

Long Term Care Professional and General Liability Policy Application

**Along with this completed and signed application, prospective insureds must also submit the following information:**

1. Past five (5) year loss run currently valued within the last three (3) months. Please provide detailed information on all claims with a $25k incurred loss or greater.
2. Copy of the most current audited financial statement
3. Copy of current State License
4. Copies of most recent State Inspection Reports including any complaint investigations. Include all statements of deficiencies and plans of correction
5. Updated Form CMA 671 Facility Staffing and 672 Resident Census (SNF/ICF only) for each facility
6. Resumes and Job Descriptions of the Administrator and Director of Nursing
7. Current Quality Indicator Profile for the past 3 months
8. Skin Care Policy and Procedure
9. Resident Admission Agreement
10. Elopement Policy and Procedure
11. Description of Fall Prevention Program
12. Restraint Protocol
13. Abuse & Prevention Policy and Procedure
14. Medication Administration Policy
15. Names and locations of all entities to be covered under this policy (Attachment #1)
16. Diagram/Map of the facility
17. Marketing brochures and advertising materials

**Instructions:**

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print “N/A” in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet using the applicant’s letterhead and reference the applicable question number.

Use 🗹 for Yes or No answers and other selections.

This application supplement must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

I. Applicant Information

1. Named Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Website Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Contact Name: \_\_\_\_\_\_\_\_\_\_ Contact Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Facility is: (please check all applicable categories)

|  |  |  |
| --- | --- | --- |
| For Profit | Individual | JCAHO Accredited |
| Not for Profit | Partnership | CARF Accredited |
| Hospital Affiliated | Corporation | Medicare Certified |
| Religious Affiliated | Governmental | Medicaid Certified |
|  | CCRC |  |

1. Is the facility part of a chain?  Yes  No
2. Corporate / Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Corporate / Parent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list the officers or general partners of the parent company:

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Status** |
|  |  | Active  Inactive |
|  |  | Active  Inactive |
|  |  | Active  Inactive |
|  |  | Active  Inactive |

1. Please list all subsidiaries of the Applicants:

|  |  |  |
| --- | --- | --- |
| **Name** | **Location** | **Description of Operations** |
|  |  |  |
|  |  |  |
|  |  |  |

1. How many years has the parent company been under current ownership?
2. How many facilities does the parent company own?
3. Number of years facility has been:

Operating:

Owned by Present Management:

Managed by Present Management:

1. Is a management company used to manage the Applicant’s operations?  Yes  No

If yes, what is the name of the management company?

1. Have any locations been acquired in the past three (3) years?  Yes  No
2. Have any locations been closed, sold or otherwise divested in the past three (3) years?  Yes  No
3. Has the organization/ facility ever filed for bankruptcy?  Yes  No
4. During the next 12 months, are there any plans for mergers, acquisitions, sale of assets or business or change in service?  Yes  No

If yes, provide details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. During the past five (5) years have any claims been presented to the Applicant’s current or prior insurance carrier(s) or to the Applicant?  Yes  No
2. In the last five (5) years, has any malpractice insurance carrier denied, restricted, limited or terminated coverage? .  Yes  No

If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has the Applicant, or any other person for whom insurance is being requested, aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against the Applicant? .  Yes  No

If yes, please provide detail:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Current Professional and General Liability carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Policy Form:  Claims Made, Retro Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Occurrence

Per occurrence limit: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Aggregate limit: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retention: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Abuse / Misconduct Coverage Included?  Yes, Limits: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No

Premium: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the Applicant have any Excess Coverage or an Umbrella Policy?  Yes  No

If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the Applicant’s Professional and General Liability Insurance currently “packaged” with other coverage? .  Yes  No
2. Please provide details about the Applicant’s insurance history for the two years prior to the current coverage:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Carrier** | **Policy Term** | **Limits** | **Claims Made?** | **Retro Date** |
|  |  |  | Yes  No |  |
|  |  |  | Yes  No |  |

1. Has the Applicant had their Professional and/or General Liability insurance canceled or non-renewed in the last three (3) years?  Yes  No

