER. THERE IS NO PROTECTION UNDER THE PROVISION OF THE COLORADO INSURANCE GUARANTY ASSOCIATION ACT.

RESPITE PROVIDERS SIGNATURE: ____ DATE: _________

APPLICANT HAS READ AND UNDERSTANDS THE ABOVE INFORMATION AND REALIZES THERE WILL BE NO CANCELLATION REFUNDS

PAYMENT OPTIONS

You may complete your application for RENEWAL ONLINE at www.careassociation.net, credit or debit cards are accepted. If you need assistance with online applications, please contact our office at 303-333-0375. If you are submitting your application via mail, please attach a CHECK OR MONEY ORDER made payable to CARE ASSOCIATION. Any returned checks will be assessed at $25.00 charge plus the premium payment. NO CANCELLATION REFUNDS will be issued even if contracts change mid-year. All applicants must be approved prior to binding coverage. Certificates of Insurance will be issued upon approval. If approval is denied, your payment will be returned to you within 15 days of denial.