Name of Insurance Company
To Which Application is Made: **Lexington Insurance Company**
(*Herein called the Company*)

APPLICATION FOR HEALTHCARE FACILITY
PROFESSIONAL & COMMERCIAL GENERAL LIABILITY INSURANCE

Instructions:
1. Please type or print clearly.
2. Answer ALL questions completely, leaving no blanks. If any questions or part thereof, do apply, print "N/A" in the space.
3. If the applicant needs more space for responses, continue on a separate sheet of the applicant's letterhead and indicate question number.
4. This form must be completed, dated and signed by a principal of the applicant's facility.

I. GENERAL INFORMATION

Producer Name: **Executive Perils Insurance Services**

Address: **11845 W. Olympic Blvd., Suite 750 , Los Angeles , CA 90064**

Telephone Number:

Applicant's Name: **CALIFORNIA PSYCHCARE, INC.**

Business Address: **16946 SHERMAN WAY BLVD. #100 , VAN NUYS, CA 91406**

Mailing Address: **N/A**

Years in Business: **7** Employer Federal Tax I.D No: Telephone No: **818-401-0661**

Reporting/Fiscal Year Start Date: **01-01-2010**

Requested effective date: **09-02-2010** Retroactive date: **09-02-2004**

Current Form of Insurance:		**Retro Date for Claims Made**
Professional Liability	Claims Made	**09-02-2004**
General Liability	Claims Made	**09-02-2004**

Requested Coverage:		**Retro Date for Claims Made**
Professional Liability	Claims Made	**09-02-2004**
General Liability	Claims Made	**09-02-2004**

Applicant is a: **Corporation**

Applicant operates: **Profit**

Limits of Liability
$3,000,000/$5,000,000

**Professional Liability and General Liability Limits must be the same, but apply separately.*

Deductible (*applies separately to Professional Liability and General Liability*): $5,000

List all subsidiaries, date acquired, and description of operations & ownership in percentages:

Subsidiaries	Date Acquired	Description of Operations	% Ownership

II. PROFESSIONAL LIABILITY

1. Services Provided: Indicate all services provided by the applicant's facility, giving requested information for each classification. Information given should be projected numbers for the next 12 months. "Visits" are defined as the number of patients entering the applicant's facility for health related services. DO NOT tally the number of departments visited or the number of procedures or treatments performed. "Beds" are defined as the average number of occupied beds.

Professional Employees/Independent Contractors. Please provide information requested for each physician/ surgeon providing services at the applicant's facility.

Medical Director* Name	Specialty	Insurance Carrier & Policy Number	Type of Surgery**	Procedures/ Month	Employee/ Contractor	Hours/ Month
Other Physicians & Surgeons Names	Specialty	Insurance Carrier & Policy Number	Type of Surgery	Procedures/ Month	Employee/ Contractor	Hours/ Month

***A PHYSICIAN WILL ONLY BE COVERED IN HIS/HER CAPACITY AS A MEDICAL DIRECTOR FOR ACTIVITIES RELATING TO ADMINISTRATION OF THE FACILITY.**

**Surgery Definitions:

No Surgery – No surgery procedures performed other than circumcisions, incision of boils and superficial abscess or suturing of skin and superficial fascia. Includes closed fractures of the fingers and toes.

Minor Surgery –Assisting in surgery on physician's own patients, including closed bone fractures, except those of the fingers and toes, and D&Cs or vasectomies performed under local anesthesia.

Major Surgery – Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen pelvis; any other operation which, because of the condition of the patient or length or circumstances of the operation presents a distinct hazard to life. It also includes removal of tumors, open bone fractures, amputations, abortions, cesarean sections, the removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies and any operations done using general anesthesia.