II. Applicant Licensing/Credentials

1. Please list all licensing and accreditation information for the Applicant:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Type/Number | Expiration Date | Restrictions? | Provisions? |
| License: |  |  | Yes  No | Yes  No |
| License: |  |  | Yes  No | Yes  No |

1. Are all applicable permits up to date?  Yes  No

If no, please explain:

1. Does the Applicant maintain any association memberships?  Yes  No
2. Date of last State Inspection/Survey:
3. Total Number of Deficiencies:

|  |  |
| --- | --- |
| Number of D, E & F Deficiencies: |  |
| Number of G, H & I Deficiencies: |  |
| Number of J, K, L Deficiencies: |  |

1. Was a Corrective Action Plan accepted by the State?  Yes  No  Not Applicable, no deficiencies

Date Accepted:

1. Number of complaints investigated by the State in the past three (3) years:
2. Number of substantiated complaints in the past three (3) years:
3. Is the Applicant approved to accept Medicare?  Yes  No Medicaid?  Yes  No

If yes, number of Medicare-eligible beds?       Number of Medicaid-eligible beds?

1. In the past five (5) years:
   1. Has the Applicant’s license for any location been limited, suspended, or revoked?  Yes  No
   2. Has the Applicant’s Medicare or Medicaid Certification been limited, suspended or revoked for any reason? .  Yes  No
   3. Has the applicant been fined by a state or federal agency?  Yes  No

III. Classification

1. Select the level of care based upon the Applicant’s license. If the license is not specific with respect to the level of care, select the level of care that best describes the primary medical services provided by the Applicant. Please indicate the level of total licensed beds.

|  |
| --- |
| **Sub-Acute Care:** Dedicated beds for the care of medically fragile residents requiring more intensive care than provided in skilled nursing. Includes intravenous tube feeding, tracheotomy care, ventilator care, and complex wound care.  **Total Licensed Beds:       Average Occupancy:** |
| **Skilled Nursing:** Administration of medication by injection, catheter insertion, sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding.  **Total Licensed Beds:       Average Occupancy:** |
| **Memory/Alzheimer’s Care:** Dedicated beds for the care of residents with memory loss or impairment. Provides Alzheimer’s care and services.  **Total Licensed Beds:       Average Occupancy:** |
| **Assisted Living:** Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to care for themselves. Assisted Living provides a protective environment, meals, assistance with medications, group socials and spiritual activities, etc.  **Total Licensed Beds:       Average Occupancy:** |
| **Independent Living:** Residents of retirement age, total self-care, live self-sufficiently, occupy apartments/living units which include cooking facilities. Residents do not receive health care services or administer their own medications without assistance. A full time care taker resides on the premises.   1. What is the total number of living units? 2. At full occupancy, what is the total number of residents? 3. Are there common dining facilities?  Yes  No 4. Do individual units have cooking appliances (excluding microwaves)?  Yes  No   If yes, please check the type:  Gas  Electric   1. Is there a daily process or procedure to keep track of residents?  Yes  No   If yes, please explain the process/procedure:   1. Are residents allowed home health aides?  Yes  No   If yes, please provide the following:   1. Are the home health aides independent contractors?  Yes  No 2. Are the home health aides under contract with the Applicant?  Yes  No 3. Are home health aides required to maintain separate professional liability insurance?  Yes  No 4. Are there licensed nurses on staff?  Yes  No   If yes, please provide the following:   1. What hours are the licensed nurses available to residents? 2. What services do the licensed nurses provide to residents? |
| **Home and Community Based Services:** Services provided may include home repair services, hospice care, rehabilitation therapy, respiratory services or skilled nursing care. Additionally durable medical equipment, home health aides, oxygen suppliers, prosthetics/orthotics, or homemakers may be supplied.   1. Does the Applicant provide home health care services?  Yes  No   If yes, please provide the following:   1. Describe the home health care services provided by the Applicant: 2. Gross receipts: 3. Number of home health care visits per year: 4. Is home health care provided by independent contractors?  Yes  No |
| **Adult Day Care:** Social Services include, but will not be limited to: crafts, games, shopping trips or other intergenerational programs. Promotion of wellness and socialization programs, as well as music and educational programs may be provided. Enhanced Services are provided to persons who are mentally challenged, cognitively impaired, developmentally disabled or chronically ill. Enhanced Services include Social Services, but may also include, but will not be limited to, additional services such as: medication supervision, medical, nursing, nutritional and therapy services, disabled and rehabilitation services, counseling services, physical therapy, occupational therapy and speech.   1. Does the Applicant provide adult day care services?  Yes  No   If yes, please provide the following:   |  |  | | --- | --- | | Social Services:  Yes  No | Total Participants: | | Enhanced Social Services:  Yes  No | Total Participants: |   Total number of licensed locations:  Average occupancy:  Hours of operation:  Number of employees:   1. Does the Applicant provide transportation to and from the facility?  Yes  No   Does the Applicant provide transportation to and from events?  Yes  No   1. Does a physician perform a physical examination prior to admission?  Yes  No   If yes, please describe:   1. Does the Applicant provide medical services?  Yes  No   If yes, please describe: |

