Insurance Guidelines for Chapter 35-Group Home for Persons with Intellectual Disabilities (GHPID) and Chapter 34-Community Residence Facility (CRF)

Title 22 DCMR 35 requires that each GHPID licensee shall carry or ensure that the premise carries the following insurance in at least the following amounts:

- Hazard (fire and extended coverage) in the minimum amount of five hundred dollars ($500) per resident to protect belongings, with a minimum of two-thousand dollars ($2,000) per GH PID;
- Liability coverage (premises, personal injury, and products liability in the amount of three hundred thousand dollars ($300,000) per occurrences; and
- Professional liability.

Title 22 DCMR 34 requires all Community Residence Facilities, licensed shall carry sufficient insurance to cover the following:

- Hazard (fire and extended coverage) in the amount of five hundred dollars ($500) per resident to protect belongings, with a minimum of two-thousand dollars ($2,000) of coverage per facility; and
- Premises, personal injury, and products liability for at least the limits set forth as follows:

<table>
<thead>
<tr>
<th>No. of Beds</th>
<th>Limit per occurrence (combined single limit and aggregate limit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>$100,000</td>
</tr>
<tr>
<td>3-9</td>
<td>$300,000</td>
</tr>
<tr>
<td>10 or more</td>
<td>$500,000</td>
</tr>
</tbody>
</table>

- Incidental malpractice coverage in respect only of duties required of a resident Director or staff member pursuant to this title, for a limit of at least one hundred thousand ($100,000).

In the case of a facility which is not owned by the operator, the operator shall be responsible for obtaining proof of the owners’ premises liability coverage (such as a certificate of standard landlord coverage) or placing the owner on the operator’s policy as an additional named insured.
Insurance Verification Request:

I, ___________________________  ____________    __________________________________ __________
Licensee Signature  Facility Address
authorize on this date__________________ the release and verification of the requested information regarding
policy(ies) issued for the above listed premise(s).

The maximum capacity of residents in this facility is ________________.

Insurance Company _____________________________________________________
Address ________________________________________________________________
________________________________________________________________________
Telephone Number: ______________________________________________________

Please verify that the above named licensee has current insurance policy(ies) with your company that provides
coverage for non-related residents who pay for their care. Please complete the appropriate areas below:

Hazard (fire and extended coverage)                  $ ___________________________
Policy Number __________________________Effective Date____________ Expiration Date ___________

Liability coverage
(1) Premises, personal injury, and products ____________________________
Policy Number _________________________Effective Date______________ Expiration Date___________
(2) Professional liability $______________________________________
Policy Number _________________________Effective Date______________ Expiration Date___________

__________________________________________________________
Signature _________________________________ Insurance Representative

Return to:
Health Regulation and Licensing Administration
899 North Capitol Street, N.E., 2nd Floor
Washington, D.C. 20002

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