NOTE: If any physician/surgeon is to be provided coverage under this policy, a supplemental application must be completed and an additional charge will be applied

2. Other Health Care Professionals. Indicate the number in each category, full-time and part-time.

Profession	Employees		Contractors		Volunteers	
	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time
Other	1379	0	0	0	0	0
Totals	1379	0	0	0	0	0

3. Does the applicant currently comply with any state licensing requirements for the applicant's facility? **Yes**
   If yes, describe. If no, state reasons for non-compliance and corrective actions being taken.
   CA STATE

4. If the facility is a member of any professional organizations or associations, enter name(s).

N/A

5. If the facility is accredited and/or inspected by any governmental body or other organization indicate below:

Number of Facilities	Organization	Status	Date of Last Inspection
1	AAAASF	Accredited	08-26-2010

Describe the type(s) of inspections (physical plant, nursing protocols) and include a copy of any accreditation report(s).
N/A

6. If the applicant has written requirements that the following providers carry Professional Liability Insurance indicate the limits required.

	Yes/No	Limits
Physicians	No	0
Surgeons	No	0
Oral Surgeons	No	0
Dentists	No	0
Nurse Anesthetists	No	0
Nurse Midwives	No	0
Other	No	0

Other Description:

III. RISK MANAGEMENT/LOSS CONTROL

1. If the applicant has a Risk Management Program, list the Manager's name, title and phone number:

   N/A

2. If the facility owns any biomedical or other equipment used for diagnosis, monitoring or treatment purpose that is responsible for inspection and maintenance of the equipment? **NoneOwned**

3. Do qualified personnel inspect and maintain the equipment on a regular basis? **No**

4. Are manufacturers recommendations followed for all maintenance and repair of equipment? **No**

5. Does the applicant have any contractual agreements with independent contractors/providers to provide services at the Applicant's facility? **No**
   If yes, please provide a copy of a sample contract.

6. Are certificates of insurance obtained from all contracted providers? **No**

7. If the facility provides service to others on a contractual agreement please describe services provided and include a copy of the contract. **N/A**

8. If the facility agreed to hold harmless or indemnify others under contract please describe and include a copy of the contract. **N/A**

9. If the facility rents or leases any biomedical or other equipment, please describe: **N/A**

10. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at the applicant's facility:

Check of educational background, or residency program, when applicable. **No**
Check of previous employers **No Check**
Check of personal references **No Check**
Check on hospital privileges for physicians, oral surgeons and dentists **No**
How often does the applicant update their list of specific privileges? **Annually**
Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities: **No**
Require information on any professional liability or work-related claim that has previously been made against any individual **No**
Does the applicant's facility have written job descriptions? **No**

IV. COMMERCIAL GENERAL LIABILITY INFORMATION

1. Please provide physical plant information as requested:

Address/Occupancy	Square Footage	Age	Type of Construction	# Floors	Type of Fire Protection*	Designed for Patient Care?	Designed for Overnight Guests?	Number of Exits per Floor

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

2. Please indicate any additional insureds to be included under the applicant facility's General Liability Coverage, including an explanation of their interest:

Name	Address	Interest

3. If the applicant sells or leases any medical equipment or products to patients or others in connection with the Applicant's Operation please complete the following:

Total Annual Sales: $

Total Annual Lease/Rental Receipts: $

Category I. EXPENDABLE ITEMS – Intended for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.)

Annual Sales: $

Category II. NON-EXPENDABLE ITEMS – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc. and prosthetic devices and I.V. stands including medical and surgical instruments unless considered diagnostic or treatment, etc.

Annual Sales: $ Annual Lease/Rental Receipts: $

Category III. DIAGNOSTIC OR TREATMENT DEVICES – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices.

Annual Sales: $ Annual Lease/Rental Receipts: $

Category IV. LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES – This category includes dialysis or heart/lung machines, apnea monitors, SIDA monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition.

Annual Sales: $ Annual Lease/Rental Receipts: $

Have any of the products that the applicant distributes ever been recalled? **No**
Have any claims been made against the applicant? No

4. If the applicant provides preventive maintenance or repairs on medical equipment leased to others please provide details: **N/A**

V. POLICY AND LOSS INFORMATION

1. Please provide past policy information as requested. List all Commercial General Liability and Professional Liability policies for each of the past five years. Begin with the current policies on the top line.