1. What percentage of residents correspond to the following age ranges:

< 30 \_\_\_\_\_\_ 30-64 \_\_\_\_\_\_ 65-74 \_\_\_\_\_\_ 75-84 \_\_\_\_\_\_ 85-94 \_\_\_\_\_\_ >95 \_\_\_\_\_\_

1. If there are any residents below the age of 64, please explain:
2. Are there any swimming pools onsite?  Yes  No

If yes, please check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Indoor |  | Full time lifeguard on duty |
|  | Outdoor |  | Diving board / Sliding board |
|  | Open to the public |  | Depth markings |
|  | Locked when not in use |  | Daily maintenance processes and procedures in place |
|  | Fenced |  |

1. Are there any other bodies of water present?  Yes  No

If yes, please describe:

1. Are there any saunas and/or hot tubs?  Yes  No

If yes, how many?

Is there a full time lifeguard or attendant on duty?

1. Are there any tennis/racquetball/handball courts?  Yes  No

If yes, how many?

1. Is there an exercise/weight room?  Yes  No

If yes, how many exercise/weight rooms?

Is there a full time attendant on duty?  Yes  No

Are there treadmills?  Yes  No

1. Is there a community center?  Yes  No

If yes, what is the square footage?

Is the facility used by persons other than residents?  Yes  No

If yes, please describe:

1. Is there a restaurant that is open to the public?  Yes  No

If yes, what are the gross receipts?

1. Does the facility have a liquor license?  Yes  No

If yes:

Is alcohol served?  Yes  No

Does the facility have an alcohol consumption policy?  Yes  No

1. Are pets allowed in the facility?  Yes  No

If yes, are vaccinations required and documentation maintained by the Applicant?  Yes  No

IV. Administrator

1. Name of Administrator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_
2. Length of time at this facility:
3. Length of time as a Nursing Home Administrator (NHA)?
4. Is the Administrator:  Full Time  Part Time \_\_\_\_\_\_\_\_\_\_ Hours per week

V. Nurse Staff

1. Name of Director of Nursing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Professional Credentials:  RN  LPN
2. Length of time at this facility:
3. Length of time as a Director of Nursing:
4. What is the total number of employed nurses?
5. Please list the total number of employed nurses by category:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Category | 1st Shift | 2nd Shift | 3rd Shift | Turnover % |
| RN |  |  |  | % |
| LPN/LVN |  |  |  | % |
| CNA/Personal Caregiver |  |  |  | % |
| Agency |  |  |  | % |
| Pool |  |  |  | % |
| Nurse Practitioner |  |  |  | % |

1. Does the Applicant require nurses to carry malpractice coverage?  Yes  No

If yes, does the applicant obtain and review nurses’ certificates of malpractice insurance?  Yes  No

1. Does the Applicant verify nursing licenses upon hire and annually thereafter?  Yes  No
2. Does the Applicant verify nursing assistant certifications of employed nursing assistants upon hire and annually thereafter?  Yes  No
3. Are background checks completed for agency and pool staff?  Yes  No
4. What was the Applicant’s prior year’s employee turnover rate? \_\_\_\_\_\_\_\_\_\_%

VI. Medical Director and Physicians

1. Name of Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_

Length of time at this facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the Medical Director:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Full Time |  | Employed |
|  | Part Time |  | Contracted |

