POLICY: It shall be the policy of MHDS Developmental Services to ensure certified and/or approved providers maintain appropriate liability insurance as required by State of Nevada Risk Management.

PURPOSE: The purpose of this policy is to provide clear guidelines regarding required general liability insurance and applicable waivers for this requirement.

SCOPE: Developmental Services Provider Agencies

REFERENCES: State of Nevada Risk Management

PROCEDURES:

I. State of Nevada Risk Management requires the following for all DS providers:

A. Commercial General Liability Policy shall include bodily injury, property damage and broad form contractual liability coverage.
- General Aggregate $2,000,000
- Products – Completed Operations Aggregate $1,000,000
- Personal and Advertising Injury $1,000,000
- Each Occurrence $1,000,000

1. The policy shall be endorsed to include coverage for physical/sexual abuse and molestation.
2. The policy shall be endorsed to include the following additional insured language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor."

B. Crime Coverage has additional specifications for those contracts where providers are involved in providing extensive in-home services.
1. This coverage would be necessary to protect the client's loss of valuables or property.
2. Crime polices should be endorsed to include third party fidelity coverage and list the State of Nevada and the state clients' as Loss Payee.

C. Individual providers (those who do not have employees, are not incorporated, nor an LLC) may have minimum requirements of $100,000 Each Occurrence with $300,000 General Aggregate. The crime coverage does not apply.

D. Criteria for Providers' Exemption from Physical and Sexual Abuse and Molestation coverage follows. The provider must be certified as an Individual Provider (no employees, not incorporated, nor an LLC).
1. The provider is not paid to provide intimate personal care (showering or bathing, toileting, incontinence care or full assistance with dressing);

2. If the person receiving services lives in the provider's home (family member, host home or Intensive SLA), the provider will agree to background checks (State and FBI) for all other adults living in the home.

E. Procedure to Request Waiver of Insurance Requirement for Physical/Sexual Abuse and Molestation follows.
   1. The provider must submit a completed Request to Waive the Requirement for Physical and Sexual Abuse and Molestation (DS-LC-03) form to the Regional Center QA Department.
   2. The support team for the person served must review the request. Based on the team's knowledge of the person, the services contracted for, and the provider, the team will determine if the provider meets the waiver requirements stated in the exemption criteria.
   3. The request must be approved by the Regional Center Director or designee.
   4. The waiver must be renewed at least annually.
   5. Any changes in status of the exemption criteria of the approved Request to Waive the Requirement for Physical and Sexual Abuse and Molestation form must be promptly reported to the assigned Regional Center Service Coordinator and QA Department.

ADMINISTRATOR

ATTACHMENT:
Request To Waive Requirement for Insurance Coverage for Physical and Sexual Abuse and Molestation

EFFECTIVE DATE: 5/20/10
REVIEWED / REVISED DATE:
SUPERSEDES: New
APPROVED BY MHDS ADMINISTRATOR: 4/29/10
APPROVED BY MHDS COMMISSION: 5/20/10

Request To Waive The Requirement For Insurance Coverage For Physical and Sexual Abuse and Molestation

Provider Name: _____ Date: _____

Person(s) Served: _____ Case # _____

_____ Case # _____

_____ Case # _____

I request that the State of Nevada Risk Management requirement for coverage for physical and sexual abuse and molestation be waived. I certify that:

a. I am certified by the Regional Center as an Individual Provider (I have no employees, am not incorporated, nor an LLC);
b. I am not paid by the Regional Center to provide intimate personal care (showering or bathing, toileting, incontinence care, or full assistance with dressing);
c. If the person receiving services lives in my home (family member, host home), I agree to background checks (State and FBI) for all other adults living in the home. I will provide the Regional Center with 2 fingerprint cards (obtainable from local law enforcement or Fingerprint Express) and a money order or cashier's check for $51.25 made out the Nevada Highway Patrol (SRC and RRC) or Nevada Department of Public Safety - Records and Identification Bureau (DRC), for each adult named below.

The following adults, other than myself, live in the home:

Name: Relationship:

_____ _____

_____ _____

_____ _____

I understand my responsibility to promptly report changes related to any of the above information or additional risks (such as other business activity or extended visits by others) and to my assigned Regional Center Service Coordinator and QA Department.

_____ _____

Provider Signature Date

RETURN THIS FORM TO REGIONAL CENTER QA DEPARTMENT

For Regional Center use only Background Check Submitted: _____ ☐ N/A

Date

The support team, for the person(s) named above, has reviewed this request. Based on the team's knowledge of the person served, the services contracted for, and the provider, the team agrees the provider meets the waiver requirements above.

_____ _____ _____ _____

Service Coordinator Signature Date Quality Assurance Signature Date

I approve the waiver requested above for a maximum of one year. This waiver may be revoked if background checks are not cleared.

_____ _____

Regional Center Director/designee Signature Date