Type	Policy Period	Insurer	Premium	Limits	CM Or Occurrence	If CM, enter Retro-Date
ProfessionalLiability	09-02-2009 - 09-02-2010	UNDERW RITERS AT LLOYD'S LONDON	$34,000	3/5M	ClaimsMade	09-02-2004
GeneralLiability	09-02-2009 - 09-02-2010	UNDERW RITERS AT LLOYD'S LONDON	$	3/5M	ClaimsMade	09-02-2004

2. If the applicant is aware of any circumstances, accidents or loses which have occurred after the retroactive date, provide complete details.

3. If any claims have ever been made against the applicant, please give dates, allegations and disposition of each claim or suit.

4. If the facility ever had any Insurance Company or Lloyd's Syndicate decline, cancel, refuse to renew or accept only on special terms any Professional Liability Insurance provide explanation: **N/A**

VI. FACILITY SPECIFIC INFORMATION

INPATIENT FACILITIES

1. Are the electrical, heating and plumbing systems up to code and regularly inspected? **No**

FIRE PROTECTION

1. Are there evacuation plans posted and drills held regularly? **No**
2. Are there non-slip surfaces in bathing areas and handrails? **No**
3. How are the beds licensed? (nursing home, ambulatory facility, etc.) **N/A**
4. What is the minimum number of staff on duty at night? **0**
5. What level of care is provided for the beds maintained?

   Is skilled nursing care provided including medication administration, injections, catheterizations or other procedures ordered by physicians? **No**

   Is assistance with daily living activities and some medication administration provided but no skilled nursing care? **No**

   Are patients responsible for their own medication but some daily living activities planned, such as meals and social activities? **No**

6. Does the applicant provide residential care to children or adolescents? **No**

Please include the following information with the completed application:

Previous Insurance Company loss runs for the past five years.
Current audited financial statement.
Brochures, pamphlets or other advertising material utilized by the applicant's facility.
Copies of any inspection reports/surveys conducted by outside organizations within the past three years.
Copies of any contracts for professional services provided to the applicant's facility or by the applicant's facility.

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

APPLICANT

Name of Applicant:____

Title: ____

Signature: ____

Date: ____

AGENT OR BROKER

Agency: ____
Name

____
Address

____

Agent: ____
Print Name

Signature: ____

Date: ____

MENTAL HEALTH FACILITIES – SUPPLEMENTAL APPLICATION

This is a Supplemental Application which attaches to and becomes part of the Lexington Miscellaneous Facilities Application. The Applicant represents that the statements and facts are true and no material facts have been suppressed or misstated. If a policy is issued, this Supplemental Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Supplemental Application does not bind coverage.

Supplemental Questions

Applicant's Name: **CALIFORNIA PSYCHCARE, INC.**

1. Enter the exposure information and revenues for the following (historical, current and projected):

	Number of Visits				Revenue
Inpatient Visits - Specify Type	«3 Yrs Prior»	«3 Yrs Prior»	«3 Yrs Prior»	Projected	Current Year by Type
Outpatient Visits - Specify Type					
«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»
Other Visits or Revenue Sources					
Total Revenues from Operations					«Inpat Viists 3»

2. Patient Population Information:

Types	Current Year Avg. Daily Census	Current Year Avg. Length of Stay	Current Year Adjusted Patient Days Per Year	Current Year Number of Licensed Beds
Children (up to age 12)	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»
Adolescent (ages 12-19)	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»
General Adult (ages 20-65)	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»
Geriatric (greater than age 65)	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»
Total	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»