1. How many hours does the Medical Director spend onsite per month?
2. How many residents utilize the Medical Director as their attending physician?
3. Do you require the Medical Director to maintain separate medical malpractice liability for their non-administrative duties?  Yes  No
4. Is there an annual evaluation of the Medical Director’s performance?  Yes  No

If yes, please define:

1. Is the Medical Director:

Involved in credentialing the Applicant’s medical staff?  Yes  No

An active participant in the Applicant’s quality improvement program?  Yes  No

Involved with the peer review of physicians?  Yes  No

1. Number of physicians: Employed:       Affiliated:       Contracted:
2. Number of physician assistants: Employed:       Affiliated:       Contracted:
3. Does the Applicant request and review physician’s certificates of malpractice insurance?  Yes  No
4. Does the Applicant require that physicians maintain limits of liability equal to its own?  Yes  No

If no, please explain the difference in limits:

1. Are the physicians credentialed?  Yes  No

If yes, do credentialing activities include the following:

Verification of a current professional medical license?  Yes  No

Verification of a current DEA license?  Yes  No

1. Is a physician on site or on call on a 24 hour basis?  Yes  No

VII. Staff/Employee Selection and Hiring

1. Is there a formal, documented assessment process to measure staff competency skills?  Yes  No
2. Does the Applicant conduct a new-hire orientation?  Yes  No
3. Does the Applicant conduct regularly scheduled in-service education programs for all staff/employees? .  Yes  No
4. How are new employees recruited by the applicant?
5. Does the employee screening/hiring process performed by the Applicant on a new employee include a review of the following:

Work history with at least two previous employers?  Yes  No

Educational Background?  Yes  No

Criminal record (including national, state or local criminal or sex offender background checks)?  Yes  No

Driving record – Motor Vehicle Record (MVR) when appropriate?  Yes  No

Drug testing?  Yes  No

Abuse registry?  Yes  No

Any pending license suspensions, revocations, or pending disciplinary actions  Yes  No

Other, please describe:        Yes  No

VIII. Non-resident and Additional Services

1. PACE (program of All Inclusive Care for the Elderly)

Is the Applicant a licensed PACE center?  Yes  No

If yes, how many participants:

1. Children Day Care

Is the Applicant a licensed children day care center?  Yes  No

If yes, please provide the following:

Total number of licensed locations:

Open to the public:  Yes  No

Average occupancy:

Hours of operation:

Number of employees:

Number of children:

Number of employee’s children:

Does the Applicant provide any transportation for children?  Yes  No

If yes, please describe:

1. Respite Care

Does the Applicant provide respite care services?  Yes  No

If yes, number of patients per year:

1. Hospice Care

Does the Applicant provide hospice care services?  Yes  No

If yes, please provide the following:

Gross receipts:

Number of patients per year:

1. Rehabilitation Services

Does the Applicant provide rehabilitation services?  Yes  No

If yes:

Number of patients per year:

Describe the in-house rehabilitation services provided by the Applicant:

Does the Applicant provide rehabilitation services to non-residents?  Yes  No

1. Meals on Wheels

Does the Applicant provide meals on wheels services?  Yes  No

If yes, please explain:

1. Does the Applicant provide the following services?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Service** | **Provided?** | **Number of Residents** | **Service** | **Provided?** | **Number of Residents** |
| IV Infusion Therapy | Yes  No |  | Developmentally Disabled | Yes  No |  |
| Ventilation Therapy | Yes  No |  | Alzheimer’s/Dementia | Yes  No |  |
| Physical Therapy | Yes  No |  | Psychiatric Care | Yes  No |  |
| AIDS Therapy | Yes  No |  | Chemical Dependency Treatment | Yes  No |  |

1. Are any other services provided by the Applicant to its residents or the community?  Yes  No

If yes, please describe:

