

CARE ASSOCIATION/CENTERPOINT INSURANCE GROUP
Respite-Community Access-In Home Services Insurance Program

RESPITE, COMMUNITY ACCESS, IN-HOME SERVICES, FAMILY CARE GIVER APPLICATION

Application Valid from: 03/01/2021 through 03/01/2022

SECTION 1: Name and Mailing Information

FULL NAME: (Not your consumers 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)

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. Contact our office for further clarification)	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 of your clients Developmentally Disabled?	Yes	No
Check the age groups that you work with: Under 18 <input type="checkbox"/> 18 to 64 <input type="checkbox"/> 65 Years Old and Older <input type="checkbox"/>		
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 in order for you to provide overnight respite 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

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9. Have you had a law suit 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: **\$350.00**
 Make Check or Money Order Payable to Care Association
 Mail to: 8400 E. Prentice Ave. Suite 735
 Greenwood Village, Co 80111

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.

FURTHERMORE, THE APPLICANT UNDERSTANDS THAT ANY COVERAGE PROVIDED BY THE COMPANY WILL BE PART OF A MASTER INSURANCE PROGRAM WITH A \$1,000,000 LIMIT OF LIABILITY PER CLAIM AND A MAXIMUM POLICY AGGREGATE LIMIT OF \$5,000,000 (Effective 3/1/2021 – 3/1/2022). THEREFORE, IT IS POSSIBLE THAT CLAIMS ASSOCIATED WITH OTHER COLORADO HOST HOMES MAY PARTIALLY REDUCE OR ENTIRELY ELIMINATE LIMITS OF LIABILITY AVAILABLE TO YOU. IT IS AGREED THAT SUCH COVERAGE AS IS AFFORDED BY SECTION 102(1) OF THE TERRORISM RISK INSURANCE ACT OF 2002 IS INCLUDED FOR NO PREMIUM CHARGED.

RESPITE PROVIDERS SIGNATURE: _____ DATE: _____

PAYMENT OPTIONS

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

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 attached 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 should 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.