3. What is the average percentage of patients who are involuntarily committed to the facility? **«Inpat Viists 3»**
4. Are medication regimens used to treat patients? **«Inpat Viists 3»**
5. Do guidelines exist for observation of medication administration? (If yes, provide copy of guidelines.) **«Inpat Viists 3»**
6. Does the facility have emergency medical equipment or a plan for managing medical emergencies? **No**
7. Is family counseling offered upon the discharge of a patient? **«Inpat Viists 3»**
8. Are case records maintained on all patients? **No**
9. What is the current staff to patient ratio? **«Inpat Viists 3»**
10. Does the facility treat potentially aggressive or assaultive patients? (If yes, provide copy of guidelines.) **«Inpat Viists 3»**
    (a) How many actual incidents occurred in the past year? **«Inpat Viists 3»**
    (b) How many patient to patient incidents occurred in the past year? **«Inpat Viists 3»**
    (c) How many patient to staff incidents occurred in the past year? **«Inpat Viists 3»**
    (d) Do guidelines exist referencing the use of patient restraints? If yes, provide copy. **«Inpat Viists 3»**
11. Does the facility accept patients who are a known suicide risk? (If yes, provide copy of guidelines.) **«Inpat Viists 3»**
12. Suicide Exposure Data (for current and prior 2 years):

Suicide Exposures	«Inpat Viists	«Inpat Viists 3»	Current Year

MENTAL HEALTH FACILITIES – SUPPLEMENTAL APPLICATION

(if none or zero, indicate "none")	3»		
Attempted Suicides Without Using Lethal Means	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»
Attempted Suicides Using Lethal Means	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»
Completed Suicides	«Inpat Viists 3»	«Inpat Viists 3»	«Inpat Viists 3»

13. Does the facility have a specialized patient population? **«Inpat Viists 3»**

    If so, specify nature of specialized patient class: **«Inpat Viists 3»**

14. Inappropriate Sexual Contact Exposure Data (if yes to any of the following, then provide copy of guidelines):
    (a) Supervision of staff to prevent staff to patient sexual contact? **«Inpat Viists 3»**
    (b) Education of staff to prevent staff to patient sexual contract? **«Inpat Viists 3»**
    (c) Does the applicant's facility use guidelines to institute environmental modifications once an incident has occurred? **«Inpat Viists 3»**

Number Inappropriate Sexual Contact Exposures (if none or zero, indicate "none")	«Inpat Viists 3»	Current Year
Incidents of Patient to Patient Consensual Contact	«Inpat Viists 3»	«Inpat Viists 3»
Allegations of Patient to Patient Non-Consensual Contact	«Inpat Viists 3»	«Inpat Viists 3»
Substantiated Incidents of Patient to Patient Non-Consensual Contact	«Inpat Viists 3»	«Inpat Viists 3»
Substantiated Incidents of Staff to Patient Consensual Contact	«Inpat Viists 3»	«Inpat Viists 3»
Allegations of Staff to Patient Consensual Contact	«Inpat Viists 3»	«Inpat Viists 3»
Allegations of Staff to Patient Non-Consensual Contact	«Inpat Viists 3»	«Inpat Viists 3»

15. Does the facility take any of the following steps to safeguard geriatric patients? If yes, provide copy of guidelines.
    (a) Use of Restraints? **«Inpat Viists 3»**
    (b) Skin Integrity? **«Inpat Viists 3»**
    (c) Elopement Prevention? **«Inpat Viists 3»**
    (d) Do exit doors require a key or magnetic key? **«Inpat Viists 3»**
    (e) Fall Prevention? **«Inpat Viists 3»**

16. Do employees undergo criminal background checks? **«Inpat Viists 3»**
    (a) State Only? **«Inpat Viists 3»**
    (b) State and National? **«Inpat Viists 3»**

17. Does the facility take any precautions to warn identified third parties of threats made against them by any patients? If yes, provide copy of guidelines**.** **«Inpat Viists 3»**

18. Please provide copies of the following:
    (a) Risk management guidelines.
    (b) Any screening guidelines and procedures.
    (c) Any accreditation agency reports and responses to any recommendations.

19. LOSS HISTORY – Submit company produced 5 year loss history with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses).

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS SUPPLEMENTAL APPLICATION

MENTAL HEALTH FACILITIES – SUPPLEMENTAL APPLICATION

CHANGES BETWEEN THE DATE OF THIS SUPPLEMENTAL APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

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Name of Applicant:____

Title: ____

Signature: ____

Date: ____