IX. Consultants/Independent Contractors and Services

1. Indicate which of the following services are (1) provided to the Applicant by a consultant or independent contractor, (2) if a contract is in place, and (3) the requested limits of liability:

|  |  |  |  |
| --- | --- | --- | --- |
| **Services Provided** | | **Contracted or Non Contracted Service** | **Limits of Liability** |
| Physicians | Yes  No | Yes  No |  |
| Dental | Yes  No | Yes  No |  |
| Nursing | Yes  No | Yes  No |  |
| Mental Health | Yes  No | Yes  No |  |
| Pharmaceutical | Yes  No | Yes  No |  |
| Physical Therapy | Yes  No | Yes  No |  |
| Occupational Therapy | Yes  No | Yes  No |  |
| Speech Therapy | Yes  No | Yes  No |  |
| Dietary | Yes  No | Yes  No |  |
| X-Ray | Yes  No | Yes  No |  |
| Medical Records | Yes  No | Yes  No |  |
| Laboratory | Yes  No | Yes  No |  |
| Social Services | Yes  No | Yes  No |  |
| Recreational Services | Yes  No | Yes  No |  |
| Transportation | Yes  No | Yes  No |  |
| Barber/Beautician | Yes  No | Yes  No |  |
| Food | Yes  No | Yes  No |  |
| Laundry | Yes  No | Yes  No |  |
| Day Care | Yes  No | Yes  No |  |
| Other: | Yes  No | Yes  No |  |

1. Have certificates of insurance been obtained from Independent Contractors?  Yes  No

Are these reviewed annually?  Yes  No

1. Do the independent contractors have limits of liability equal to the Applicant’s limits of liability?  Yes  No

If no, please explain:

X. Volunteers

1. How many volunteers provide services for the Applicant?
2. What are the primary sources for volunteers?
3. Is there a formal selection, screening and orientation process for volunteers?  Yes  No

If yes, please explain:

1. Does the formal screening process involve criminal background checks?  Yes  No
2. Are roles and responsibilities of volunteers clearly communicated to staff and volunteers?  Yes  No
3. Do volunteers assist with resident feeding?  Yes  No

XI. Risk Management

1. Has a risk management program been implemented by the Applicant throughout all facilities?  Yes  No
2. Does the Applicant employ a full time, dedicated Risk Manager?  Yes  No

If yes, please provide the following:

Please indicate the Risk Manager’s Name:

How long has the Risk Manager been in that position with the Applicant?

If no, who is the individual responsible for risk management (name/title):

1. Does the Applicant have an “incident reporting” policy?  Yes  No

If yes, please indicate the following:

Are all incident reports reviewed by the Risk Manager, Administrator and Medical Director?  Yes  No

Are incidents trended and presented to the quality/risk management committee and Board of Directors? .  Yes  No

1. Does the Applicant have a formal safety program?  Yes  No

If yes, does it include the evaluation and reduction of exposures relating to:

Life safety?  Yes  No

Employees?  Yes  No

Hazardous materials?  Yes  No

Environment?  Yes  No

1. Does the Applicant have a formal preventative maintenance program?  Yes  No

If yes, please provide the following:

Who is the individual responsible for the program? (Name/Title)

Does the program include:

Evaluation of all electrical devices/equipment brought into the facility?  Yes  No

Scheduled evaluations of equipment and devices including electrical supply?  Yes  No

Retention of maintenance and inspection records?  Yes  No

1. What security measures are used to control unauthorized entrances and exits from the facility?
2. Are Wander Guards or similar devices used as part of elopement prevention practices?  Yes  No

If yes, please provide the type:

Are Wander Guard devices for residents and buildings maintained and inspected according to manufacturer’s specifications?  Yes  No

1. Number of elopements in the past three (3) years?
2. Does the Applicant have nursing assessment protocols in place to identify residents at risk for:

Elopement?  Yes  No

Falls?  Yes  No

Cognitive impairment?  Yes  No

Nutritional deficiency?  Yes  No

Skin breakdown?  Yes  No

1. Are there written policies and procedures for the prevention and treatment of skin breakdown?  Yes  No
2. Does the Applicant have a wound care team or designated individual responsible for this program? .  Yes  No

Please describe:

1. What is the Applicant’s current resident population with facility acquired Stage III or IV Pressure Ulcers?
2. Does the Applicant perform monthly reviews of drug regimens?  Yes  No

If yes, by whom?

