Desired effective date: _____

## 1. GENERAL INFORMATION

Name of Applicant: _____

Address: _____

City: _____ State: _____ County: _____ ZIP: _____

Contact for Inspection: _____ Email Address: _____

Website URL: _____

## 2. APPLICANT INFORMATION

Applicant is:

☐ Not-for-Profit ☐ For-Profit ☐ Other (describe): _____

Annual Budget: $ _____ Years Operational: _____

Is Applicant licensed by state or local authorities: ☐ Yes ☐ No

**If yes,** name the authority and provide copies of licenses: _____

## 3. RECORD OF EXISTING INSURANCE (must be fully completed):

| Coverage | Company | Limits | Premium | Effective Date | Retro Date |
|---|---|---|---|---|---|
| Professional Liability | | $ | $ | | |
| General Liability | | $ | $ | | |
| Excess and/or Umbrella | | $ | $ | | |

a. If no insurance exists, is this a new venture? ☐ Yes ☐ No
**If no,** explain: _____

b. Is expiring professional liability coverage on a claims made policy? ☐ Yes ☐ No Retroactive Date: _____
If yes, do you desire prior acts coverage? ☐ Yes ☐ No

c. Does this policy provide Physical/Sexual Abuse Coverage? ☐ Yes ☐ No
If yes, is this a sublimit? ☐ Yes ☐ No Limit: $ _____

d. Is coverage claims made? ☐ Yes ☐ No
Retro Date: _____ What are the "sublimits"? _____

e. CLAIMS HISTORY
Has the applicant had **ANY** Professional Liability or General Liability claims and/or incidents (including Physical/Sexual Abuse) that may give rise to a claim in the past 5 years? ☐ Yes ☐ No
**If yes,** please describe in detail—date claim reported, date of loss, allegations, amount reserved/paid, current status (open or closed). Attach an additional sheet if necessary.

## 4. PHYSICAL AND SEXUAL ABUSE

a. Does your employment application include questions about whether the individual has ever been convicted for any crime, including sexual-abuse related offense? ☐ Yes ☐ No

b. Does your state permit you to do criminal background investigations? ☐ Yes ☐ No
**If yes,** do you routinely request and receive such background investigations? ☐ Yes ☐ No

c. Do you verify employment related references? ☐ Yes ☐ No
**If yes,** by what method? ☐ Telephone ☐ In person

d. Does your organization conduct a personal interview? ☐ Yes ☐ No

e. Do you have a plan that monitors staff in day-to-day relationships with clients? ☐ Yes ☐ No

f. Have you ever had an incident which resulted in an allegation of physical/sexual abuse? ☐ Yes ☐ No
**If yes,** please describe in detail each incident in a separate attachment.

## 5. RISK MANAGEMENT

a. Does management have a written "safety program"? ☐ Yes ☐ No
**If yes,** does it include the following elements?
   i. Loss control: ☐ Yes ☐ No
   ii. Identification and investigation of potential claims: ☐ Yes ☐ No
   iii. Safety/security controls and procedures: ☐ Yes ☐ No
   iv. Written emergency plan including evacuation and transportation: ☐ Yes ☐ No

b. Are staff members made aware of procedures in the event of an emergency? ☐ Yes ☐ No

c. Do you have a fall prevention program? ☐ Yes ☐ No
**If yes,** does it include the following elements?
   i. An assessment tool for determining residents who are at risk of falling: ☐ Yes ☐ No
   ii. Falls monitored and tracked so as to assess patterns or trends: ☐ Yes ☐ No
   iii. Handrails provided in bathrooms and halls: ☐ Yes ☐ No
   iv. Call buttons operational in all rooms: ☐ Yes ☐ No
   v. 24-hour "awake" staff on duty: ☐ Yes ☐ No

d. If you have Alzheimer's residents, please answer the following.
   i. Is there a specialized unit to handle only these residents? ☐ Yes ☐ No
   ii. Is elopement risk assessment performed on the resident at the time of admission? ☐ Yes ☐ No
   iii. How often are assessments performed ? ☐ Quarterly ☐ Annually
   iv. Does staff report wandering behavior to facility administrator or social worker? ☐ Yes ☐ No
   v. How many elopements have occurred in the past 12 months? _____
   vi. How are residents at risk for wandering protected? Check as applicable:
   ☐ All doors alarmed ☐ Wanderguard or similar system used ☐ Other (describe): _____

## 6. ADMISSION POLICIES

a. Is a comprehensive nursing assessment completed for new residents? ☐ Yes ☐ No For re-admissions? ☐ Yes ☐ No

b. How frequently is the nursing assessment repeated (check all that apply)? ☐ Quarterly ☐ Monthly
☐ Other (list): _____

c. Who completes admission assessments? _____

d. Does the nursing assessment include these evaluations (check all that apply)?

Mobility Limitations? ☐ Yes ☐ No
History of prior injuries? ☐ Yes ☐ No
Required Assistance? ☐ Yes ☐ No
History of Falls? ☐ Yes ☐ No
Disorientation, history of wandering or elopement? ☐ Yes ☐ No
History of skin problems? ☐ Yes ☐ No
Psychiatric history? ☐ Yes ☐ No
Cognition limitations? ☐ Yes ☐ No

e. Does the facility obtain advance written consent from the resident or guardian that allowed the facility to provide emergency medical care when it is needed? ☐ Yes ☐ No

f. Do you accept residents who are a threat to themselves or others? ☐ Yes ☐ No

g. Is a current (within last 60 days) physical required before admission? ☐ Yes ☐ No

**7. MONITORING AND CONTROLS**

a. Do residents have their own attending physician? ☐ Yes ☐ No
**If no,** who performs the role of the attending physician? _____

b. Are written orders from an attending physician required for the following (check all that apply)?
Admission ☐ Yes ☐ No
Any other therapy/treatment? ☐ Yes ☐ No
All drugs and medications? ☐ Yes ☐ No
Restraints? ☐ Yes ☐ No
Special dietary requirements? ☐ Yes ☐ No
Facility or hospital transfers? ☐ Yes ☐ No

c. Who determines if the resident must be transferred to another facility for further medical diagnosis or treatment? _____

d. Who determines if the resident's needs are beyond the scope of the services provided by the facility? _____

e. Fully describe the involuntary move-out criteria.

f. In the past 12 months, how many residents have involuntarily been moved from the facility? _____
Describe the reasons.

**PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:**

1. Employment application
2. Currently valued loss runs
3. Copies of state licenses
4. Copies of D.O.H. or other inspections
5. Property ACORD form 125 and 140 for each location to be insured if property coverage is desired

THE NAMED INSURED **AND** FACILITY DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, IT WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT, INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

**Notice applicable in most states:** 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

**I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.**

***NOTE:*** *Application must be signed and dated by* ***both applicant and agent.***

**APPLICANT SIGNATURE PANEL**

Authorized signature

Date

Typed or printed name: _____

Title: _____

**AGENT SIGNATURE PANEL**

Authorized signature

Date

Typed or printed name: _____

Title: _____

LOCATION INFORMATION SUPPLEMENT ▶

# Location Information **Supplement**

**Please complete a separate copy of this supplement for each location to be insured.**

**1. LOCATION NUMBER**: _____

Number of beds at this location: _____

a. Name of Facility (if different from named insured): _____

b. Address: _____

Information that concerns this facility:

a. Year of construction: _____

b. Number of stories in building: _____

c. Number of stories occupied by applicant: _____

d. Was the building occupied by the insured at this location built specifically for LTC occupancy? ☐ Yes ☐ No

**If no,** has it been modified so that it has necessary safety and security devises as required by Federal, State and local authorities?

☐ Yes ☐ No

e. Protective Devices

☐ Automatic Sprinklers

☐ Heat Sensors

☐ Smoke Detectors

f. Number of fire escapes: _____

g. Swimming pool? ☐ Yes ☐ No

h. Enter year of updates in: Construction: _____ Plumbing: _____

i. ☐ Owned ☐ Leased

**NOTE: Attach Property ACORD forms 125 and 140.**

**2. DESCRIPTION OF SERVICES PROVIDED**

☐ **Basic Care/Independent Living:** Basic Care is defined as non-medical, aged including developmentally disabled and trained intellectually disabled persons. Residents are 100% ambulatory. The goal of the facility is to provide a protective environment where the client is responsible for his/her own care.

**Number of Licensed Beds:** _____ **Number Occupied:** _____

☐ **Intermediate Care/Assisted Living:** Intermediate care is defined as limited medical care provided. All non-ambulatory residents are on the ground floor if the facility is more than one story. Usually 10% or less of the population will include residents with dementia. The care provided includes help with daily living and personal care issues such as walking, and meals. Dispensing of medication prescribed by each clients' personal physician is acceptable.

**Number of Licensed Beds:** _____ **Number Occupied:** _____

☐ **Alzheimer's Care:** Includes residents who are senile—aged; up to and including those with fully developed Alzheimer's disease.

**Number of Licensed Beds:** _____ **Number Occupied:** _____

☐ **Skilled Care:** Skilled Care provides more intensive care that goes beyond intermediate or assisted living care and usually provides complex nursing such as IVs, tube feeding and critical medication dispensing.

**Number of Licensed Beds:** _____ **Number Occupied:** _____

## 3. RESIDENT CENSUS

| Current Age Groups | | |
|---|---|---|
| Age Group | Number of beds Designated/Licensed | Number of occupied beds |
| Less than 21 | | |
| 21–49 | | |
| 50–55 | | |
| Over 55 | | |

| Current Patient Census—Residents receiving services related to: | | |
|---|---|---|
| Service | Number of Ambulatory | Number of Non-Ambulatory |
| Alzheimer's | | |
| Aged but mentally functional | | |
| Aged but physically functional | | |
| Aged but mentally and physically functional | | |
| Other | | |

NUMBER OF RESIDENTS USING:

a. Wheelchairs: _____ Canes: _____
   Walkers: _____ Scooters: _____

b. Total Number of residents at this location: _____

## 4. CURRENT ADMINISTRATION

| Position | Name | Years in this position as this facility | Years of experience in this position | Hours worked per week | Employee or independent contractor? |
|---|---|---|---|---|---|
| Administrator | | | | | |
| Director of Nurses (DON) | | | | | |
| Medical Director | | | | | |
| Risk Manager | | | | | |

## 5. ADMINISTRATOR INFORMATION

a. Who is in charge when the administrator is absent (provide name and title)? _____

b. How many administrators has the facility employed in the past 10 years? _____

## 6. STAFFING RATIO

Provide the total number of standard daily staff working on each shift:

| Staff Member | Day Shift (First Shift) | Evening Shift (Second Shift) | Night Shift (Third Shift) | Does the staff member carry their own malpractice insurance? |
|---|---|---|---|---|
| Contracted Physician(s) | | | | ☐ Yes ☐ No |
| DON/ADON | | | | ☐ Yes ☐ No |
| RN (Graduate Nurses) | | | | ☐ Yes ☐ No |
| LPN (Practical Nurses) | | | | ☐ Yes ☐ No |
| CNAs | | | | ☐ Yes ☐ No |
| Resident Assistants | | | | ☐ Yes ☐ No |
| Medication Aide | | | | ☐ Yes ☐ No |
| Other | | | | ☐ Yes ☐ No |