# *CARE ASSOCIATION/CENTERPOINT INSURANCE GROUP*
## *Host Home Insurance Program*
**HOST HOME PROVIDER INSURANCE APPLICATION**
**Application Valid from: 03/01/2023 through 03/01/2024**

**SECTION 1: Name and Mailing Information**

| | | | |
|---|---|---|---|
| FULL NAME:<br>(Not your consumers name) | | | |
| Trade Name if Applicable: | | | |
| Mailing Address: | City: | State: | Zip: |
| HOST HOME Address (IF DIFFERENT FROM MAILING) | City: | State: | Zip: |
| Home Phone Number: | Cell Phone Number: | | |
| Email Address: | | | |
| PLEASE LIST ALL AGENCIES THAT YOU ARE CONTRACTED WITH: | | | |

**Section 2: Underwriting Questions (CIRCLE ANSWERS)**

| | | |
|---|---|---|
| 1. Are you an LLC or S-Corp? | **Yes** | **No** |
| 2. Do you have EMPLOYEES, or do you pay anyone to perform services for you? **(This program is for individual care providers. If you pay anyone to perform services for you contact our office for further clarification)** | **Yes** | **No** |
| 3. Do any of your developmentally disabled clients have a history of physical or sexual abuse to others? | **Yes** | **No** |
| 4. Do you have homeowners or renters' insurance? **(Homeowner/Renters insurance is required to qualify for this program)** | **Yes** | **No** |
| 5. Are **ALL** individuals receiving services in your home 18 years of age or older and are they Developmentally disabled? | **Yes** | **No** |
| 6. Do you provide any **CHILD** Foster Care in your home? **(If you are providing foster care you do not Qualify for this program. You can contact our office for further information)** | **Yes** | **No** |
| 7. How many years of experience do you have as a provider serving individuals with Developmental Disabilities? | | |
| 8. Have you authorized the placement agency to initiate a background check on you and Anyone 18 years of age or older in your home? (**This is a requirement)** | **Yes** | **No** |
| 9. Has your placement agency inspected your host home and do they make periodic visits throughout the year? **(This is a requirement)** | **Yes** | **No** |
| 10. Do you provide any **SKILLED MEDICAL CARE** other than medication support to your clients? **(If you are providing any skilled medical care you do not qualify for this program. You can contact our office for further clarification)** | **Yes** | **No** |
| 11. Within the last 5 years, have you been subject to any **disciplinary action** as a Host Home Provider by a Court, Community Centered Board, Service Provider Organization or any other placement agency you contract with? **(If yes please give a brief description)** | **Yes** | **No** |
| 12. 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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| | Yes | No |
|---|---|---|
| 13. Have you had a lawsuit filed against you as a Host Home Provider or are you aware of any Past incidents that could result in a lawsuit being filed against you? **(If yes please give a brief description)** | | |
| 14. 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: ___**

****COMPLETE THIS SECTION ONLY IF YOU HAVE SOMEONE 65 YEARS OLD OR OLDER****

| | Yes | No |
|---|---|---|
| 1. Is your consumer ambulatory…can they walk on their own without assistance? | **Yes** | **No** |
| 2. Is your consumer in a wheelchair all or most of the time? | **Yes** | **No** |
| 3. Is your consumer confined to a bed? | **Yes** | **No** |
| 4. Does your consumer require medical or skilled nursing care in your home? **(THIS PROGRAM IS NOT FOR SKILLED OR NON-SKILLED HOME HEALTH CARE)** | **Yes** | **No** |
| 5. Can your consumer care for themselves? If not, what things must you do for your consumer on a daily basis? (Check all that apply) **COOK: ___ BATHE: ___ CLEAN: ___ ADMINISTER MEDICATIONS: ___** | **Yes** | **No** |

**How many individuals ages 18-64: ☐** **How many individuals 65 years or older: ☐**

| **PREMIUMS UNDER 65:** | **1 Client = $378.00** | **2 Clients = $675.00** | **3 Clients = $965.00** |
|---|---|---|---|

**PREMIUM TOTAL if you have ANYONE OR ALL in your home that is over Over 65:**

| **1 Client = $488.00** | **2 Clients = $785.00** | **3 Clients = $1,075.00** |
|---|---|---|

**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 HOST HOME INSURANCE PROGRAM WITH A $1,000,000 LIMIT OF LIABILITY PER CLAIM AND A MAXIUMUM POLICY AGGREGATE LIMIT OF $5,000,000 (Effective 3/1/2023-3/1/2024). 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.**

**HOST HOME PROVIDERS SIGNATURE: _____ DATE: _____**

**APPLICANT HAS READ AND UNDERSTANDS THE ABOVE INFORMATION 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 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.**