1. Is there a system in place to identify, track and trend medication errors?  Yes  No
2. How are medications stored and distributed?
   1. Are records kept on drug supplies and dispersal?  Yes  No
   2. What is the maximum value of medications the Applicant keeps on hand at all facilities?
3. 1 Does the Applicant have a licensed pharmacist on staff?  Yes  No
4. Does the Applicant use:  An outside pharmacy  An onsite pharmacy

If the Applicant uses an onsite pharmacy, provide the following:

Revenue per year:

Does the Applicant provide prescriptions to non-residents?  Yes  No

1. Does the Applicant have a Specialized Alzheimer’s Unit within the facility?  Yes  No

If yes, please provide the following:

Number of beds:

Describe the type of beds:

Is it a locked unit?  Yes  No

1. Has the Applicant established admission, discharge and transfer criteria?  Yes  No

If yes, who ensures compliance with the criteria?

1. Does the Applicant receive advance written consent from the resident or his or her guardian that allows medical care be provided when necessary?  Yes  No
2. Does the Applicant have a written policy addressing abuse?  Yes  No

If yes, please provide the following:

* 1. Does the policy include procedures for reporting and investigating alleged incidents of abuse?  Yes  No
  2. Who is responsible for the investigation of abuse?
  3. Are employees and volunteers educated about the abuse policy, and recognizing and reporting and investigating procedures? .  Yes  No
  4. Are policies in place for the immediate suspension/termination of employees suspected or involved in resident abuse?  Yes  No
  5. Are policies and procedures reviewed and updated as necessary at least every two (2) years? .  Yes  No
  6. What is the number of alleged abuse incidents investigated and/or reported in the last twelve (12) years?  Yes  No
  7. Has the Applicant (including any employees or volunteers) had any claim or suit brought against them as a result of abuse within the last ten (10) years?  Yes  No
  8. If yes, please explain the claim, the investigation and the outcome, including any corrective actions taken:

1. Does the Applicant have a formal grievance process in place to address resident/family complaints?  Yes  No

If yes, please explain the process:

1. Does the Applicant have arbitration agreements included in their Resident Agreement?  Yes  No

If yes, what percentage of the Applicant’s residents has executed the Resident Agreement?

XII. Additional Property/Life Safety Information

1. Building Construction and Occupancy
   1. Is the Applicant:  building owner  tenant  general lessee
   2. Type of building construction:       Year built:       Number of Floors:       Number of Elevators:
   3. Dates of last inspections: Electrical:       Plumbing:       HVAC:
   4. Was the building constructed for elder care occupancy?  Yes  No

If no, please explain:

* 1. Are there other occupancies in the building not related to residential care?  Yes  No

If yes, please describe:

* 1. Is there a “no smoking” policy in effect throughout the facility?  Yes  No
  2. Are smoking materials allowed in a resident’s room?  Yes  No
  3. Are residents supervised and/or restricted to designated areas while smoking?  Yes  No
  4. How many exits (other than the front entrance) are there?
  5. Are the exits equipped with panic alarms?  Yes  No
  6. Do panic alarms ring into the central security desk or nurses station?  Yes  No
  7. Are there at least two remote exits on each floor?  Yes  No

1. Protection
   1. Does the Applicant have an automatic sprinkler system protecting 100% of the building and have these systems been tested by a qualified contractor with results documented?  Yes  No

If not 100%, please advise which areas are not protected:

If not tested, please explain:

* 1. Are all alarm signals monitored by a UL-approved central station or the responding fire department?  Yes  No
  2. Is there a written emergency plan covering fire, natural disasters and threats?  Yes  No

If yes, do employees receive instruction training regarding this plan?  Yes  No

* 1. Has the fire department pre-planned emergency procedures?  Yes  No

If yes, indicate the last date when these procedures were updated:

* 1. When was the Applicant’s facility last inspected by local fire authorities?
  2. Does the building have a bulk medical gas distribution system?  Yes  No

If yes, are emergency shutoffs provided?  Yes  No

If no, is there storage of individual tanks?  Yes  No

If yes, are these tanks on rolling carts?  Yes  No

If yes, are the tanks properly chained to the rolling carts?  Yes  No

* 1. Is there a fire suppression system in cooking areas (other than independent living units)?  Yes  No

If yes, please provide the following:

Is there a hood and grease filter?  Yes  No

How often the system is cleaned (i.e. monthly, quarterly)?

Is an outside contractor used for cleaning?  Yes  No

Is the area of equipped with an automatic fuel shutoff?  Yes  No

* 1. Do residents rooms/apartments have hardwire smoke detectors?  Yes  No
  2. Are doors equipped with approved self-closing devise where required?  Yes  No
  3. How many fire extinguishers are there throughout the Applicant’s facilities?  Yes  No
  4. If the Applicant has a multi-story building, do non-ambulatory residents reside on lower floors (1st/2nd)?  Yes  No
  5. Are corridors, doors, ramps, stairs, etc. free and clear of obstructions?  Yes  No
  6. Does the Applicant use video surveillance?  Yes  No

If yes, please describe extent of use:

* 1. Does the Applicant conduct fire drills regularly?  Yes  No

If yes, please describe:

* 1. Does each room/unit have an emergency call button?  Yes  No
  2. Does each resident room have an intercom or bell?  Yes  No
  3. Do hallways and bathrooms have handrails?  Yes  No
  4. Do bathtubs/showers have non-slip surfaces?  Yes  No

# Section XIII. – Fraud Warning, Declaration & Certification, and Signature

**Notice To Alabama Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines, or confinement in prison, or any combination thereof.

**Notice to Arkansas, Louisiana, Rhode Island & West Virginia applicants:** Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to California applicants:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Notice to Colorado applicants:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Notice to District of Columbia applicants:** WARNING: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.

**Notice to Florida applicants:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Notice To Kansas Applicants:** Any person who commits a fraudulent insurance act is guilty of a crime and may be subject to restitution, fines, and confinement in prison. A fraudulent insurance act means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy, or a claim for payment or other benefit pursuant to an insurance policy, which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

**Notice to Kentucky applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Notice to Maine applicants:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Notice to Maryland applicants:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice To Missouri Applicants:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice To Minnesota Applicants:** Any person who knowingly and with intent to defraud any Insurance company or Another person, files an application for insurance containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and MAY subject such person to criminal and civil penalties.

**Notice to New Jersey applicants:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Notice to New Mexico applicants:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMAITON IN AN APPICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**Notice to New York applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Notice to Ohio applicants:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Notice to Oklahoma applicants: WARNING:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Notice to Oregon applicants: WARNING:** Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Notice to Pennsylvania applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Notice to Tennessee & Virginia and Washington applicants:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Notice To Vermont Applicants:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law

**NOTICE TO ALL OTHER APPLICANTS:**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

## Declaration And Certification

**By signing this application, the applicant warrants to the company that all statements made in the underwriting submission and any supplements and attachments thereto about the applicant and its operations are true and complete, and that no material facts have been misstated or misrepresented in this application or have been suppressed or concealed.  Completion of this form does not bind coverage.**

**The applicant agrees that if after the date of this application, any incident, occurrence, event or other circumstance should render any of the information contained in this application or any other documents submitted in connection with the underwriting of this application inaccurate or incomplete, then the applicant shall notify the company of such incident, occurrence, event or circumstance and shall provide the company with information that would complete, update or correct such information. Any outstanding quotations or binders may be modified or withdrawn at the sole discretion of the company.**

**Completion of this form does not bind coverage. The applicant’s acceptance of the company’s quotation is required before the applicant may be bound and a policy issued. The applicant agrees that this application and any other documents submitted in connection with this application, if the insurance coverage applied for is written, shall be the basis of the contract with the insurance company, and be deemed to be a part of the policy to be issued as if physically attached thereto. The applicant hereby authorizes the release of claims information from any prior insurers to the company.**

**The applicant agrees to cooperate with the company in implementing an ongoing program of loss-control and will allow the company to review and monitor such programs that the applicant undertakes in managing its medical professional exposures.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Applicant |  | Signature of Agent/Broker |
|  |  |  |
| Title |  | Date |
|  |  |  |
| Date |  | Signed by Licensed Resident Agent |
|  |  | (Where Required By Law) |